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.