

previous 3 months) in a randomised controlled trial of HIV self-testing (FORTH). Participants completed a baseline survey at enrolment. We constructed a HIV Testing Self-Efficacy (HTSE) scale measuring confidence in one's perceived ability to undertake HIV testing comprising 8 items ('not at all confident' = 0 to 'completely confident' = 4; Cronbach's  $\alpha$  = 0.81). Total HTSE score consisted of the sum of scores for all items. We determined the factors associated with HIV testing frequency in the past 12 months and perceived likelihood to self-test in the future using logistic regression.

**Results** A total of 355 GBM were included. Median age was 33 years (inter-quartile range [IQR] = 26–41), and 63% were Australian-born. Overall, 95% reported having previously tested for HIV, and 65% reported being 'very likely' to self-test for HIV. The median HTSE score was 26 (IQR = 23–29, range = 8–32). In multivariate analysis, factors independently associated with  $\geq 3$  HIV tests in past 12 months were: HTSE score (adjusted odds ratio [AOR] = 1.07 for one unit increase, 95% CI = 1.02–1.13,  $p$  = 0.011); and  $>10$  partners in past 6 months (AOR = 1.85, 95% CI = 1.10–3.12,  $p$  = 0.020). Only HTSE score was associated with being 'very likely' to self-test (OR = 1.08, 95% CI = 1.03–1.13,  $p$  = 0.001).

**Conclusion** HIV testing self-efficacy is independently associated with testing frequency and likelihood to self-test. Improving GBM's confidence in HIV testing, by improving their knowledge and experience may lead to higher testing frequency. Future longitudinal analysis will provide information about the causal pathways between HTSE, testing frequency and actual self-testing measured in the trial.

**Disclosure of interest statement** The research is funded through a NHMRC Program grant from the NHMRC and self-test kits were purchased from OraSure Technologies Inc. (Bethlehem, PA, USA). The Kirby Institute and the Centre for Social Research in Health receive funding from the Australian Government Department of Health.

#### P17.11 PUBLIC SEXUAL HEALTH CLINICS INCREASE ACCESS, HIV TESTING AND RE-TESTING AMONG HIGHER RISK GAY AND BISEXUAL MEN

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**Introduction** Most HIV diagnoses in Australia occur in gay and bisexual men (GBM), however the majority of higher-risk GBM are testing for HIV at less than recommended frequency (3–6 monthly). In recent years, public sexual health clinics (SHCs) have implemented a range of initiatives to increase access to HIV testing in GBM including express clinical models, after-hours/drop-in services, online-booking, rapid-testing, and SMS reminders. We measured HIV testing trends among GBM at New South Wales (NSW) SHCs in the time period of the initiatives.

**Methods** We utilised routinely collected data from 33 SHCs in NSW, and calculated the following annual indicators among HIV negative GBM from 2009–2013: number attending clinics; proportion tested for HIV at least once; proportion re-tested within 1–12 months; and HIV positivity. Indicators were calculated for all GBM and higher-risk GBM ( $>5$  partners in last 3 months or previous sexually transmissible infection diagnosis). Chi-square tests were used to assess trends over time.

**Results** In the 5-year period, 29,623 unique HIV-negative GBM attended participating SHCs and 21% were higher-risk men. Among all HIV-negative GBM, there were significant increasing trends ( $p$ -values  $<0.001$ ) in: the number of individuals attending (4,748 in 2009 to 7,387 in 2013, relative increase:56%); proportion tested (73% to 85%, relative increase:16%); and proportion re-tested within 1–12 months (42% to 52%, relative increase:24%). Among higher-risk GBM, greater increases were observed in individuals attending (934 to 1,667, relative increase:78%) and proportion re-testing (51% to 64%, relative increase:26%), but a smaller change in the proportion tested (89% to 93%, relative increase:5%), though starting from a higher base (significant increasing trends,  $p$ -values  $<0.001$ ). HIV-positivity in all GBM fluctuated (1.3–1.1%) with no significant trend over time ( $p$  = 0.790).

**Conclusion** NSW SHCs have successfully increased attendance and HIV testing among GBM, particularly in higher-risk men. HIV-positivity suggests that testing increases have been well-targeted to higher-risk GBM. There is potential to further improve testing uptake and re-testing.

**Disclosure of interest statement** ACCESS study is funded by the NSW Ministry of Health and the Victorian Department of Health.

#### P17.12 PROVIDING EVIDENCE TO SUPPORT COMMUNITY BASED HCT SCREENING PROGRAMS – THE VOICE OF VULNERABLE RURAL YOUTHS IN SOUTH-WEST NIGERIA

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**Background** Low uptake of HIV testing services (HCT) in healthcare settings was reported by a study carried out in the South-south region of Nigeria. High acceptability of home based HCT has been reported in a previous study in South Africa. Home based testing also increased uptake of screening for HIV and syphilis among previously untested individuals in Brazil.

**Methods** A cross sectional descriptive study was carried out among out-of-school youths in two rural communities in south-west Nigeria. The aim of the study was to determine the prevalence of HIV testing and the preferred venue for the tests. Multistage sampling method was used to select 360 respondents in each of the communities. Information was collected by trained interviewer's using a pretested questionnaire. Data was analysed using Epi info statistical software version 3.6.3 and IBM SPSS version 20. Bivariate and multivariate analysis was carried out at  $p < 0.05$ .

**Results** Mean age of respondents was  $19.85 \pm 2.71$ , majority were males (55.0%) and had at least secondary school education (66.7%). Most (86.5%) had heard of HCT, the commonest source of information being TV/Radio (49.0%), Health worker (14.2%), friends/family members (12.3%). Only 14.6% had been tested for HIV. Among this group, 8.3% were tested for medical

reasons and 6.3% tested voluntarily. Testing was conducted at the health facility and laboratories in 11.3% out of the 14.6% of respondents that had been tested. Youths who had at least a secondary school education and use condoms were more likely to have been tested. Majority (78.0%) were willing to be tested among this group, more than a third (36.8%) will prefer to be tested within the community (workplace, school, home or mobile outreach).

**Conclusion** Rural youths in this study are willing to be tested for HIV. Provision of this service within the community will improve access and uptake.

**P17.13 EVALUATING THE IMPLEMENTATION OF COUPLES HIV COUNSELLING AND TESTING (CHCT) AMONG MOST AT RISK POPULATIONS: AN EXPERIENCE FROM BALI, INDONESIA**

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**Introduction** A pilot project of couples HIV counselling and testing (CHCT) was conducted among most-at-risk populations (MARPs) in Bali from April to September 2013. The project provided financial incentives for outreach workers and counsellors during the implementation. The study evaluated the process of CHCT program and explored the readiness to continue the program implementation.

**Methods** A mixed method study conducted in July–December 2013. The number of couples participated during and after the project were compared. Four focus group discussions were conducted with counsellors and outreach workers, while in-depth interviews conducted with 22 couples (men who have sex with men, female sex workers and their partners).

**Results** There were 100 couples participated during the 6 month project (average: 16–17 couples/month). The number, however, decreased significantly with only 19 couples in the following 5 months (average: 3–4 couples/month). Due to the availability of incentives for staff, they were more active in searching and enrolling clients during the project than after the project. It was revealed that counsellors and outreach workers face more challenges in CHCT than in the individual VCT, particularly the issues of couples' separation, significantly increased workload, and a limited number of trained counsellors. Interviews with couples show the need of better services and supporting facilities such as after-hour services, treatment support system, computerised data management, one day laboratory service, and more friendly staff. Even though the level of knowledge was generally good, there were some misperceptions among couples regarding the natural history of HIV infection, thus complete information during the counselling process is required.

**Conclusion** CHCT among MARPs in Bali can be sustainable, however, some kind of incentives and training for counsellors are needed to motivate staff, while promotion of CHCT and improved facilities are required to attract couples and to provide better services.

**Disclosure of interest statement** The study is funded by National AIDS Commission of Indonesia and HIV Corporation Program for Indonesia (HCPI).

**P17.14 BARRIERS AND FACILITATORS TO COUPLES HIV TESTING AND COUNSELLING AND VIEWS ON INCENTIVES FOR COUPLES TESTING: A QUALITATIVE STUDY FROM ZIMBABWE**

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**Introduction** Couples HIV testing (CHTC) has greater health impact and is more cost-effective than individual testing. Despite widespread promotion, uptake remains sub-optimal. We explored i) barriers and facilitators to CHTC, ii) anticipated impact of incentives on CHTC uptake and linkage to post-test services, iii) incentives which might stimulate CHTC.

**Methods** Focus group discussions (FGDs) were held among rural Zimbabweans. FGDs started with role plays depicting couples with differing circumstances to stimulate discussion and were transcribed verbatim and analysed thematically.

**Results** Four FGDs were held with 17 men and 17 women. Both sexes said men were opposed to CHTC; barriers were more pertinent to men. The main barrier was fear of HIV diagnosis which respondents firmly believed would result in relationship dissolution. Participants understood discordancy as possible but were unaware/had not internalised benefits of discordant couple interventions. Discussions focused on the difficulty of broaching CHTC within a relationship as it raises uncomfortable issues of distrust. Women reportedly broached CHTC if they suspected infidelity, often threatening suicide or relationship dissolution in the event they tested positive. Interventions that took the decision out of the couple's hands e.g. perceived 'mandatory testing' for prevention of mother-to-child-transmission were viewed as facilitators for CHTC. Participants unanimously agreed that incentives would make discussing CHTC easier as the focus would shift to incentives. Participants said small items such as food and soap would stimulate CHTC. Participants were against monetary incentives as these would likely be abused or lead to conflict. Small, fixed incentives were preferred over larger lottery-based incentives. Participants said couples who received incentives to test would be more likely to link to post-test services with expectation of receiving additional rewards.

**Conclusion** This study suggests that small non-financial incentives may increase uptake of CHTC and subsequent linkage to care. We propose to test this intervention in a cluster randomised trial.

**Disclosure of interest statement** The study was funded by the Integrated Support Programme and no conflicts of interest are declared.

**P17.15 BARRIERS AND FACILITATORS TO UPTAKE OF CERVICAL CANCER SCREENING AMONG CLIENTS ATTENDING INTEGRATED HIV/SEXUAL AND REPRODUCTIVE HEALTH CLINICS IN ZIMBABWE**

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