

### P341 TRENDS IN CONDOM USE AMONG A NATIONALLY REPRESENTATIVE SAMPLE OF WOMEN AND MEN WITH OPPOSITE-SEX PARTNERS IN THE U.S

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**Background** As STIs continue to increase in the United States, one possible explanation is that declines in condom use have contributed to these increases. To date, condom use trends from nationally representative data on individuals with opposite-sex partners have not been examined.

**Methods** We used data from the National Survey of Family Growth (2002, 2006–10, 2011–15) to examine trends in condom use at last sex among unmarried, non-cohabiting women and men aged 15–44 with past-year opposite-sex partners, by race/ethnicity (Hispanic, non-Hispanic white, non-Hispanic black), age (15–24, 25–29, 30–44), any past-year non-monogamy (two or more partners or perceived partner non-monogamy), and past-year STI testing. Year of survey was included as a categorical variable. Chi-square tests and adjusted prevalence ratios were used to test differences in the prevalence of condom use in 2002, 2006–2010 and 2011–2015.

**Results** Overall, condom use prevalence remained stable among women (2002, 35.5%; 2006–10, 39.1%, 2011–15, 37.4%) and among men (2002, 49.4%; 2006–10, 53.3%, 2011–15, 53.3%), with no differences in temporal trends by race/ethnicity or age in adjusted models. Any reported non-monogamy was also not associated with changes in condom use over time for any group. There was a significant decline in condom use among women aged 30–44 who reported STI testing, from 2006–10 to 2011–15 (36.3%, 95%CI: 29.4–43.1; 25.0%, 95%CI: 20.8–29.2, respectively), and among non-Hispanic black men who reported STI testing, from 2002 to 2006–10 (77.9%, 95%CI: 68.9–86.8; 61.8%, 95%CI: 54.6–69.0, respectively).

**Conclusion** Overall and for most subgroups, condom use has remained stable over time, suggesting it is not contributing to increases in STI. Models adjusting for demographics suggest these results are not due to demographic shifts. However, certain sub-groups may be using STI testing as a protective strategy when not using condoms. Examination of other explanatory factors is needed.

**Disclosure** No significant relationships.

### P343 PRIMARY OUTCOMES FROM IMPLEMENTING A BEHAVIORAL COUNSELING INTERVENTION PROGRAM IN FOUR FEDERALLY QUALIFIED HEALTH CENTERS

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**Background** The U.S. Preventive Services Task Force (USPSTF) recommends behavioral counseling for youth at high-risk for STDs, but little work has explored translation of these guidelines into practice. Here, we evaluated a large-scale implementation of behavioral counseling in federally qualified health centers (FQHCs).

**Methods** Implementation occurred between June 2017 and May 2018 in four FQHCs in Northeastern US. Many patients were below the poverty level (27–65%) or uninsured (13–47%). Training content comprised motivational interviewing skills and techniques for talking to youth about sex and sexual histories, delivered to pilot providers via 15 hours of online and in-person training. We measured the proportion of patients who received (a) a sexual history, (b) behavioral counseling, (c) HPV vaccine and (d) chlamydia screening. We tracked changes in work-flow and implementation and allowed for tailoring of sexual history taking per the needs of FQHCs. **Results** 39,631 eligible patients (13–24 years old, 71.0% Hispanic, 68.3% white, 24.9% black) were seen during the implementation period, of whom 9,675 (24.4%) saw a pilot provider. Similar proportions in each group completed a sexual history (70.6% vs. 71.4%,  $p=0.1787$ ). However, higher proportions of patients exposed to the pilot providers received behavioral counseling (67.5% vs. 43.5%,  $p<0.0001$ ), HPV vaccine (71.7% vs. 51.2%,  $p<0.0001$ ) and chlamydia screening (38.4% vs. 32.1%,  $p<0.0001$ ). Of youth who were seen by a pilot provider and given a sexual history, 84.2% received behavioral counseling. Of counseled patients, 83.6% received HPV vaccine and 85.2% were screened for chlamydia. Work flows were individualized to each health center and became increasingly efficient over time.

**Conclusion** Primary outcomes from this translation study support the conclusion that an intensive, but short, training regimen on behavioral counseling, coupled with a flexible strategy for assessing sexual histories, results in higher rates of behavioral counseling and provision of prevention services as compared to those who did not receive training.

**Disclosure** No significant relationships.

### P344 TRANSMUTATION IN HIGH-RISK SEXUAL BEHAVIOR OF MEN IN INDIA: AN ASSESSMENT OF MAGNITUDE AND PREDICTORS

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**Background** Modern Indian society has witnessed rapid socio-cultural transformation where loosening of cultural values is observed at all levels. In the era of transition, traditional norms and values are at change where young male individuals are found to be associated with high-risk multi-partner sexual behaviour. This study intends to determine the changes in magnitude and predictors of such high-risk sexual behaviour among men in India.

**Methods** The sample of 74,369 and 112,122 men aged 15–54 from two rounds of the National Family Health Survey (NFHS) conducted during 2005–2006 (NFHS-3) and 2015–2016 (NFHS-4) has been used. The economic inequalities in the prevalence of high-risk sexual behaviour have been analysed using poor-rich ratio, and concentration index (CI) in addition to adjusted effects of major correlates through multiple logistic-regressions.

**Results** The burden of high-risk sexual behaviours over the last decade remains disproportionately higher among younger, unmarried, urban men and mainly from better economically households. Despite tremendous efforts of the governments in condom promotion as part of HIV/AIDS prevention

programme, the improvements in condom use over the last decade, has not yet reached to the desired level. The disparities in high-risk sexual behaviour among men, coming from rich and poor households have been narrowed over the last decade. However, there are few states like Andhra Pradesh, Assam and Orissa where socio-economic inequalities in high-risk sexual behaviour have been increased. The findings also underline an apparent paradox in the relationship between knowledge of HIV/AIDS and indulgence into high-risk sexual behaviour and adopting safe sexual practices.

**Conclusion** It is recommended that all HIV prevention programmes in India should promote the concept of men as the responsible sexual partner. This concept may be promoted among young and unmarried men by reinforcing the shift from violence to respect and projecting the condom as sexual stimuli rather than a means of disease prevention.

**Disclosure** No significant relationships.

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#### CORRELATES OF CONSISTENT CONDOM USE AMONG URBAN ADOLESCENTS ATTENDING HIGH-SCHOOL IN PANAMA

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**Background** Consistent condom use, defined as using a condom in every sexual encounter, is an effective measure for preventing sexually transmitted infections (STIs). However, few studies have examined condom use among Latin American youth. This study estimated the correlates of reported condom use among school-going adolescents in four urban sites of Panama during 2015–2018, where one site was studied each year. Additionally, we assessed condom use practices among adolescents with herpes simplex virus 2 (HSV2).

**Methods** Adolescents aged 14–19 years completed a self-administered tablet-based questionnaire that measured reported sexual history and practices. Blood samples from sexually experienced adolescents were evaluated for HSV2. Associations between sociodemographic characteristics, sexual behaviors, HSV status and condom use were estimated with the chi-square statistic. Univariate odds ratios (ORs) and age-adjusted (AOR) analyses were performed.

**Results** Among 2466 adolescents, there was no significant difference in reported sexual activity prevalence among males (58.4%) and females (56.7%) ( $p=0.402$ ). Reported consistent condom use was low (25%) among sexually active participants. Older adolescents (17–19 years) were less likely to report consistent condom use (17 years OR=0.63, 95% CI 0.41–0.97 and 18–19 years OR=0.66, 95% CI 0.43–0.99). Males had higher reports of consistent condom use (AOR=1.65, 95% CI 1.08–2.53) compared to female adolescents. Adolescents reporting two or more lifetime sexual partners (OR=0.43, 95% CI 0.31–0.61), current sexual activity (OR=0.70, 95% CI 0.51–0.96), and sex with a casual partner (OR=0.60, 95% CI 0.44–0.82), were less likely to report consistent condom use. HSV2 prevalence was 20.8% among sexually active participants. HSV2 seropositivity was not correlated with reported condom use ( $p=0.124$ ).

**Conclusion** Reported consistent condom use among sexually active, school-going adolescents in Panama was low, particularly among females and older adolescents. Condom use interventions should include information regarding effective condom negotiation strategies between sexual partners. These strategies are important throughout adolescence.

**Disclosure** No significant relationships.

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#### PSYCHOSOCIAL FACTORS ASSOCIATED WITH CHLAMYDIA RETESTING AMONG YOUNG PEOPLE IN THE UK

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**Background** Repeat chlamydia infections are common, and the risk of receiving complications increases with the number of lifetime infections. However, retesting rates in the UK remain low and interventions to increase retesting have had variable effects. In order to change behaviour (e.g., to increase retesting), behavioural-science theoretical models may help identify influential factors. One such model, the COM-B Model proposes behaviour results from an interaction between capability, opportunity and motivation. The aim of this study was to identify theoretically-based demographic and psychosocial factors associated with retesting behaviour and intentions to retest amongst those previously diagnosed with chlamydia.

**Methods** An online questionnaire was developed, based on a comprehensive literature review and expert and lay consultation. Participants were 263 young people (16–24 years) in the UK who had been diagnosed with chlamydia (via healthcare settings or online platforms). In addition to demographic questions, each measure was representative of COM-B components: susceptibility and severity, fear, stigma, shame, knowledge, social support, social norms, perceived advantages/disadvantages of retesting.

**Results** 35% had not retested, the most common reason for which was unawareness of the need to retest (31%). In those who had not retested, moral norms, injunctive norms, and STI knowledge significantly predicted intentions to retest ( $F_{[1,53]}=6.20, p=0.016, R^2=0.45, \text{Adj}R^2=0.42$ ). Retesters were slightly older and more likely to have had other STIs. The most common location of retest was a sexual health clinic (57%), followed by general practice (14%) and online services (11%). Multivariable regression demonstrated that social norms (injunctive, descriptive, and moral) significantly predicted having retested ( $F_{[1,171]}=7.44, p=0.007, R^2=0.12, \text{Adj}R^2=0.10$ ).

**Conclusion** This research has identified potential targets for public health campaigns aimed at eliminating STIs. Specifically, future interventions should focus on social (e.g., social approval one expects from others for engaging in a responsible sexual health action) and psychological (awareness and education) to increase retesting rates.

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