engage in compensated sex (10% MU vs. 4% FC, p < 0.05), not use condoms during their last sexual encounter (64% MU vs. 45% FC, p < 0.05), and be a first-time HIV tester (50% MU vs. 41% FC, p < 0.05; see Table 1).

MU HIV prevalence was 5% (vs. 17% FC, p < 0.05). Among first-time testers, HIV prevalence in both MSM and TW was not significantly different between MU and FC attendees (MSM: 13% MU vs. 19% FC p = 0.14; TW: 41% MU vs. 50% FC p = 0.71).

Conclusion MU testing reached large numbers of high-risk (TW/MSM) and potentially bridging (MSMW) populations engaged in unsafe sexual behaviours. MU HIV prevalence for MSM/TW first-time testers was similar to that of the FC, making MU outreach a worthy complement to FC testing. Further investigation into whether MU attendees would not otherwise access HIV testing is warranted to determine the impact of MU testing.

Abstract P5.033 Table 1 Proportion of first-time HIV testers in MU vs. FC attendees stratified by sexual identity

	MU (n = 3,496)	FC (n = 1,854)	p value
MSM	164/590 (28%)	366/1,031 (36%)	< 0.05
TW	42/282 (15%)	4/50 (8%)	.19
MSMW	590/942 (63%)	88/154 (57%)	.20
Total	1,764 (50%)	765 (41%)	< 0.05

P5.034 BRITISH CO-OPERATIVE CLINICAL GROUP (BCCG) PROJECT - HOW OFTEN ARE MEN WHO HAVE SEX WITH MEN (MSM) ADVISED TO ATTEND FOR REPEAT SEXUAL HEALTH SCREENING IN THE UK?

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Background Within the UK rates of HIV, STIs, and sexual risk taking behaviours are increasing in MSM. 24% of new UK HIV diagnoses in MSM are recently acquired. Increased frequency of sexual health screening could reduce transmission of STIs, and this policy is advocated in Australia and America. UK guidelines are vague, advising increased screening for MSM with risk taking behaviours but without specifying frequency or behaviours. Aim: to assess what advice UK clinics give MSM about how frequently they should receive sexual health screening, and how this varies with risk taking behaviours.

Methods BCCG members representing UK level 3 sexual health clinics were asked to complete an online survey assessing how often they would advise MSM with different patterns of risk taking behaviours to attend for screening.

Results 53 clinics responded. 53% had local guidance on screening frequency, with 89% based on national guidelines. 94% BCCG members and 59% local guidelines identified behaviours requiring increased screening frequency. The majority (53–66%) advised 3 monthly screening for MSM with over 10 partners in the last 6 months, attending sex on premises venues, using recreational drugs during sex, using the Internet to find partners, participating in group sex, or being HIV positive and sexually active. 32% and 40% respectively recommended 6 monthly screening for sexually active MSM and for those who had unprotected anal sex in the last 12 months.

Discussion Whilst the majority of clinics surveyed would recommend 3–6 monthly screening for MSM with risk taking behaviours, this varies with many clinics providing no specific advice on screening frequency. Clear UK guidance is needed to respond to the HIV epidemic in MSM by promoting early diagnosis of incident infection, and to ensure that efforts to contain costs through service contraction do not impinge on access or screening for this important group.

P5.035 WITHDRAWN BY AUTHOR

P5.036 THE FIRST CLUSTER RANDOMISED TRIAL OF A MOLECULAR CHLAMYDIA AND GONORRHOEA POINT-OF-CARE ASSAY

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Introduction In many settings, control of sexually transmissible infections (STIs) is compromised by lack of laboratory infrastructure, physical distance from laboratories and loss to follow up of patients. Point-of-care (POC) tests have the potential to provide timely diagnosis, treatment and partner notification, and in turn reduce infection rates. In April 2013, we will implement the first cluster randomised trial of chlamydia and gonorrhoea POC testing in remote Aboriginal communities where STIs are endemic.

Methods The study, called TTANGO (test, treat and go), will measure the effectiveness, cost-effectiveness and cultural and operational acceptability of POC testing for chlamydia and gonorrhoea infections. The study design is a crossover, cluster, randomised controlled trial involving 12 health services in remote Aboriginal communities in Australia. The primary outcome is the percentage of people with persistent chlamydia and gonorrhoea positive tests. The trial runs for 2 years and is a partnership between research, government and community organisations.

Results TTANGO is reaching the conclusion of the preparation phase and has achieved significant steps, including the engagement of remote health services and communities, a comprehensive laboratory and field evaluation to select the ideal assay, development of the first formal training package for chlamydia and gonorrhoea POC testing, and a quality assurance programme. The GeneXpert® CT/NG molecular POC assay was selected for the trial as it showed very high sensitivity and specificity compared to other assays, was easy to use and results were available in approximately 90 minutes. This paper will discuss progress in preparing and implementing TTANGO, the methodology and evaluation.

Conclusion The results of this RCT will provide crucial information to guide sexual health clinical practise in remote Aboriginal communities and other settings internationally. Mathematical modelling and health economic analyses will be used to make the case for large scale implementation of this technology.

P5.037 EXPERIENCE OF RAPID HIV TESTING INCREASES ITS ACCEPTABILITY TO CLINICAL STAFF IN PUBLIC SEXUAL HEALTH CLINICS IN SYDNEY

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Background Rapid HIV testing is well established in many countries, yet few studies have evaluated the acceptability of rapid testing among clinical staff over time. We assessed staff acceptability of rapid HIV testing before and after its implementation in Australian sexual health clinics.

Methods From September 2011 onwards, men who have sex with men (MSM) attending four Sydney sexual health clinics were offered rapid HIV testing using the Alere Determine HIV Combo assay. Staff were trained in rapid HIV testing using this assay, with staff acceptability assessed via two anonymous questionnaires completed after training and at least six months later. Five-point Likert scales were used, with '1' indicating strong agreement and '5' strong disagreement to a range of acceptability statements. T-tests were used to assess differences in mean Likert scores between rounds, with stratification by staff profession and testing experience.

Results Of 68 trained staff, 67 completed the first questionnaire and 53 the second. Mean scores improved for confidence in conducting rapid testing (1.87 vs 1.44; $p < 0.01$), confidence in delivery of negative results (1.52 vs 1.25; $p < 0.01$) and in disagreement that rapid testing was disruptive (3.27 vs 3.83; $p < 0.01$). Comfort with your own role in rapid testing increased between rounds, particularly for nurses (1.71 vs 1.41; $p = 0.04$). In round two, doctors had a stronger preference for faster rapid tests than nurses (1.75 vs 2.50; $p = 0.02$) and stronger agreement that rapid testing interferes with consultations (2.63 vs 3.39; $p = 0.01$). Belief that patients were satisfied with rapid testing was stronger in staff who had performed > 10 tests than ≤ 10 tests (1.58 vs 2.07; $p < 0.01$). Acceptability did not vary with experience of false results.

Conclusions Acceptability to staff of rapid HIV testing for MSM increased with time and experience of rapid testing. Differences between professions may indicate variations in staff training and support needs and capacity to adapt to change.

P5.038 DEVELOPMENT OF PREDICTION RULES FOR CHLAMYDIA TRACHOMATIS INFECTION ON POPULATION AND INDIVIDUAL LEVEL - POTENTIAL FOR INNOVATIVE SELECTIVE SCREENING

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Background Prediction of Chlamydia trachomatis (Ct) infection is important to identify subjects at high risk. We aimed to develop Ct prediction rules with different levels of detail in information, i.e. with readily available registries only and with additional detailed questionnaires.

Methods In the Chlamydia Screening Implementation (CSI) study all inhabitants of Rotterdam and Amsterdam aged 16–29 were invited yearly from 2008 until 2011 for home based urine testing. This resulted in 80,385 unique participants of whom 3,440 were infected. In addition to registry data (gender, age, ethnicity, neighbourhood level socioeconomic status [SES]) participants were asked to fill in a questionnaire on education, STI history, symptoms, partner information and sexual behaviour. We developed prediction rules based on registry risk factors only and with additional questionnaire risk factors by multilevel logistic regression to account for clustering within neighbourhoods. We assessed the discriminative ability by the area under the receiver operating characteristic curve (AUC). The models were internally validated with a bootstrap procedure.

Results Strong registry based predictors for Ct infection were young age (especially for women) and either Surinamese, Antillean or Sub-Sahara-African ethnicity. SES was of minor importance especially when questionnaire predictors were added. From the questionnaire, low to intermediate education level, ethnicity of the partner (non-Dutch) and having sex with casual partners showed strong associations with Ct infection. The AUC at internal validation was 0.67 based on registry risk factors only and 0.75 when questionnaire risk factors were added. To find 80% of the Chlamydia infections approximately 50% of the population needed to be screened when using the prediction rule including questionnaire risk factors.

Conclusion The registry based prediction rule can potentially facilitate selective Ct screening at population level, with further refinement at the individual level by including questionnaire risk factors.

P5.039 TITLE: CAN STD CLINICS RIDE THE CERVICAL CANCER SCREENING BIKE? EXPERIENCES FROM AN URBAN STD CLINIC

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Identifying screening venues that reach underserved women may be an important step in reducing cervical cancer. STD clinics often serve women who may not have ready access to other healthcare services. An urban US STD clinic was selected to test suitability of the STD clinic setting for cervical cancer screening.

Methods Women 30 years of age and older were recruited from clinic waiting rooms and compensated $20 for study participation. Women were offered cervical cancer screening and were asked to be available for follow up by a method of their choosing. Liquid based cytology and HPV DNA (Roche, Indianapolis, IN) testing were both performed. HPV DNA assays were performed comparing results of vaginal self- swab specimens to cervical swab results. Up to 3 attempts were made to contact participants with results using the patient-preferred contact method. Outcomes of interest included reasons for not accepting screening and proportion of results delivered to this classically hard-to-reach population.

Findings At the time of this abstract, 52 participants have completed follow up (age range 30–48, median age of 37 years); 30 African American women, 19 White, 1 Native American and 2 of multiple races). Only 2 eligible clinic patients refused study participation, 47 were available for follow up contact, and 35 reported having no regular doctor. Sixteen were high risk HPV positive and 4 of this group had an accompanying pap result of LSIL or greater.

Conclusion The findings suggest that cervical cancer screening can be successfully done in this urban STD clinic setting. Despite concerns regarding the willingness of this population to provide reliable contact information, our experience suggests that women are eager to receive cervical cancer screening results. Future studies will evaluate staff provision of follow up and navigation services in a variety of STD clinic settings.