Background Bacterial STI testing is a necessary component of sexual health care for MSM living with and at risk for HIV. Guidelines recommend testing at least once a year or more often if at ongoing risk. As part of a larger mixed methods study with the overall goal to prioritize new STI testing interventions, our aim was to determine barriers and facilitators to offering bacterial STI testing to MSM according to healthcare providers in Toronto, Canada.

Methods In 06/2018–07/2018, we circulated invitations for an online, anonymous survey to an estimated 172 providers in Toronto. Providers were eligible if they provided care for ≥1 MSM per week and were involved in the decision-making process in providing a STI test (e.g., taking sexual histories, ordering tests).

Results Of 93 respondents, 68% worked in primary care, 32% worked in public health/sexual health clinics, 70% were physicians, and 30% were nurses or other allied health professionals. Most (67%) saw between 1 and 30% were nurses or other allied health professionals. Among those whose practice incorporated sexual health services (89%), provider alerts when patients are due for testing (87%), self-collected specimen sampling by patients (84%), standing orders for tests (79%), and nurse-led STI testing (78%). Primary care providers were more in favour of provider alerts whereas providers at sexual health clinics favoured patient reminders.

Conclusion Among those whose practice incorporated sexual health care for MSM, providers were in favour of initiatives to simplify and expedite bacterial STI testing (including self-collection of samples), prompts/reminders for testing, and expanding testing delivery to other healthcare professionals.

Disclosure No significant relationships.
UNIVERSITY OF BIRMINGHAM, HEALTH ECONOMICS UNIT, BIRMINGHAM, UK; \textsuperscript{3}UNIVERSITY OF BIRMINGHAM, HEALTH ECONOMICS UNIT, BIRMINGHAM, UK; \textsuperscript{4}UNIVERSITY HOSPITAL NHS FOUNDATION TRUST, BIRMINGHAM, UK

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\textbf{P090 UNDERSTANDING YOUNG PEOPLE’S PRIORITIES FOR SEXUALLY TRANSMITTED INFECTION (STI) SCREENING}
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\textsuperscript{1}Louise Jackson*, \textsuperscript{2}Hareth Al-Janabi, \textsuperscript{3}Tracy Roberts, \textsuperscript{4}Jonathan Ross. \textsuperscript{1}University of Birmingham, Health Economics Unit, Birmingham, UK; \textsuperscript{2}University of Birmingham, Health Economics Unit, Birmingham, UK; \textsuperscript{3}University Hospital NHS Foundation Trust, Birmingham, UK


\textbf{Background} It is important that STI screening provision reflects the priorities of young people, as they bear the greatest burden of disease. Such provision has become possible in a wider range of settings but there are constraints due to budget pressures. The objectives of the study were: \begin{itemize}
\item To assess how young people prioritise different characteristics of STI screening;
\item To analyse whether there are differences across socio-demographic groups;
\item To predict participation rates for different service configurations.
\end{itemize}

\textbf{Methods} Eight qualitative focus groups were used to design a discrete choice experiment (DCE) to analyse the choices made by young people. DCEs are an attribute-based survey method which involve respondents making choices between hypothetical scenarios, comprising two or more alternatives. The DCE included the following service characteristics: waiting times for appointments, waiting times for results, type of consultation, staff attitude, type of screening test, STIs tested for, and setting. The DCE was administered to 2000 young people who were part of an online panel in the UK, with quotas set to ensure inclusion of minority ethnic groups.

\textbf{Results} Analyses indicated that all seven service characteristics investigated were statistically significant factors for participants. Feeling that staff were non-judgemental was the most important characteristic to young people. Being tested for all STIs, having a full consultation and getting results quickly were also characteristics identified as important. Further analyses revealed some heterogeneity in priorities by gender, ethnicity and age group.

\textbf{Conclusion} This study provides valuable insights into the service characteristics that are seen as the most important by young people. This knowledge will allow those involved in providing and designing services to understand the relative importance of different service characteristics. At a time when sexual health services are facing pressures, such findings can be used to inform service development to ensure that decision-making is informed by young people’s priorities.

\textbf{Disclosure} No significant relationships.

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\textbf{P091 ESTIMATING NEONATAL HERPES SIMPLEX V P091 ESTIMATING NEONATAL HERPES SIMPLEX V}
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\textsuperscript{1}James Matthias*, \textsuperscript{2}Sonya Du Bernard, \textsuperscript{3}Gayle Keller, \textsuperscript{4}Julia Schillinger, \textsuperscript{5}Thomas Peterman, \textsuperscript{1}Craig Wilson. \textsuperscript{1}Centers for Disease Control and Prevention, Division of STD Prevention, Tallahassee, USA; \textsuperscript{2}University of Florida, Gainesville, USA; \textsuperscript{3}Florida Department of Health, STD and Viral Hepatitis Section, Tallahassee, USA; \textsuperscript{4}Centers for Disease Control and Prevention, New York City, USA; \textsuperscript{5}Centers for Disease Control and Prevention, Division of STD Prevention, Atlanta, USA

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\textbf{Background} Neonatal infection with Herpes Simplex Virus (nHSV) is a reportable condition in Florida. Healthcare providers are required to report cases of nHSV, and clinical laboratories are required to report the results of tests in which HSV is detected. However, electronic laboratory reporting (ELR) to the Florida Department of Health is incomplete, and results are not captured in the repository used for case-based reporting of other nationally reported sexually transmitted infections. We estimated the incidence of laboratory-confirmed nHSV in Florida using provider-reported cases alone, ELR alone, both provider and ELR reports, and the incidence yielded by a capture-recapture methodology.

\textbf{Methods} Provider-reported cases of nHSV (infants $\leq 60$ days of age with HSV infection confirmed by culture or polymerase chain reaction) during 2011–2017, and laboratory reports of HSV-positive culture or PCR results in the same age group, over the same period, were extracted and analyzed. Provider-reported cases were matched with ELR results using name, date of birth, and specimen collection dates. Chapman’s estimator for capture-recapture was used to estimate nHSV incidence in Florida. Rates of nHSV infections per 100,000 live births were calculated.

\textbf{Results} Providers reported 113 nHSV cases and ELR identified 197 nHSV cases during 2011–2017. Of these, 44 cases were common to both datasets, leaving 266 unique nHSV reports. Given the number of unmatched cases, Chapman’s estimator suggests 501 (95% C.I. 401–600) nHSV cases occurred in Florida during the study period. The incidence of nHSV using