barriers to ongoing testing within primary care. A Testing Month allows for a range of targeted initiatives but is short enough to maintain momentum. It is a model that translates easily to other smaller jurisdictions and supports relationships between key stakeholders.

Disclosure of interest No commercial contributions were received.

P13.09 EVALUATION OF A PILOT TO IMPROVE PRIMARY CARE SEXUAL HEALTH SERVICES IN ENGLAND: ANALYSIS OF CHLAMYDIA TESTING AND DIAGNOSIS RATE CHANGES

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Introduction Provision of sexual health services in primary care is necessary to reduce STIs, such as chlamydia. We piloted an educational training programme, based on the theory of planned behaviour, for general practice staff with the aim of increasing chlamydia and HIV testing, and provision of condoms and contraceptive information (3Cs and HIV).

Methods The pilot was delivered with a step wedge design over three phases. Chlamydia testing and diagnosis rates pre and post-training were compared separately for men and women using a multivariable negative binomial regression model with general practice fitted as a random effect. Month of test and practice population size were adjusted for and an interaction between the intervention and area of implementation fitted.

Results 460 general practices agreed to participate in the pilot. These conducted 2448 tests across the pre and post intervention period. Intention to treat analysis showed decreased median test and diagnoses per month post-intervention (2.68 vs 2.67; 0.14 vs 0.13 respectively). The multivariable regression analysis did not find a significant change in testing or diagnoses of men. There was a significant increase in testing (IRR 1.15 CI 1.01–1.31) of women but no change in diagnoses (IRR 0.98 CI 0.84–1.18). Interaction between the intervention and area of implementation was found in both testing rate models for women.

Conclusion This large national pilot found that educational support sessions slightly increased chlamydia testing in women within general practices after they received the 3Cs and HIV training but not diagnoses. The area of implementation had an impact on the programme's effect, so further exploration of the factors that contribute to this increase is required.

Disclosure of interest statement Public Health England is funded by the UK Department of Health.

P13.10 CLUB DRUG USE, SEXUAL BEHAVIOUR AND STI PREVALENCE IN SEXUAL HEALTH CLINIC ATTENDEES IN A UK CITY

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Introduction Club drug (CD) use is increasing, but use in non-swinging heterosexuals and associations with sexual behaviour and STI prevalence is undocumented worldwide.

Methods Sexual health clinic attendees aged ≥16 years were invited to complete a questionnaire on sexual behaviour and drug use for two weeks per quarter in 2013–14. CD use was compared with age, sexuality, sexual behaviour and STI rates to determine any associations.

Results 2332 questionnaires were analysed; mean age 27 (16–81) years; 52% male; 75% white British; 82.6% heterosexual; 11% MSM.

Lifetime CD use was 38%; 36% of these had used in the past 4 weeks (active use). CD use was higher in MSM than heterosexuals, in heterosexual males than females, and in those <25 years.

Self-perceived risky sex was higher in MSM than heterosexuals using mephedrone (OR4.38 p = <0.0001), ecstasy, GHB and ketamine. MSM reported more difficulty in controlling their drug use (OR1.6, p = 0.02).

Lack of condom use in the past 12 months in heterosexual CD users and non-users was the same, but CD users were more likely to have ≥3 partners (OR2.3 p = 0.0001). Heterosexual CD active users were more likely to have had anal sex in the past 4 weeks (OR2.6, p = 0.0001); recent heterosexual anal sex was associated with chlamydia (OR2.41, p = 0.0007).

There were no associations between lifetime or active use of CD and STI prevalence in heterosexuals (lifetime OR0.91, p = 0.54; active OR1.02, p = 0.94) or MSM (lifetime OR1.30, p = 0.35; active OR1.21, p = 0.63).

Conclusion This is the first sexual health clinic study in the UK to assess CD use in all sexualities. Lifetime use of CD was high. CD use in heterosexuals was associated with higher risk sex but lifetime or recent CD was not associated with a higher prevalence of STIs. STI acquisition is multifactorial and is not solely determined by CD use.

Disclosure of interest statement No disclosures of interest.

P13.11 SELF-TAKEN EXTRAGENITAL SAMPLING FOR CHLAMYDIA AND GONORRHOEA IN WOMEN – IS IT ACCEPTABLE? FEEDBACK FROM A SELF-SWAB AND CLINICIAN-SWAB TRIAL

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Introduction Self-taken vulvovaginal swabs analysed by nucleic acid amplification tests (NAATs) for chlamydia and gonorrhoea are standard practice worldwide. Extra-genital sampling (rectum and pharynx) is becoming increasingly important in women, with evidence that urogenital sampling alone may miss infections. Yet, little is known about women's views of extra-genital sampling. We explored the acceptability of self-taken extra-genital samples for women as part of a clinician versus self-taken extra-genital sampling study.

Methods Women attending a sexual health clinic were invited to participate in a 'swab yourself' trial. After randomisation, both clinician and self-taken samples for chlamydia and gonorrhoea NAATs from vulvovaginal, pharyngeal and rectal sites were taken. Participants were then invited to complete a questionnaire about the extra-genital sampling.

Results 400 surveys were returned from 402 women recruited (response rate >99%), age range 17–57 (mean 25.2) years.

75% disagreed/strongly disagreed with the statement 'taking my own samples was difficult'. 72% agreed/strongly agreed that they felt confident taking their own swabs but 30.5% agreed/strongly agreed they felt uncomfortable taking their own swabs; of these 53 (43%) stated they had never had anal sex. 42% agreed/strongly agreed that they would prefer to take their own samples compared to 34% who agreed/strongly agreed they would prefer clinician-taken swabs. 66% agreed/strongly agreed they would be happy to take the samples themselves in a non-clinic setting.

Free comments covered themes of 'more confidence if had clinician samples taken before', 'concerns if self-swabbing would give correct results'. Nine commented specifically on discomfort, but none disagreed with the statement 'I would be happy to take my own swabs in a non-clinic environment'.

Conclusion Extra-genital sampling was highly acceptable to the majority of women, with high levels of confidence and low reports of discomfort. This has positive implications for the future of extra-genital testing in women, especially in non-clinic settings.

Disclosure of interest statement Dr Janet Wilson has received honoraria and travel and accommodation expenses from BD Diagnostics, and research grants in the form of diagnostic kits from Hologic/Gen-Probe.

P13.12 HIV SENSITISATION HEALTH CARE WORKER TRAINING IN VANUATU

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Introduction College of Medicine, Nursing and Health Sciences (CMNHS) in collaboration with The Albion Centre (Albion) conducted a 2-day HIV Sensitisation workshop in Port Vila, Vanuatu from 10th – 11th March 2015. The HIV Sensitisation training is an activity of the Pacific Health Worker Support Project.

The HIV Sensitisation training aims to positively reshape health workers' perceptions about HIV and people from key populations (KP), including sex workers, men who have sex with men and PLHIV, by:

- Addressing shortfalls in knowledge and understanding about HIV;
- Demystifying/clarify personally-held attitudes and beliefs about HIV and PLHIV; and
- Learning about the perspectives and experiences of KP.

Methods This training was provided by two representatives from KP groups, who had previously completed training-of-trainers (ToT) workshops in Suva, Fiji.

Results Altogether 24 health workers, including representation from all six Vanuatu provinces attended the two-day workshop. The workshop was evaluated using two mechanisms: a Knowledge, Attitudes and Practices Survey (KAPS) administered to participants at pre and post training; and an anonymous course evaluation form, administered to participants at post training. Participants demonstrated improvement in all areas; however a paired-samples t-test analysis indicated that this improvement was significant only in the area of improved knowledge, across the group. Some of the key themes which emerged from the evaluations included that the training: raised their awareness of KP and challenged their personal attitudes; heightened their awareness of how stigmatising language and behaviour can alienate KP; and was needed through-out the healthcare workforce in Vanuatu.

Conclusion Overall the HIV Sensitisation Training workshop in Vanuatu was a success. The 2-day training raised their awareness of KP and challenged their personal attitudes; heightened their awareness of how stigmatising language and behaviour can alienate KP; and was needed through-out the healthcare workforce in Vanuatu.

Disclosure of interest statement The Pacific Sexual Health and HIV Health Worker Support Project is funded by Australian aid's Regional HIV/AIDS Capacity Building Program (2012–2015). No pharmaceutical grants were received in the development of this study.

P13.13 SEXUALLY TRANSMITTED INFECTION CARE IN TERMINATION OF PREGNANCY CLINICS IN THE NETHERLANDS

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Introduction Women attending termination of pregnancy (TOP) clinics are a risk group for STIs, and those with STIs are at increased risk of developing postabortal complications. We explored what STI care is provided in Dutch TOP clinics, and we compared these results with the United Kingdom (UK).

Methods A qualitative study including 14 semi-structured interviews with health care professionals (HCPs) in TOP clinics (Netherlands: 9, UK: 5). Interviews were recorded, transcribed, and analysed by thematic content analysis.

Results In the Netherlands, azithromycin prophylaxis is routinely prescribed after a surgical TOP, but not routinely after a medical TOP. STI tests are only offered by Dutch clinics if clients are considered at high STI risk based on the intake questionnaire. High costs of STI testing form the main barrier for clients not accepting STI testing, as costs are not covered by all health insurances. Alternatively, some clinics refer women to the Public Health Service (PHS), where STI testing is free for high-risk groups. This also involves barriers as not all women go for testing. HCPs in TOP clinics that collaborate with PHSs in the Sense program (sexual and reproductive health care) experience less barriers, as free STI testing is then offered on location of the TOP clinic. Sexual health counselling in TOP clinics is often limited to birth control conversations, also in the UK. The major difference between Dutch and UK TOP clinics is that UK clinics (who are not privately owned) offer free STI testing to all clients.

Conclusion HCPs in Dutch TOP clinics consider STI testing an important part of their service, but financial barriers prevent STI testing on location. In the UK, free STI care is broadly implemented in TOP clinics. Collaboration with PHSs (in Sense program) could improve STI testing and sexual health counselling in Dutch TOP clinics.

Disclosure of interest statement The study is funded by the RIVM. No pharmaceutical grants were received in the development of this study.