Momentary Assessment (EMA) increases self-esteem and behaviour change intentions.
Conclusion An identifiable gap exists in the evidence-base for the effectiveness of psychosocial interventions to support the wellbeing of sex workers. Available studies are weak in their design and lack generalisability beyond female street-based sex workers. Future intervention and research should better represent the diversity of workers and types of work within the sex industry. Sex workers should be engaged in the design of interventions/research in a 'by and with' rather than 'to and for' approach so that findings adequately address and respond to their actual needs.

Health care services

O17.1 WHAT MAKES SENSE? STRATEGICAL USE OF EHEALTH TECHNOLOGY TO STIMULATE SELF-CARE IN PUBLIC SEXUAL HEALTH CARE

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Background The 24 Sexual Health Clinics (SHCs) at the municipal public health centres covering The Netherlands provide sexual health care for key-populations and provide about 150.000 consultations annually. Adolescents 12–25 years can anonymously contact the SHCs free-of-charge for personal consultations on sexual health subjects including STI-testing. However financial restrictions result in prolonged waiting times. Moreover, specific high-incidence populations (e.g. multicultural, low SES) are insufficiently reached. The SHCs and the national sexual health institutes developed and implemented eHealth interventions to increase the accessibility and efficiency of sexual health services and to stimulate self-care.
Approach A stepped care model (SCM) approach was used to reshape Dutch public sexual health care for young people (www.sense.info). Important principle is that clients do not receive more care than is necessary. Not all clients need the same type – or level – of care: some may be helped by a online self-assessment tool in combination with a home STI testing package, others need (immediate) support by a health professional.
Outcomes/Impact The SCM approach leads to a re-organization of public sexual health care in the Netherlands for young people. The steps in the cascade refer to different types of consultations: on- and off-line, including, video-consultations and referral to (commercial) self-testing. The SCM increased the accessibility of the health system by allocating the scarce capacity of medical professionals to those who really need it and stimulated eHealth support and self-care by others.
Innovation and Significance The SCM approach proves to decrease fragmentation of sexual youth services and eHealth solutions by offering one nationwide online sexual health platform. This increases the findability of the information, and greatly enhances efficiency. It promotes self-care and relieves the workload of public health care professionals. This systematic, efficient and blended approach provides a sound basis for cooperation between SHCs and national institutes and enables developing a strategical agenda for innovations and eHealth solutions.

O17.2 EXPLORING FREDDIE: LESSONS FROM A NOVEL VIRTUAL HIV PREP CARE MODEL IN CANADA

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Background/Purpose To combat the HIV Epidemic, the concept of pre-exposure prophylaxis (PrEP) has gained considerable traction since demonstrating efficacy in 2012 and approval in Canada in 2016. Unfortunately, this HIV prevention method has not been ubiquitously taken up by those most at risk for many reasons, including difficulty in accessing care. Innovation, and necessity during the COVID pandemic, has increased the use of technology with new care models providing 100% of PrEP care virtually.
Approach This presentation will focus on the impacts and early findings of Freddie, a novel and entirely virtual PrEP care model in Canada focused on gender and sexual minority communities. This online health program connects those most at risk of HIV transmission with affirming prescribers across multiple provinces to break down physical and social barriers to PrEP initiation and ongoing use.
Outcomes/Impact Freddie has reached the benchmark of 1,000 patients in Canada, the majority of which have never been on PrEP before, representing a quick uptake in virtual PrEP services in Canada. The observations made thus far affirm theories that inclusive virtual care models can lead to increased access to STBBI prevention methods.
Innovation and Significance Presenters will discuss the innovative components of Freddie's virtual care model, explore findings as they relate to PrEP uptake and initiation by speaking to its initial successes and challenges, as well as how it addresses PrEP access barriers in Canada. This includes Freddie's focus on LGBTQ2S+ Canadians who are known to be at higher risk of HIV and historically have faced extraordinary barriers accessing sexual health care in inclusive settings. The intervention explored in this presentation continues to address such barriers through an innovative and accessible care model.

O17.3 MAINTAINING SERVICES, RESPONDING TO NEED: THE KINGSTON (ONTARIO) QUICK TEST CLINIC

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Background In early 2020, routine STI clinical services ground to a halt across Canada as a result of COVID-19 shutdowns, yet the need for STI screening, testing, and treatment continued unabated. We report on an innovative model for maintaining high-volume, low-barrier STI services during the pandemic.
Approach The Quick Test Clinic was established in June, 2020 by Kingston, Frontenac and Lennox & Addington (KFL&A) Public Health to facilitate nucleic acid amplification testing (NAAT) for gonorrhea (GC) and chlamydia (CT). Operating two half-days per week, the clinic invited clients to complete an intake form and submit a self-collected urine or swab specimen [rectal, meatal, vaginal, pharyngeal] without seeing a healthcare provider. Results were communicated by

telephone, and persons with documented infection were promptly treated.

Outcomes/Impact During the first six months of operation (19 June 2020 – 18 Jan 2021), the clinic provided 383 STI screenings to 347 unique individuals (mean age 27.9 years [IQR 21.0–32.0]) and a total of 864 self-collected specimens were tested. GC was detected in 13/184 (7.0%) males vs. 4/163 (2.5%) females (p = 0.47). CT was detected in 30/184 males (16.3%) vs. 17/163 (10.4%) females (p =0.11). A total of 4 persons were co-infected with GC and CT. Overall positivity with either GC or CT was 5.8%. Sample site positivity was highest for self-collected rectal specimens (6/46, 13.0%), followed by genital (55/664, 8.3%) and pharyngeal (5/88, 5.7%) specimens.

Innovation and Significance Findings demonstrate the ongoing need for sexual health services during the COVID crisis, and the feasibility of no-exam, drop-off testing of self-collected specimens. Gonococcal and chlamydial positivity rates exceeded that of standard pre-COVID clinic operations, supporting wider expansion of the Quick Test Clinic model. Future innovations may include text messaging and web-based applications for results notification and treatment referral.

O17.4 FIRST CLINICAL EVALUATION OF A 30-MINUTE POINT-OF-CARE-TEST FOR CHLAMYDIA TRACHOMATIS AND NEISSERIA GONORRHOEAE INFECTION IN UK SEXUAL HEALTH CLINICS

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Background As part of a programme of work seeking to facilitate adoption of multi-STI POCTs in English sexual health services (SHS), we implemented an approach to facilitate adoption of the binx health io CT/NG Assay ('binx POCT'). This included supporting analysis and interpretation of data following clinical validation and routine use of the binx POCT as implemented into clinical care, prior to SHS adoption decisions.

Methods Binx POCT diagnostic accuracy was compared to locally-used laboratory-based nucleic acid amplification tests (NAATs) and expressed as positive (PPA) and negative percentage agreement (NPA), with 95% confidence intervals (95% CI). Individual SHS reported turnaround time (TAT) from sample collection to patient receipt of results, before and after binx POCT implementation.

Results Three SHS participated, and were a mix of high, medium and low-throughput in south England. Of N=417 patients across all services, n=396 (195 women and 201 men) were successfully tested with both the binx POCT and SHS routine NAATs. CT: male PPA 92.5% (79.6–98.4), NPA 99.4% (96.6–100.0); female PPA 82.1% (63.1–94.0), NPA 98.2 (94.8–99.6). NG: male PPA 91.7% (61.5–99.8), NPA 100% (98.1–100.0); female PPA 90.9% (58.7–99.8), NPA 100% (2.0–100.0). Median TAT decreased from 5 days (IQR 3–7.25) pre-implementation, to 1 day (1=same-day (IQR 1–2)) during implementation; p <0.000001.

Conclusion Binx POCT PPA and NPA, as compared to participating SHS routine NAATs, were largely within expected ranges of the diagnostic evaluation conducted in the United States for FDA approval, and there was significant decrease in TAT time across all services. The binx POCT was not available for purchase directly following the programme's end, however, local data gave confidence to SHS to use the test in routine care, and all indicated interest in adoption. Providing services the ability to test new POCTs in local settings prior to purchase could help facilitate their wider implementation.

O17.5 BLOOD BORNE VIRUSES SCREENING (BBVS) FOR TEMPORARILY HOUSED ROUGH SLEEPERS IN BRIGHTON & HOVE DURING THE COVID-19 PANDEMIC

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Background At the start of the Coronavirus pandemic the UK Government pledged to house all rough-sleepers in temporary accommodation. This provided healthcare workers with a unique opportunity to access this 'hard-to-find' group, offer blood borne viruses screening (BBVS) and link clients testing positive into individualised treatment.

Approach A collaborative working group (HIV clinicians, HIV prevention specialists, hepatitis C outreach nurses and rough-sleepers health-engagement workers) established comprehensive risk-assessments, PPE supplies and dried blood spot procurement. Two experienced outreach workers worked along-side trusted homeless key-workers to offer BBVS (HIV, hepatitis B&C) in hotels, a hostel and student halls over 13-weeks (Jun-Sep 2020). Clients were offered £5 food-voucher for participating.

Outcomes 270 clients were housed during this time, 256 (95%) were offered BBVS; 192 (72%) tested. 148 (77%) tested 'mainly due to the incentive'. Of the 192 testers the median age (range) was 40y (18–69). Clients were mainly male 161 (83%); white-British 164 (85%) and heterosexual 179 (93%). 54 (28%) stated previous IVDU; 39 (20%) other drug use and 92 (48%) prison as risk-factors. 70 (36%) had not previously tested. 31 (16%) were hepatitis C antibody positive; 13 (7%) RNA positive. To date 4 have started treatment; 5 deferred; 3 did not engage with services despite being aware of the diagnosis; 1 left the area. No new HIV diagnoses (two clients re-engaged with care). Most clients considered the service good or excellent, and would recommend (99%). Challenges included lab delays due to competing Covid-19 testing and engaging disenfranchised clients.

Innovation and Significance This project brought together a multidisciplinary collaboration, drawing on specialist knowledge to meet complex needs. Despite challenges during a pandemic, we obtained a useful snap-shot of BBV rates. Offering an incentive to a cohort sensitised to BBVS was important. New outreach testing opportunities were identified which will be progressed in 2021.