program, in terms of HIV infections averted, far out-weigh the costs from the number of new infections generated from the early resumption of sex see Abstract O2-S2.02 table 1.

Conclusion The resumption of sexual behaviour during the wound healing period poses increased risk for the transmission and acquisition of HIV-1 for individuals. The early resumption of sex is of particular concern for programs that circumcise HIV+ men or a large proportion of men who are not HIV tested. However, at the population level, such behaviour seems less of a concern.

Abstract O2-S2.02 Table 1 Sexual behaviour with 6 weeks post MC

Percent having sex within 6 weeks post-MC	
Among all MC clients	24%
Among all MC clients who were sexually active by baseline survey	30%
Among all MC clients who had sexual partners at baseline	28%
For those having sex…	(N=54)
Mean number of sex acts in last 4 weeks	2 (min=1, max=12)
Mean number of partners	1.6 (min=1, max=4)
Reported at least one unprotected sex act	82%
Reported 2 or more sexual partners in period	26%
Report sex with a commercial sex worker or bar girl	4%
Resumed sex within first week of MC	22%
Resumed sex within first 2nd and 3rd weeks of MC	24%
Resumed sex 4+ weeks of MC	41%

O2-S2.03 FEASIBILITY OF GIVING HSV SEROLOGICAL TEST RESULTS BY MAIL AND PHONE

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Background Accurate serological tests for the herpes simplex virus have been commercially available since 1999. Despite this availability, they are offered infrequently. Concerns about the resources required for testing including time spent on counselling and follow-up are among the barriers to testing. The purpose of this study was to determine the feasibility of using letters and phone calls to give HSV-1 and HSV-2 serological test results and to document the resources used to deliver results and respond to subjects' concerns.

Methods Subjects were recruited from an urban STD clinic and tested for HSV-1 and HSV-2 as part of a multi-site study of HSV serological test performance (N=612). Subjects were offered the option of having an investigator mail or call with test results. Result letters included a one page hand-out on HSV-1 and HSV-2 and the phone number of an investigator who could address concerns. Number of phone calls received, time spent on the phone, level of subject distress, and request for referrals were documented. Descriptive statistics were calculated for all variables and data was examined for bivariate relationships using SPSS.

Results Sixty-seven per cent of the subjects requested that their results be mailed (n=410) and 33% requested that their results be given by phone (n=202). Approximately 6% of the subjects who received letters called for additional information. Seventy-one per cent of the calls took less than 5 min and only 2% required more than 10 min. A total of approximately 6.4 h were spent on the phone to give results and respond to questions. <1% of the subjects required multiple phone calls and less than 1% requested a referral to a clinician. Investigators rated 55% of subjects spoken to on the phone as not at all distressed, 31% as somewhat distressed, and 12% as very distressed. Distress was significantly associated with longer time on the phone, but not with testing positive for HSV-2 vs HSV-1.

Conclusions Delivery of HSV serological test results by phone or mail is feasible and requires minimum time on the part of providers.

O2-S2.04 TARGETING HIV PREVENTION EFFORTS ON HIV-INFECTED MEN USING CONDITIONAL CASH TRANSFER (CCT): DOES IT WORK?

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Background Preventing HIV infections in female spouses of HIV-infected men is limited by low HIV testing rates among these women who are at an increasingly high risk for HIV acquisition. We explored the effect of conditional cash transfer (CCT) on HIV-infected men for spouse testing and HIV status disclosure to their spouses.

Methods Using medical charts we identified all eligible HIV-infected married men receiving care at the PIMS HIV clinic, Islamabad. Selection criteria for CCT were sexually active married men receiving care >6 months including at least two counselling sessions whose spouses had never been tested for HIV (HIV status unknown). CCT was cash given to cover travel/accommodation (US $14 for out-town and US$ 5 for in-town) costs for bringing the spouse to the HIV clinic for testing. All study participants underwent a brief study questionnaire looking at patient demographics, visit history, factors influencing spouse testing, barriers to care and self-disclosure. The CCT acceptance rate was 90% among HIV-infected men. Outcome of interest was spouse testing and status disclosure to spouse at 6 months post CCT.

Results Of the 230 married men, 138 men (60%) had spouses' never tested/unknown status. Baseline disclosure of HIV status to wife was 29%, and median duration of receiving care was 14.3 months. From these 138 men we were able to contact and enrol 94 (68%) men for CCT; 53 (56%) brought their spouses for HIV testing within 4 months; 19 (20%) self-reported getting their wives tested elsewhere, and only 22 (24%) did not comply with the CCT conditionality. CCT improved disclosure of HIV status from baseline 29% to 62% ($p < 0.05$). Factors associated with spouse testing were men <50 years, high ART compliance score, and prior self-disclosure of status to one family member ($p < 0.05$).

Conclusions Even within the context of a socially conservative society CCT can significantly improve HIV testing rates for female spouses and self-disclosure of HIV status by HIV-infected men. Using CCT for timely prevention of HIV infection in wives and children of HIV positive men reduces risk and can be an effective strategy to overcome socio-cultural and financial barriers. Further studies are needed to explore cost-effectiveness of this approach in preventing new infections.

O2-S2.05 START WITH THE SOCIAL DETERMINANTS OF HEALTH TO TAILOR SEXUAL HEALTH PROMOTION FOR FIRST NATIONS, INUIT AND MéTIS YOUTH IN CANADA

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Background Sexual health promotion and approaches for the prevention of sexually transmitted and blood-borne infections (STBBI) should be tailored to the needs and realities of youth. Engaging youth and building their capacity is an important step in health promotion and has proven to be critical in the development of a promising initiative aimed at engaging First Nations, Inuit and Métis youth in Canada.

Methods Community consultative processes were used to engage First Nations, Inuit and Métis (FN/I/M) youth in the development of sexual health promotion and STBBI prevention approaches. Engagement began in 2008 through the establishment of a steering committee, which included FN/I/M youth stakeholders, with representatives from governmental and non-governmental agencies. The steering committee aimed to make effective use of relevant technologies and social media to reach and engage FN/I/M youth in Canada. In 2009, a workshop was held to enhance the involvement of youth to identify priorities for STBBI messaging and explore the best mediums to reach youth. The outcomes of this consultation process informed the development of capacity building social media pilot projects to reach FN/I/M youth.
Results FN/I/M youth identified the importance of taking a holistic approach by viewing sexual health through the lens of social determinants. Youth highlighted poverty, social support networks and education as major influences on sexual health outcomes for their peers. Key challenges youth noted included the lack of sexual health education and the need to strengthen social support networks. By tying in these determinants into promotion, youth identified themes such as addressing homophobia, and raising the importance of cultural relevancy to de-stigmatise sexual health within FN/I/M communities and to help youth to relate closer to messages. Youth also indicated that peer-to-peer social media methods were an ideal mechanism to convey messages. Many youth from across Canada were engaged in developing their own STBBI messages.
Conclusions Engaging FN/I/M youth as partners from concept onwards has led to an informed approach to the development of sexual health promotion and STBBI prevention messaging. Public health practitioners learnt youth need to be involved to gain credibility within this population, youth capacity building is important and taking a holistic social determinants approach in conceptualising messages is critical when reaching FN/I/M youth.

O2-S2.06 REDUCING SEXUAL RISK BEHAVIOUR AMONG YOUTH: THE DEVELOPMENT AND EFFECT EVALUATION OF AN INTERACTIVE ONLINE INTERVENTION FOR INDIVIDUALS AND THEIR SEXUAL NETWORK

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Background This study presents an intervention and its evaluation of an innovative approach to counteract barriers to safe sex and STI testing of youth aged 16–24.
Methods The intervention—http://www.vrijlekker.nl/—has been developed based on over 200 qualitative interviews with youth investigating barriers to safe sex and STI testing. Based on these interviews, training modules were developed which participants could follow online. These modules aimed at counteracting the individual barriers for safe sex and STI testing as well as removing impeding elements in the social and sexual network. The Information-, Motivation and Behavioural Skills (IMB) model (Fisher & Fisher) was used as the theoretical basis of the intervention. The training included filmed coaches that guided users throughout the intervention, thematic films, interactive text with personal feedback and sexual network tools. The modules were offered on a tailored basis to match each user's own cognitive & behavioural risk profile. This profile was established via an automated online intake. An evaluation was conducted comparing a demographically matched control group recruited prior to the launch of the intervention and an intervention group. Behavioural outcomes were compared at 6 month follow-up.
Results The evaluation included 2944 participants of whom 1553 completed the follow-up (mean age 19, SD 2.4). The intervention group used condoms significantly more often with their most recent casual partner [OR=1.82 95% CI 1.08% to 3.04%] and/or with their steady partner [OR=2.17 95% CI 1.48% to 3.18%] than the control group at 6 months follow-up. Over 170 000 unique persons used the intervention already during its first year, and more than 100 new users continue to do so every day. Some schools in the Netherlands have adopted the site as part of their routine sexual education program.
Conclusions This study has shown than offering youth an empirically and theoretically sound intervention that is interactive and which adapts itself to the individual needs of each user and its sexual network, results in a desired behavioural change and high uptake, even among the challenging target group of youth.

Social and behavioural aspects of prevention oral session 3—Sexual and diagnostic behaviours: issues in measurement

O2-S3.01 FEASIBILITY AND ACCEPTABILITY OF SELF-SAMPLING FOR RECTAL SEXUALLY TRANSMITTED INFECTIONS (STI) AMONG BISEXUAL MEN IN THE USA

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Introduction Rectal sexually transmitted infections (STI) are a common health concern for men who have sex with men (MSM). Studies have not yet determined the relevance of these pathogens among men who have sex with both men and women (MSMW). Screening for rectal STI is not currently a widespread option for bisexual men in the USA.
Methods Qualitative data and self-obtained rectal specimens were collected from a diverse sample of bisexual men. Upon completion of the rectal self-sampling, each participant provided information regarding their overall experience with the process.
Results From a total sample of 75 bisexual men, 58 participants provided self-obtained rectal samples. While most men did not test positive, a prevalence (10.3%) of C. trachomoatis infection was found in this sample. Men who collected samples reported overall acceptability and comfort with self-sampling for rectal STI. Privacy was a primary concern for men regarding self-sampling. Of the men who did not provide a rectal self-sample, the most common reason was having been tested in the recent past. Discussion: Self-sampling is a feasible and acceptable option when offered to bisexual men. Research and interventions are needed to ascertain which combinations of STI testing (including self-sampling) and treatment methods are most appropriate for diverse groups of bisexual men.

O2-S3.02 ASSESSING THE VALIDITY OF SEXUAL BEHAVIOUR REPORTS IN A WHOLE POPULATION SURVEY IN RURAL MALAWI

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Background Sexual behaviour surveys are widely used, but underreporting of particular risk behaviours is common, especially by