Background There is uncertainty associated with all medical testing and diagnosis. However, a growing number of studies highlight disconcerting levels of misdiagnosis in the scale-up of HIV rapid testing programmes. Evaluation studies point to user errors as potential sources of misdiagnosis, yet very little has been done to understand the views and experiences of clinicians and primary counsellors who perform rapid HIV testing.

Methods This study draws on interviews with 28 health facility staff who perform rapid HIV tests on a daily basis. The testers were recruited from 11 health facilities across Zimbabwe, eight of which have above average rates of misdiagnosis. Interviews were translated, transcribed and thematically interrogated.

Results Reflecting on their rapid HIV testing practices, potential sources of misdiagnosis included uncertainties associated with new testing algorithms and test kits; reading test results too quickly or too late; misreading of test results if the test produces faint or unclear lines; and failure to record and document test results accurately. Anxiety about potentially making such mistakes and the resulting feelings of guilt and self-blame in the case of a wrong diagnosis being handed out meant that testers found comfort in complying with standard operating procedures and associated quality controls. Misdiagnosis was thus portrayed as a result of deviating from ‘rituals of care’. The testers located deviance from the procedures in the wider context of high workloads and growing demands for HIV testing, arguing that distractions, and HIV test kit stock-outs occasionally made it difficult for testers to follow the procedures.

Conclusion Rather than attributing misdiagnosis to malfunctioning test kits or complicated standard operating procedures, testers saw misdiagnosis largely as human error – failure to follow laid out procedures. Their recognition of how a resource-depleted work and HIV testing environment can contribute to misdiagnoses, highlight the need to adequately resource HIV rapid testing programmes.

Disclosure No significant relationships.
data of the respondents through structured questionnaire. Data analysis was done using SPSS.

**Results** The respondents were mostly housewives on the age range of 20–34 years and finished Senior High School, officially married, but only half of them that living in Kupang officially married. Their husbands generally worked as non-professional and merchant. The sex behaviors of the pregnant women were categorized as not risky, but 47–78% having sex in the last week without condom. Only 10% were referred to STI clinic for being checked up and receive consultation. Prevalence rates of infections on these pregnant women were: Chlamydiosis 5.9–6.6%; Gonorrhea 0.6–0.7%; Syphilis 0–1.8%; Trichomoniasis 0.6–9.5%; Bacterial Vaginosis 18.8–65.1%; Candidiasis 13–45.6%; Herpes Simplex-2 IgM 0.7–39.2%; Herpes Simplex-2 IgG 0–7.8%; and HIV 0–1.8%.

**Conclusion** The prevalence rates of RTIs-STIs in pregnant women in this study were high and as high as previous study in 1990s. This is urgent and need strategies to support more of the output of the program in all part of Indonesia as the rising of HIV prevalence in Indonesia.

**Disclosure** No significant relationships.

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**P225 PRACTICAL COGNITIVE SCREENING FOR PATIENTS WITH HIV**

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**Background** In clinical practice it is imperative that patients with HIV, especially those with a concomitant mental illness, be screened for cognitive deficits. Not only is this important to document baseline levels of cognitive function, monitor for onset or progression of HIV-dementia, but to provide tools to improve treatment compliance for patients who demonstrate cognitive deficits. This study endeavored to determine what cognitive screening tools were most practical and effective to assess this population.

**Methods** HIV-positive participants were recruited from a psychiatric inpatient facility. Participants were administered five cognitive screening tools: Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), Montreal Cognitive Assessment (MoCA), Mini-Mental Status Examination (MMSE), Trail Making Test- Parts A and B (TMT), and Wisconsin Card Sorting Test (WCST). The sample consisted of 21 participants with diagnoses including bipolar disorder (42%), schizophrenia/schizoaffective disorder (25%), depressive and anxiety disorder (17%), psychotic disorder not otherwise specified (8%), delusional disorder (4%), and adjustment disorder (4%). (Diagnostic and Statistical Manual of Mental Disorders- Fourth Edition was utilized.) Fifty-eight percent of the sample had co-occurring substance use disorders.

**Results** The mean age of participants was 42.08 years with 13.25 years of education. Ninety six percent of the sample had co-occurring substance use disorders. Ninety five percent of the sample were newly diagnosed HIV-positive. The RBANS demonstrated the most cognitive deficits consistent with the known literature in this population. The RBANS specifically revealed impairments in domains of delayed memory and attention. This, in turn, translates into problems retaining verbal and visual information.

**Conclusion** Development of cognitive assessment tools that can be utilized by non-psychologists to target this high-risk population is necessary as an important prognostic and treatment guide.

**Disclosure** No significant relationships.

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**P226 SELF-ESTEEM, BODY IMAGE, AND SUBCULTURE IDENTIFICATION AMONG GAY, BISEXUAL, AND OTHER MEN WHO HAVE SEX WITH MEN**

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**Background** Previous research shows that low self-esteem may negatively affect self-efficacy, increase substance use, and underlie some patterns of risky sexual behaviour. This suggests low self-esteem may hinder the prevention of HIV and other sexually transmitted infections (STI). Therefore, we explored factors related to self-esteem among gay and bisexual men (gbMSM), including associations with risk behaviour.

**Methods** Between 2012–2015, we used respondent-driven sampling to recruit sexually-active HIV-positive and HIV-negative gbMSM, aged ≥16 in Metro Vancouver. Participants completed visits every 6-month until 2018. Generalized estimating equations identified correlates of self-esteem (study α = .90, range = 0–21), including key measures of sexual behaviour, substance use, social embeddedness, body image, and sub-cultural identification.

**Results** Among 341 participants, 3,497 visits (Median: 7, Q1-Q3: [3–9]). In bivariable analyses, self-esteem scores did not differ by HIV-status (p = 0.59), and were not associated with seroadaptive behaviour (p = 0.19 across 7 strategies). After adjustment, higher self-esteem was associated with older age (p < 0.001), more social support (p < 0.001), larger social network size (p < 0.003), lower emotional and social loneliness (each p < 0.001), Asian (p = 0.002) or Latin American (p = 0.001) identity (vs. White), higher self-report physical attractiveness (p < 0.005) and muscularity (p < 0.001), and subcultural identification as a Professional (versus not; p = 0.04). While higher BMI was not associated with self-esteem (p = 0.94), identifying as a bear, cub, or otter (versus not; p = 0.009) predicted lower self-esteem scores. Self-esteem was associated with several sexual (e.g., oral sex, masturbation, sex toy use) and substance use (i.e., binge drinking, cannabis, cocaine, methamphetamine) behaviours – but these became non-significant after multivariable adjustment.

**Conclusion** Subcultural identification, self-rated body-image, and social embeddedness are key to gbMSM’s self-esteem. Given these factors overshadowed self-esteem’s association with sexual and substance use behaviours, holistic HIV and STI interventions should leverage socially-supportive, community-based, and inclusive messaging to address potentially negative effects of low self-esteem on gbMSM’s sexual health.

**Disclosure** No significant relationships.