O14.2 CAN COMMUNITY *CHLAMYDIA TRACHOMATIS* SCREENING OF YOUNG HETEROSEXUAL MEN HELP IDENTIFY INFECTED NETWORKS?

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10.1136/sextrans-2019-sti.183

Background Despite interventions to reduce *Chlamydia trachomatis* (Ct) rates in women, rates have increased or remained stable, particularly for African American (AA) women. Men could be a potential reservoir of infection yet the Centers for Disease Control and Prevention do not recommend screening men stating lack of evidence for feasibility and potential to reduce infection in women. The purpose of this study was to explore if venue-based screening is feasible and has high-yield.
Methods Venue-based screening (e.g. barbershops, colleges, community events) was conducted between March–December 2018 among AA men aged 15–24 who had sex with at least one woman in the last two months and spent most of their time in New Orleans. Men were offered a modest incentive, were screened for Ct via urine NAAT and underwent an audio/computer-assisted self-administered survey eliciting information about sexual partners
Results Of 599 men screened, 590 (98.5%) enrolled. Men enrolled received Medicaid (60.9%), were Ct tested in the last year (29.3%), reported a history of Ct (12.7%), were asymptomatic (97.1%) and 9.3% were Ct+. Men reported 873 partners (average 2.2, s.d. 1.4). Most of these partners were someone he knew for a long time (69.9%) or met through people in his social network (14.4%), were able to be re-contacted (80.1%), and with whom future sexual contact was planned 61.4%. In over one-third of partnerships (35.4%) men believed that their partner was having sex with one of his friends. Most men (53.3%) found out about the program from someone in their social network.
Conclusion Venue-based screening of young AA heterosexual men is feasible, detected a high rate of Ct infection, most partners were from social networks and could be re-contacted. Screening of young AA men has the potential to identify infected sexual networks and ultimately could reduce Ct disparities among men and women.
Disclosure No significant relationships.

O14.3 DISPARITIES IN ACCESS TO HIV POINT-OF-CARE TESTING: THE NON-URBAN CANADIAN CONTEXT

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10.1136/sextrans-2019-sti.184

Background Testing for sexually transmitted and blood borne infections (STBBIs), including HIV, is a crucial component of sexual health promotion. Testing can help facilitate timely access to care and treatment for those with a positive test result. Despite the approval of HIV point-of-care-testing (HIV POCT) for use in Canada in 2005, many jurisdictions do not have access to this testing innovation such as the 4 Atlantic provinces and there remain challenges in access in many non-urban settings elsewhere in Canada.
Methods Both qualitative and quantitative data were collected as part of an HIV POCT feasibility study with high risk populations in the largest of the 4 Atlantic Canadian provinces as well as from two scoping reviews on access to and uptake of HIV POCT with reference to Canadian non-urban settings. Together these data were examined using a PESTEL analytic framework for common emergent themes in relation to the policy-relevant factors contributing to why HIV POCT remains challenging to access in non-urban settings, even among populations at enhanced risk of infection.
Results Key emergent themes were mapped using the PESTEL analytic framework and found: perceptions of low risk for HIV among those living outside large metropolitan centres; competing public health priorities and expenditures; lack of national policy direction on testing, and issues of stigma; confidentiality; and loss to follow up in non-urban settings.
Conclusion The current jurisdictional constraints facing Federal, provincial, and territorial governments in relation to policies for testing, including access to STBBI testing innovation such as point-of-care testing, requires greater attention as Canada moves forward with the release of the 'Reducing the Health Impact of STBBIs in Canada by 2030: A Pan-Canadian Framework for Action'. Specifically, greater policy attention and national leadership is needed on the core pillar of STBBI testing in an effort to reach the undiagnosed, particularly in non-urban settings.
Disclosure No significant relationships.

O14.4 IMPLEMENTATION OF POINT OF CARE GONORRHEA AND CHLAMYDIA TESTING IN AN STD CLINIC PREP PROGRAM, SAN FRANCISCO, 2017–2018

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10.1136/sextrans-2019-sti.185

Background We assessed the impact of point of care (POC) testing for gonorrhea and chlamydia (GC/CT) on time to treatment in a HIV pre-exposure prophylaxis (PrEP) program in a STD clinic.
Methods In May 2018, San Francisco City Clinic implemented express GC/CT testing using the GeneXpert™ for PrEP follow-up visits for men who have sex with men (MSM) and transwomen. PrEP patients who were symptomatic or a contact to GC or CT were empirically treated and excluded from express testing. We describe the population screened using GeneXpert™ and test positivity. We compared their time to treatment with asymptomatic PrEP follow-up visits during the same time frame one year prior. Differences in time to treatment were compared using a t-test.
Results From May 2018-December 2018, there were 1623 visits by MSM and transwomen on PrEP at which GC/CT testing was conducted. The GeneXpert™ was used at 596 (36.7%) of visits. Of the 366 unique patients screened using the GeneXpert, the median age was 33; 40% were white, 30% Latino, 22% Asian and 6% black. Either GC or CT were positive at 87 (14.6%) of patient-visits. Positivity was higher at the rectum (10.8%) compared with throat (5.6%) and urine (1.5%). In comparison, from May 2017-December 2017, there were 611 visits by asymptomatic patients on PrEP

who were tested for GC/CT but not empirically treated. Either GC or CT was positive at 90 (14.7%) visits. Median age and race/ethnicity did not differ between the groups. Mean and median time to treatment for GC/CT decreased from 6 and 4 days prior to implementing GeneXpert™, to 1.7 and 0 days for those tested with the POC test (p<0.001).
Conclusion Prevalence of GC and CT was high among asymptomatic patients on PrEP. The introduction of POC testing decreases time to treatment, reducing duration of infectivity and potentially preventing ongoing transmissions.
Disclosure No significant relationships.

014.5 *CHLAMYDIA TRACHOMATIS* TESTING: A NATIONAL EVALUATION OF INTERNET BASED SELF-SAMPLING IN SWEDEN

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10.1136/sextrans-2019-sti.186

Background *Chlamydia trachomatis* (CT) testing in Sweden is free of charge and now exceeds 600,000 annual tests in a population of 10 million. These tests include internet-based self-sampling tests, a service that gradually has been implemented as a part of routine diagnostics in all 21 counties. To our knowledge Sweden is the country with the highest coverage of internet based self-sampling for CT. This study evaluates the diagnostic outcome for self-sampling.
Methods Requests for both self-sampling at home and clinic based sampling for CT-testing were sent to the laboratories in 18 of 21 counties. All 18 counties provided data on self-sampling in 2017 and 12 counties (representing 80% of the population) provided data on both self-collected samples at home and clinic based testing for the years 2013 to 2017.
Results The proportion of self-sampling increased from 12.9% in 2013 to 17.8% in 2016 when compared to national chlamydia test figures. Between 23% and 26% of delivered test kits were never sent back for analysis during 2013–2017. In analysis of 12 counties self-sampling increased by 110% between 2013 (n=32,993) and 2017 (n=69,181) for women, compared to 67% for men (2013: n=21,008; 2017: n=35,091). Test volumes for clinic based sampling was fairly constant for both sexes (women 2013 n=245,274; 2017 n=243,338; men 2013 n=97,519; 2017 n=110,617). The proportion of men was 36% for self-sampling compared to 30% (p<0,00001) for clinic based sampling, and the positivity rate decreased for both groups from 2013 to 2017 (7,8% to 7,1% (p<0,01)) vs 9.1% to 7.0% (p<0,0001)). Corresponding figures for women went from 5.3% to 4.6% (p<0,0001)and from 4.9% to 4.1% (p<0,0001).
Conclusion Self-sampling has increased significantly in recent years, especially among women.

The positivity rate is similar in self-collected and clinic collected samples.

Self-sampling reaches men more than clinic based testing, but not as much as expected.
Disclosure No significant relationships.

014.6 MAFRICA: ZENZELE, A MOBILE-PHONE ENABLED HIV TESTING AND LINKAGE TO CARE PATHWAY FOR YOUNG PEOPLE IN RURAL SOUTH AFRICA

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10.1136/sextrans-2019-sti.187

Background The uptake of HIV testing with linkage to care or prevention interventions such as Pre-Exposure Prophylaxis (PrEP) remains low among young men and women outside antenatal settings. This contributes to the high HIV incidence and HIV-related mortality in South Africa.
Methods We conducted formative work (8/2016–12/2018)to co-develop and pilot *Zenzele*,a mobile-phone enabled HIV self-test to support decentralized HIV care and preventionin a HIV high burden rural area of South Africa. We conducted surveys with a representative sample of 13–35-year-olds (n=3460); provider and user interviews (n=40 and 54 respectively); and group discussion (n=9). We piloted *Zenzele*,a simulated online pathway with n=30 individuals aged 18–30 attending a rural clinic. The *Zenzele* application supported an audio-visual guide in isiZulu and English; a timer to support self-testing according to the manufacturer guidelines; photographing the test using the smartphone camera and providing an automated interpretation of the result; and post-test health promotion and linkage to care.
Results 75.6% of 13–35-year-olds owned a mobile phone. After adjustment phone ownership was associated with age (aOR:1.48;95%CI1.42–1.54); male (aOR:1.64;95%CI 1.33–2.03); and recent HIV test (aOR:1.33;1.09–1.62). Interviews suggested that the mobile-phone enables HIV-self testing was broadly acceptable to users and providers. During the pilot study, everyone completed the self-test and received a result, the majority without resorting to the online support. The one participant testing positive was successfully linked to care. Post-pilot interviews found that young people liked the privacy and convenience and valued the availability of a hotline nurse. Main challenges were waiting 20 minutes to receive the test results and variable digital literacy.
Conclusion Mobile-phone enabled HIV self-testing combined the advantages of self-testing with provision of live support for those who struggle with the test, or who test positive. It provides the prospect of safe, decentralized, de-medicalised HIV care and prevention, including PrEP.
Disclosure No significant relationships.