healthcare elsewhere. This is of more concern for those at higher STI risk for example the younger, MSM and those with concurrent partners, although higher proportions of younger people reported Chlamydia testing elsewhere. We used unsafe sex as one measure of exposure to risk, which does not take into account characteristics of partner(s) and the wider sexual network. Further improvements are necessary to reach those at-risk, including through effective, diverse service provision.

P4.61 SEXUAL IDENTITY, ATTRACTION AND EXPERIENCE IN BRITAIN: THE IMPLICATIONS OF USING DIFFERENT DIMENSIONS OF SEXUAL ORIENTATION TO ESTIMATE THE SIZE OF SEXUAL MINORITY POPULATIONS

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Introduction Sexual orientation encompasses three dimensions: sexual identity, attraction and behaviour. Many health and policy surveys and inequality monitoring activities collect data only on identity, while STI risk is primarily driven by behaviour. We present estimates of all three dimensions and examine the extent of their overlap, for men and women, and consider the implications of using the different criteria to estimate the size of sexual minority populations in Britain.
Methods Descriptive analyses of data from Britain's third National Survey of Sexual Attitudes and Lifestyles, a probability survey (15 162 people aged 16–74 years) undertaken 2010–2012 using a computer-assisted personal- and self-interviewing (CAPI/CASI). A standard question was used to define sexual identity (CAPI). Participants were also asked to describe their sexual attraction according to a scale ranging from exclusively opposite-sex to exclusively same-sex (CAPI). Same-sex sex was defined as ever having had sex (including genital contact) with someone of the same sex (CASI).
Results A lesbian, gay or bisexual (LGB) identity was reported by 2.5% of men and 2.4% of women, whilst 6.5% of men and 11.5% of women reported any same-sex attraction, and 5.5% of men and 6.1% of women reported ever experience of same-sex sex. This equates to approximately 5 73 000 men and 5 59 000 women in Britain currently self-identifying as LGB, less than half the number who are estimated to have ever had same-sex sex: 1,262,000 men and 1,422,000 women. Of those reporting having same-sex sex in the past 5 years, 28% of men and 45% of women identified as heterosexual.
Conclusions Substantial incongruity exists between the three measures of sexual orientation on an individual level, particularly for women. The size of sexual minority populations will depend on the dimension of sexual orientation applied, the choice of which depends on context and purpose. Regardless, the decision to use a particular dimension should be made explicitly, with a clear rationale, and with awareness of the limitations of each.

P4.62 HIV TESTING PREFERENCES AMONG LONG DISTANCE TRUCK DRIVERS IN KENYA: A DISCRETE CHOICE EXPERIMENT

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Introduction Providing HIV testing to truck drivers in Africa is crucial but challenging. The introduction of HIV self-testing provides expanded service delivery options for clients, potentially increasing demand for services and expanding coverage – especially important for high-risk and difficult-to-reach populations. This study examines the preferences regarding HIV testing service delivery models, among long distance truck drivers in an effort to identify testing services that would appeal to this population.
Methods Using a discrete choice experiment, this study examines the drivers of choice regarding HIV counselling and testing among 305 truck drivers recruited from two roadside wellness clinics along major trucking routes in Kenya. Participants made trade-offs between characteristics of HIV testing service delivery models by making hypothetical choices in a series of paired HIV testing scenarios. Conditional logit models were used to identify the HIV testing characteristics driving the selection of preferred scenarios, and determine whether preferences interact with individual characteristics – especially HIV testing history.
Results Participants preferred free, provider-administered HIV testing at a roadside clinic, using a finger-prick test, with in-person counselling, undertaken in the shortest possible time. The strongest driver of choice was the cost of the test. Those who had never tested previously preferred oral testing and telephonic counselling, while those who were not regular testers favoured clinic based- over self-testing.
Conclusion The results of this study indicate that for the majority of participants – most of whom had tested before – the existing services offered at roadside clinics were the preferred service delivery model. The introduction of oral self-testing increases the options available to truck drivers and may even improve testing uptake for some, especially among those who have never tested before. However, these findings suggest the impact on HIV testing uptake of introducing oral self-testing may be limited in this population.

P4.63 DESIGNING HUMAN IMMUNODEFICIENCY VIRUS COUNSELLING AND TESTING SERVICES TO MAXIMISE UPTAKE AMONG HIGH SCHOOL LEARNERS IN SOUTH AFRICA: WHAT MATTERS?

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