O14.2 GOOD CALL! IMPLEMENTATION OF A REGIONAL ONLINE AND TOLL-FREE STD CLINICAL CONSULTATION PROGRAM

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Introduction Following significant changes to the United States healthcare system, community health centres and private providers are providing a greater amount of STI screening, treatment and management that, in the past, would have been performed at public health specialty (STI) clinics. However, general healthcare providers without a background in STIs may be unfamiliar with STI treatment protocols and unusual presentations. To assist healthcare providers in an eight state region, the Denver Prevention Training Centre (PTC) collaborated with the Southeastern National TB Centre (SNTC) to modify their tuberculosis clinical consultation database to serve clinicians performing STI exams.
Methods The Denver PTC and SNTC created an online database and call management system modelled on the TB system. The system tracks and facilitates the clinical consultation process from initiation to completion. A toll free number (1–800–4-STD-CCN) and website (www. STDCCN.org) were set up. Marketing was done through electronic channels and at healthcare events in the region.
Results The STI clinical consultation system received 2–5 requests a week from clinicians around the region. Unlike the TB system, whose requests have been primarily received through the phone, almost all of the requests for STI consultations came through the online portal. The STI consultation program has been successful both as a means of offering clinical consultation, and, importantly, as a way of tracking the consultations and technical assistance delivered by the training centre. As a result, the STI clinical consultation program will be expanded across the United States in the coming months. The Denver PTC and SNTC are also looking at expanding the process to mobile applications so that consultation can be initiated from mobile devices.
Conclusion Web-based processes can help simplify, facilitate and track the process of STI clinical consultation.
Disclosure of interest statement The Denver PTC and SNTC are funded by the Centres for Disease Control and Prevention, USA. No pharmaceutical grants were received in the development of this study.

O14.3 REFERRING CLINIC TURN-AWAYS TO BRITISH COLUMBIA'S INTERNET-BASED TESTING PROGRAM GETCHECKEDONLINE TO INCREASE CAPACITY FOR TIMELY STI/HIV TESTING

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Introduction Many jurisdictions face pressures to meet increasing demand for STI clinical services, including prolonged wait-times and turning away drop-in clients. The BC Centre for Disease Control has implemented internet-based STI/HIV testing (GetCheckedOnline.com, GCO) as a virtual extension of clinic services. Here we report on the impact of providing same-day access to GCO through codes for clients seeking testing but unable to be seen (turn-aways).
Methods Starting March 3, 2015, clerical and nursing staff working in the provincial STI clinic in Vancouver, BC offered access codes to turn-away clients presenting in person or by phone seeking testing. On the GCO website, access codes permit clients to create accounts and print requisitions for HIV, syphilis, Chlamydia/gonorrhoea +/- hepatitis C testing. We examined offer, account creation, and testing for turn-away clients and STI clinic clients for the first month of implementation.
Results Between March 1–31, 2015, codes were provided to 57 of 107 turn-away clients by clerical staff (codes provided by nursing staff not tracked). 34 turn-away clients created accounts (26% female, 74% male; mean age 37 years). By March 31, 21 clients were known to have tested and received results. Two turn-away clients (10%) tested positive (for Chlamydia and gonorrhoea). Over the same period, 536 STI clinic clients were tested (31% female, 69% male; mean age 34 years); 64 clinic clients (12%) tested positive for these infections.
Conclusion Internet-based STI/HIV testing provides an opportunity to test for clients facing barriers due to clinic capacity. While these findings are preliminary, they suggest referring turn-away clients to GCO at this high-volume clinic increased overall testing capacity and reduced delays in diagnosis. This service has since been implemented at two other STI clinics in Vancouver with differing client populations. Findings from the first five months of implementation across all clinics will be presented.
Disclosure of interest statement The authors have no conflicts of interest to disclose.

O14.4 HOME-BASED SPECIMEN COLLECTION FOR *CHLAMYDIA TRACHOMATIS* AND *NEISSERIA GONORRHOEAE* TESTING DOES NOT IMPROVE CLINICAL MANAGEMENT OUTCOMES: SYSTEMATIC REVIEW

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Introduction Home-based specimen collection is promoted as an innovative method to improve convenience and uptake of, and reduce barriers to clinic-based *Chlamydia trachomatis* (CT) and *Neisseria gonorrhoeae* (NG) testing. It is not known whether this strategy increases successful case management or the impact of screening programmes. The objective of this systematic review was to assess the effectiveness and safety of home-based and clinic-based specimen collection for CT and NG.
Methods We searched for randomised controlled trials (RCTs) in MEDLINE, EMBASE, CENTRAL and LILACS databases, the Cochrane Sexually Transmitted Infections Group Specialised Register, two trials registers and grey literature up to February 2015. The primary effectiveness outcome was complete case management, defined as completed testing, diagnosis and treatment of index cases with positive test results. Secondary outcomes included testing uptake, test positivity, partner treatment and infections cured.
Results We screened 496 unique records and included 10RCTs (6,291 participants). All reported on testing uptake but only three (1,566 people) assessed the primary outcome. There was

no difference in complete case management between participants with home- vs. clinic-collected specimens (RR 0.88, 95% CI 0.60 to 1.29, I^2 0%). The trials were heterogeneous with respect to test uptake (I^2 100%) but eight reported more participants tested with home- vs. clinic-based testing. In nine studies (2,928 participants) the pooled positive test prevalence was lower in the home-based than the clinic-based group (RR 0.73, 95% CI 0.61 to 0.86, I^2 0%). No RCTs evaluated adverse events, rates of partner treatment or infection cure.

Conclusion We found no evidence that home- vs. clinic-based specimen collection increased complete case management for CT and NG infections. Testing uptake might increase with home-based specimen collection but heterogeneity between studies was high. Safety and biological outcomes, such as infection cure, of home-based specimen collection strategies need to be evaluated.

Disclosure of interest statement The Cochrane Sexually Transmitted Infections Group receives funding from the Faculty of Medicine, Universidad Nacional de Colombia. No pharmaceutical grants were received in the development of this study.

O14.5 BLIND SPOT ON HETEROSEXUAL MEN? MULTIPLE PATHWAYS TO STI CARE AMONG MEN IN MALAWI

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Introduction A focus on heterosexual men is critical to reducing STIs/HIV rates in Sub-Saharan Africa. Despite this, prevention efforts and national policies have insufficiently addressed men's STI and HIV needs and access to care.

Methods We undertook mixed-methods research on men's sexual (including STI/HIV) health in Malawi between 2013–14. A national household-based survey with men (n = 998), qualitative interviews (n = 162) with other men, women, male clients, health service providers and key informants, ethnographic observations and a policy review investigated men's experience of sexual health, including risks, care-seeking, and health service responses.

Results Eight percent of men reported STI symptoms, of whom only 0.3% sought STI-related health care. One in five men had multiple concurrent sexual partners. Qualitative findings included that STI-related communication and disclosure within couples was limited. STI positive men confided in closest friends but sought treatment without their partner's knowledge. Many men with STIs used private clinics – citing perceived problems in the public sector of: confidentiality; lack of male-focused services; long queues; and the requirement to be accompanied by their sexual partner. Those unable to afford private treatment took self-medication or used traditional healers (particularly in rural areas). STIs were seen as "curable unlike HIV," less stigmatising though still embarrassing, and to be "dealt with quickly" and clandestinely. Among providers and stakeholders, improving men's STI prevention and care was seen as essential, though national policies insufficiently focused on this issue.

Conclusion Men are at risk of STI (and HIV) transmission in Malawi, but their sexual health needs are not being met by the public health sector. Opportunities for more gender-equitable health care include: strengthening public-private sector linkages and a policy environment that reflects men's specific health needs. In addition, challenging male gender norms that result in men taking risks with their sexual health need to be a priority.

Disclosure of interest statement We confirm that there are no conflicts of interest in the development of this study.

O14.6 ATTRIBUTES OF DIAGNOSTIC TESTS TO INCREASE UPTAKE OF TESTING FOR SYPHILIS AND HIV IN PORT-AU-PRINCE, HAITI

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Introduction Syphilis and HIV screening is highly recommended for pregnant women and those at risk for infection. Enhanced control and prevention can be accomplished through more testing. We used conjoint analysis, an innovative method for systematically estimating consumer preferences across discrete attributes, to identify factors associated with testing preferences for HIV and syphilis infection.

Methods We recruited 298 men and women 18 years and over seeking testing or care at GHESKIO (Haitian Study Group for Kaposi's sarcoma and Opportunistic Infections) clinics. We created 8 hypothetical test profiles varying across six dichotomous attributes: cost (free vs. $4), accuracy (no false positive vs. false positive), time-to-result (20 min vs. 1 week), blood draw method (finger prick vs. venipuncture), number of draws (1 vs. 2), and test type (rapid vs. laboratory). Participants were asked to rate each profile using Likert preference scales. Ratings were converted to 100-point preference scores; higher scores suggest increased preference. An impact score was generated for each attribute by taking the difference between the preference scores for the preferred and non-preferred level of each attribute. Two-sided one-sample t-test was used to generate p-values.

Results Of 298 study participants, 61 (20.5%) were male. Of 237 females, 49 (20.7%) were pregnant. Cost (free vs. $4; impact score = 27.2, SD = 36.6, $p < 0.0001$) had the highest impact on likelihood of testing, followed by number of blood draws (1 vs. 2; impact score = 17.5, SD = 29.8, $p < 0.0001$), blood draw method (fingerprick vs. venipuncture; impact score = 9.7, SD = 26.5, $p < 0.0001$), test type (rapid vs. laboratory; impact score = -4.5, SD = 21.9, $P = 0.0005$), and time-to-result (20 min vs. 1 week; impact score = 3.6, SD = 25.6, $p = 0.0139$).

Conclusion HIV and syphilis testing preferences for this study sample in Port-au-Prince prioritised cost, single fingerprick and timeliness. Implementing a low cost dual rapid test in the laboratory for HIV and syphilis could improve screening uptake and accessibility to accelerate time to treatment.

Disclosure of interest statement The study was supported in part by Standard Diagnostics.