system for verified diagnoses of STI/HIV, that uses an index-chosen method per partner (email, text messaging, postal letter or a gay dating site; anonymous or non-anonymous). SAT was piloted at the Public Health STI clinics in Amsterdam and Rotterdam, the Netherlands. It was offered additional to counselling by the nurse.
Method We evaluated SAT use and effectiveness from March-July 2012. Numbers/method of sent SAT notifications were extracted from the SAT database, and epidemiological data from electronic patient records. Determinants for SAT use (age, sex, ethnicity, partners, STI) were assessed using logistic regression analysis.
Results Of 1184 index-clients receiving a SAT code, 160 (14%) notified through SAT. They sent 588 notifications (median 2), 82% by text messaging and 16% by email; 86% was non-anonymous. Univariate analysis of SAT use in heterosexuals showed that people with only 1 partner used SAT less often than others; this was the only significant predictor. In MSM, the STI diagnosed was the only significant univariate factor, with MSM with syphilis using SAT more often than MSM having other STI. Among all 67 SAT users in Rotterdam, 56% (225/402) of their eligible partners were notifiable, and 95% (213/225) of those were notified using SAT. In 17 MSM, 36% (87/239) of eligible partners were notifiable, and 97 (111% of 87) were notified in SAT. Of all notified partners, 56% entered SAT to see the STI they were notified for, and 20% visited the STI clinic in Amsterdam/Rotterdam. STI positivity in partners was lower in those notified by SAT (28%, n = 116) than in those with contact cards (45%, n = 152; $p < 0.001$).
Conclusion SAT is a valuable addition for supporting partner notification and management, although challenges as non-notifiable partners are not solved by SAT.

008.3 BARRIERS TO BACTERIAL STI SCREENING OF HIV+ MEN WHO HAVE SEX WITH MEN (MSM) IN HIV PRIMARY CARE SETTINGS

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L A Barbee, S Dhanireddy, S Tat, A Radford, J M Marrazzo. *University of Washington, Seattle, WA, United States*

Background In the U.S., bacterial STI disproportionately affect HIV+ MSM. Screening for STI in HIV care settings remains suboptimal, but barriers have not been fully elucidated.
Methods As part of a CDC initiative to increase STI screening among HIV+ MSM in care, we sought to (1) define current screening coverage, and (2) identify patient and provider related barriers to screening at the largest HIV clinic in the Pacific Northwest. We extracted aggregated testing data from electronic medical records, and created separate anonymous surveys for patients (written) and providers (electronic). All male clinic attendees seen during a 3-week period in 2012 were invited to participate; 110 MSM contributed. Of 33 clinic providers invited, 28 (85%) responded; 82% (23/28) were attending physicians.
Results From March 2011-September 2012, among 1,379 HIV+ MSM engaged in care, 38% had extragenital testing, 40% urine testing, and 80% syphilis serology at least once. Of patients surveyed, 71% reported having sex in the last 2 months. 31% described seeking STI screening outside of the HIV clinic; of those, reported reasons included: being "easier" (42%), preferring "anonymity" (21%), wanting "more frequent screening" (16%). Providers reported being unfamiliar with current CDC screening guidelines (32%) and uncomfortable with discussing sexual practises and performing a genital exam (21%). Many (68%) stated time was a major barrier. Eleven (40%) providers cited patients' reluctance as a barrier, reporting common patient excuses including: being unprepared (55%), testing elsewhere (82%) and preferring same-gender provider (27%). Asked about potential solutions, providers chose easier access to electronic-tracking of testing results (82%), access to results from other clinics (71%) and self-collection of specimens (57%).
Conclusion At a large academic HIV primary care clinic, STI screening was substandard, with providers reporting numerous barriers. Interventions to address these obstacles include implementation of an STI self-testing programme, and enhanced education for providers.

008.4 ONLINE ACCESS TO HOME STI SPECIMEN COLLECTION AND E-PRESCRIPTIONS LINKED TO PUBLIC HEALTH - IS A COMPARATIVE EFFECTIVENESS TRIAL FEASIBLE?

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[1]**F Spielberg**, [2]V Levy, [1]I Kapur, [3]S Lensing, [4]N Acevedo, [4]L Venkatasubramanian, [5]C Leivermann, [6]S Philip, [7]N Padian, [8]C Gaydos. *[1]George Washington University, Washington, DC, United States; [2]San Mateo County Health System, Stanford University, San Mateo, CA, United States; [3]University of Arkansas for Medical Sciences, Little Rock, AR, United States; [4]FHI360, Durham, NC, United States; [5]Contra Costa Health Services Department, Martinez, CA, United States; [6]Department of Public Health, San Francisco, San Francisco, CA, United States; [7]University of California, Berkeley, Berkeley, CA, United States; [8]Johns Hopkins University, Baltimore, MD, United States*

Background Online STI testing and treatment may improve access at lower cost and with higher acceptability than clinic-based services.
Methods We conducted a demonstration (non-significant-risk medical device) study of an online system for STI education, vaginal specimen collection for chlamydia, gonorrhoea, and trichomonas testing, treatment, and partner notification, in collaboration with 4 San Francisco Bay area health departments. English and Spanish speaking women (18–30 yr) were recruited over 3 months through various methods.
Results The website had 6,855 hits with a click through rate of 6.6%(450). Of 256 deemed eligible, 85%(217) enrolled. Among these, 54% (117) had not seen a clinician in the past year and 87%(142) had not had an STI test since last unprotected sex. Among those mailed a kit (213), 67% (143) returned the kit. Of these, 80% (115) of participants accessed test results online the same day results were posted, within 2 days (86%, 122) or by study end (92%, 131). STI prevalence was 5.6% (chlamydia and trichomonas). All STI infected participants received treatment either the same day (75%,6/8) at a pharmacy or within 7 days at a clinic (25%, 2/8). Internet recruitment reached the highest number of participants (100/217, 46%), while advertising on subways reached the highest number of positives (5/8, 63%). Of 106 participants completing follow-up surveys, 98% (104) indicated the site was easy to use and 98% (104) would recommend the project to a friend. No negative outcomes were reported. If participating in a future trial, 94% (100) would prefer an online system over clinic-based care.
Conclusions An online system for STI testing and treatment appears feasible, and highly acceptable to participants. We recommend a future comparative effectiveness trial to determine whether an online system can increase testing and treatment of STI infections at lower cost and with higher acceptability than clinic-based care.

008.5 SHOULD ALL PREGNANT WOMEN BE SCREENED FOR CHLAMYDIAL INFECTION AS RECOMMENDED BY CDC, OR ONLY THOSE YOUNGER THAN 25 YEARS AS RECOMMENDED BY USPSTF?

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G Tao, K Hoover. *CDC, Atlanta, GA, United States*

Background In the United States, chlamydia screening has been recommended for pregnant women of all ages by CDC, and for pregnant women younger than 25 years by USPSTF. The benefits of chlamydia screening are highly dependent on chlamydia prevalence. Very limited evidence, such as age-specific positivity in pregnant women, has been available to support these recommendations. We analysed data from a large commercial laboratory corporation with a substantial share of the U.S. market, with testing in all 50 states, to estimate the positivity of chlamydia among pregnant women.