

5% 5-FU and 90% TCA ( $p=0,274$ ). Subjective side effect in 1% 5-FU was significantly milder than 90% TCA ( $p=0,004$ ), but the significant milder objective side effect only found at week 2,6, and 7 ( $p<0,05$ ). Meanwhile subjective side effect in 5% 5-FU was also significantly milder than 90% TCA ( $p=0,001$ ), but the significant milder objective side effect only found at week 2 ( $p=0,000$ ).

**Conclusion** 1% 5-FU and 5% 5-FU cream have no difference effectivity compared to 90% TCA. Regarding the side effect, 1% 5-FU has significantly milder than 90% TCA. We concluded that 5-FU may become alternative topical therapy with self-application as the benefit and 1% 5-FU cream is more recommended due to milder side effect.

**Disclosure** No significant relationships.

### P320 INCENTIVE TESTING AND TREATMENT FOR STBBI IN HARD TO REACH POPULATIONS IN EDMONTON, ALBERTA, CANADA

<sup>1</sup>John Niruban, <sup>2</sup>Garret Meyer, <sup>2</sup>Penny Parker, <sup>1</sup>Jennifer Gratrix, <sup>3</sup>Petra Smyczek\*. <sup>1</sup>Alberta Health Services, Centralized STI Services, Edmonton, Canada; <sup>2</sup>Alberta Health Services, STI Clinic, Edmonton, Canada; <sup>3</sup>Alberta Health Services, STI Services, Edmonton, Canada

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**Background** Since 2014, Edmonton, Alberta, Canada has seen an alarming rise in infectious syphilis and gonorrhea infections. Individuals from vulnerable communities with substance use, involvement with corrections, transactional sex, and inadequately housed are overrepresented among cases. The aim of this project was to increase access to sexually transmitted and blood borne infections (STBBI) testing and treatment among hard to reach populations in Edmonton.

**Methods** Outreach teams from the Edmonton STI clinic consisting of a registered nurse and community health representative or licensed practical nurse offered STBBI testing at subsidized housing locations, community based organizations, and through street outreach. Clients were offered testing and treatment for chlamydia (CT), gonorrhea (NG), syphilis, HIV, Hepatitis C. Clients received a \$10 gift card for testing and a \$10 gift card when returning for results and/or treatment.

**Results** From October 2018 to February 2019, 393 testing visits were completed among 342 individuals. Nearly two-thirds (61%;  $n=207$ ) of individuals were men with a median age of 32 years. Women were younger with a median age of 20.4 years. Nearly 60% (57.9%;  $n=198$ ) of individuals reported substance use with 19.0% ( $n=65$ ) reporting injection drug use. Six percent ( $n=20$ ) of individuals were involved in transactional sex. The positivity rate for CT was 9.5% ( $n=26$ ) and 4.0% ( $n=11$ ) for NG (273 tested). The positivity rate for HCV was 5.4% ( $n=15$ ; 278 tested). The syphilis seropositivity rate was 10.8% ( $n=34$ ; 315 tested). No new HIV cases were found. Eight-percent ( $n=31$ ) of visits involved treatment for an ST

**Conclusion** Offering STBBI incentivized testing was effective in improving access to testing and treatment for hard to reach clients resulting in high positivity rates for STBBI. By offering testing and treatment to individuals linked to high transmission activities, we aim to reduce the burden of STBBI among vulnerable groups

**Disclosure** No significant relationships.

### P321 THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF THE HARD TO REACH POPULATIONS IN UGANDA

Samuel Mukasa\*. *Theta Uganda, Programs, Kampala, Uganda*

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**Background** Despite efforts by Ministry of Health (MOH) and implementing partners (IPs) to implement programs that are complementary to static services, some communities remain hard to reach and sustain low access to existing SRH services. Majority live in places where there are inadequate health services or are hard to reach within the general public and are underserved by the existing SRH services (de paz et al, 2014). Majority of these groups were displaced from their indigenous habitats in the 20<sup>th</sup> century but remain hard to reach due to factors like; geographical location, cultural beliefs, nomadic life style and biological factors. Majority suffer from attacks from neighbors, are isolated and continue to be underserved by existing service structures. As a result, there's been minimal change in SRH indicators over the past ten years despite growing focus by IPs.

**Methods** Qualitative design utilizing case study approach to qualitative inquiry

**Results** The SRHR needs of the hard to reach groups are similar though with varying levels of severity among the different groups but of greater impact in these marginalized communities compared to the general public. The key SRHR needs include; STIs, SGBV, family planning, Female Genital Mutilation, Health facility deliveries, low ANC attendance and the role of TBAs. The most significant barriers include; high levels of extreme poverty, poor cultural beliefs and practices, low literacy levels, alcohol abuse, language barriers, early marriages, poor health systems and distance between the clients and available health services

**Conclusion** Majority of the SRH needs are known in the existing literature and not unique to hard to reach groups. These needs have greater impacts among the hard to reach groups compared to the general public. The key barriers to SRHR services are; language barrier with neighbouring societies, poor cultural beliefs and practices, poverty and long distance to existing health services

**Disclosure** No significant relationships.

### P322 A BRIEF CLINIC-BASED PEER-TO-PEER EDUCATION INTERVENTION TO IMPROVE PREVENTION PRACTICES AMONG SEXUAL MINORITY MALES

<sup>1</sup>Nathan Lachowsky\*, <sup>1</sup>Karyn Fulcher, <sup>1</sup>Allan Lal, <sup>2</sup>Richard Crosby. <sup>1</sup>University of Victoria, School of Public Health and Social Policy, Victoria, Canada; <sup>2</sup>University of Kentucky, Lexington, USA

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**Background** Gay, bisexual, and other men who have sex with men (GBM) are disproportionately affected by STIs and HIV. Originally efficacious with young Black GBM, Focus on the Future (FoF) is a clinic-based, single session intervention aimed at improving prevention practices. We examined the efficacy of the program when adapted for Vancouver's ethnoracially diverse GBM communities.

**Methods** Participants were recruited from a GBM sexual health clinic and completed a one-time 60-minute education session with a peer health educator. This included condom and lubricant information and condom application skills practice. Between 09/2018–02/2019, each participant completed a baseline survey prior to intervention and again three months later, which were compared using paired t-tests.

**Results** A total of 24 HIV-negative participants received the intervention: average age was 27.8 years (SD=3.53) and 52% identified as non-white. The intervention was highly acceptable: 87% liked it and 91% would recommend it to others. At 3-month follow-up, participants agreed the intervention increased: knowledge about using lubricants with condoms (83%), condom use skills (78%), and condom use confidence (70%). At baseline, few participants used daily pre-exposure prophylaxis (PrEP, 17%); post-intervention, 6 PrEP-naïve participants reported initiating PrEP (32%). Overall, condom use frequency during anal sex with male partners did not change (51% baseline versus 58% post-intervention,  $p=0.41$ ). However, among non-PrEP users, condom use frequency significantly increased during receptive anal sex (61% baseline versus 78% post-intervention,  $p=0.04$ ) and marginally increased during insertive anal sex (24% baseline versus 48% post-intervention,  $p=0.11$ ).

**Conclusion** The adapted FOF intervention was highly acceptable to ethnoracially diverse GBM in Vancouver. A third of participants initiated PrEP within 90 days. Among participants not using PrEP, the intervention effectively increased condom use during receptive anal sex, when HIV acquisition is most likely. This low-cost intervention demonstrates promise for increasing prevention practices among GBM attending STI clinics in Vancouver.

**Disclosure** No significant relationships.

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### UNEXPECTED RISING TREND OF SEXUALLY TRANSMITTED INFECTION IN BANGKOK, THAILAND

Pannee Chaiphosri, Alisra Tattakorn\*, Kanokrat Lerdtriphop. *BMA, Health Department, Bangkok, Thailand*

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**Background** Sexually transmitted infection (STI) remain a major public health challenge in Thailand, particularly Bangkok. STI control is important for HIV prevention. With a commitment to United Nation's Fast-Track cities to end AIDS in Bangkok by 2030, situation of STI should be monitored to assess effectiveness of HIV prevention efforts. This study aimed to examine trends of STI in Bangkok from 2013 to 2017 using case reporting data and periodic surveys.

**Methods** Data were obtained from the National Notifiable Disease Surveillance Report (506) and Routine Integrated HIV Information System (RIHIS) from nine STI clinics in Bangkok between 2013 and 2017.

**Results** Bangkok is facing a rise in STI cases, especially among young people, with 40% of all STI cases occurring in 15–24 years. From 2013 to 2017, the rates of reported STI in Bangkok increased eight folds from 11.8 cases per 100,000 population to 90 cases per 100,000, while the national rate rose four folds (18.5 in 2013 to 67.2 in 2017). In 2017, syphilis

was the most commonly reported disease in Bangkok with two times the national rate and particularly common among men who have sex with men (MSM).

**Conclusion** Prevalence of STI in Bangkok was rising and much higher than the national scale. MSM account for a disproportionately large burden of STIs particularly syphilis, which are consistent with high prevalence of HIV infection among MSM. Weakening of STI control may undermine HIV prevention efforts. Strengthening STI control in Bangkok are urgently needed.

**Disclosure** No significant relationships.

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### HOW DO THE PSYCHOSOCIAL CHARACTERISTICS OF WOMEN ATTENDING SEXUAL HEALTH SERVICES DIFFER FROM THOSE ATTENDING PRIMARY CARE?

<sup>1</sup>Natalie Edelman\*, <sup>2</sup>Jennifer Whetham, <sup>3</sup>Abi Gersten, <sup>4</sup>Catherine Mercer, <sup>5</sup>Richard De Visser, <sup>6</sup>Chris Jones, <sup>6</sup>Stephen Bremner, <sup>6</sup>Jackie Cassell. <sup>1</sup>University of Brighton, School of Health Sciences, Westlain House, Brighton and Hove, UK; <sup>2</sup>Brighton and Sussex University Hospitals Trust, Brighton and Hove, UK; <sup>3</sup>Pavilion Surgery, Brighton and Hove, UK; <sup>4</sup>University College London, Institute for Global Health, London, UK; <sup>5</sup>University of Sussex, School of Psychology, Brighton and Hove, UK; <sup>6</sup>Brighton and Sussex Medical School, Primary Care and Public Health, Brighton and Hove, UK

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**Background** Women attending specialist sexual health and contraception clinics (SHAC) are younger and more likely to report substance use and sexual risk behaviours than those attending Primary Care (PC). A broader analysis of psychosocial differences between these populations may improve our understanding of the wider determinants of sexual risk and morbidity and support the development of psychosocial interventions for use in specialist settings. We therefore explored which psychosocial factors were associated with recruitment site.

**Methods** Psychosocial question responses were compared from a cross-sectional survey of convenience-sampled women aged 16–44 years attending PC (Primary Care) vs SHAC services in the city of Brighton and Hove, UK. Multivariable logistic regression was used to identify which psychosocial factors predicted attendance in SHAC versus PC.

**Results** 1238 (70%) eligible women completed a questionnaire in a PC setting and 532 (30%) women in a SHAC service. After controlling for age, several psychosocial factors predicted SHAC compared to PC attendance. These included: living in rented accommodation (adjusted odds ratio (aOR)=1.70, 95% confidence interval (CI):1.20–2.40), being a cigarette smoker (aOR=1.32, 95%CI:1.00–1.75), disagreement that 'having a partner at all times is important to me' (aOR=2.24, 95% CI:1.69–2.97) emotional dissatisfaction with most recent relationship (aOR=1.51, 95%CI:1.15–1.99) and little or no functional social support (e.g. help with chores and meals) (aOR=1.83, 95%CI:1.21–2.78).

**Conclusion** Findings suggest that women attending SHAC may be more likely to experience lack of support and dissatisfaction with sexual and other relationships, and may be more likely to be in rented or other insecure housing compared with those attending primary care settings. Thus, the potential impact of broader life circumstances on sexual risk may be