

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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**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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**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 prevention in 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% CI 1.42–1.54); 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.