Background We aimed to compare sexually transmitted infection (STI)-related risk profiles and STI testing rates by geographical area to determine areas for improvement of access to sexual health care (SHC). This could aid in optimizing and targeting interventions or service allocation.

Methods Five-year (2015–2019) individual population registry data were used (15–45yr), and matched with laboratory-based chlamydia (CT) and gonorrhoea (NG) testing data of general practitioners (GPs) and the only sexual health clinic (SH-CLIN) in the multicultural greater Rotterdam area, the Netherlands. CT/NG data were used as proxy for STI consultation. Per four-digit postal code (PC) area we calculated STI-related risk scores (based on age, non-western migrant background, education level and urbanization) and testing rates. Three PC clusters were identified: 1) high risk score with low testing rate; 2) high risk score with high testing rate; 3) low risk score, independently of testing rate. Multivariable logistic regression analysis was used to compare individual and area characteristics in cluster 1 and cluster 2.

Results The greater Rotterdam area consists of approximately 525,000 residents between 15–45yr. Around 27,000 CT/NG tests per year were reported. The PC area testing rate ranged from 2.2 to 116.1 tests per 1,000 residents. Around 45% of all residents belonged to cluster 1 and 30% to cluster 2. Characteristics associated with individuals in cluster 1 and cluster 2.

Conclusion This study combines individual population data and data of the two main SHC providers. Several determinants are associated with high STI-related risk scores and low testing rates. The next step is to develop strategies to improve SHC access for this group. Opportunities for further exploration include for example GP education, community-based testing and service (re)allocation.

Sexual partnerships and partner therapy

Background The association between meeting partners online and sexual practices has been under-studied in heterosexuals. This study aimed to examine the associations between the methods of meeting partners with sexual practices, as well as sexually transmitted infections (STIs) and human immunodeficiency virus (HIV), in heterosexuals.

Methods We conducted a survey among heterosexuals attending the Melbourne Sexual Health Centre between March and April 2019. This survey asked about the methods through which participants had met their sexual partner(s), sexual practices and intravenous drug use (IVDU) over the past 3 months. Participants’ HIV/STI (chlamydia, gonorrhoea, syphilis) status was obtained from clinical testing. A multivariable logistic regression was used to examine the association between each method of meeting partners and the participants’ sexual practices, IVDU, and STI status.

Results A total of 698 participants (325 males, 373 females) were included in the study. The majority of participants reported using only one method to meet partners (68.3% males, 65.7% females, p=0.0462). Males most commonly met partners at social-venues (e.g. bar, pub, party) (38.8%, n=126), whilst females most commonly met through friends/family (47.7%, n=178). Paying for sex was associated with males meeting partners at sex-venues (AOR=145.34, 95%CI: 26.13–808.51) and the internet (AOR=10.00, 95%CI: 3.61–27.55). There was no association between IVDU and methods of meeting. Social-venues were associated with condomless vaginal sex in males (AOR=3.31, 95%CI: 1.94–5.71) and females (AOR=2.58, 95%CI: 1.61–4.13) and testing STI positive in males (AOR=3.04, 95%CI: 1.24–7.48) and females (AOR=3.75, 95%CI: 1.58–8.89).

Conclusion Heterosexuals that met sexual partners at social-venues had a more than threefold risk of testing positive for STIs, indicating that heterosexuals may benefit from health promotion campaigns that are delivered through a more public setting.
Characteristics and outcomes of people choosing accelerated partner therapy (APT) in a cluster-randomised controlled trial comparing APT, as an additional PN method to enhanced patient referral (2018–2019, ISRCTN Reference 15996256). Clusters were 17 UK clinics, assigned in the first period by random permutation. Each period lasted 6 months, with a two-week washout. Participants were heterosexual women and men, ≥16 years with a positive C. trachomatis test and/or clinical PID, cervicitis, non-gonococcal urethritis or epididymo-orchitis, reporting ≥1 contactable sexual partner in the past six months. Analysis was by intention-to-treat, fitting random effects logistic regression models.

Results All clinics completed both periods. 1536 and 1724 index patients provided data in intervention and control phases. In total, 4807 sex partners were reported, of whom 1636 (34%) were committed/steady partners. Characteristics of index cases and partners were balanced. Overall, 293/1536 (19.1%) of index patients chose APT for a total of 305 partners, of whom 248 accepted. In intervention and control phases, 666 (43%) and 800 (46%) of index patients were tested for C. trachomatis; 31 (4.7%) and 53 (6.6%) were positive, adjusted odds ratio (aOR) 0.66 (95% CI 0.41–1.04, p=0.07). The proportion with ≥1 sex partner treated was 775 (92.7%) in intervention and 760 (89.3%) in the control phase, aOR 1.43 (95% CI 0.98–2.07, p=0.06). There were no significant harms reported.

Conclusion The findings suggest a benefit from the offer of APT supplementation enhanced PN. Differences in the outcomes were however small, with lower than expected uptake.

Characteristics and outcomes of people who used accelerated partner therapy for chlamydia in the Lustrum cluster cross-over randomised control trial

1C Estcourt, 1O Stirrup, 1F Mapp, 1A Copas, 1A Howarth, 1M Woode Owusu, 2N Low, 3J Saunders, 3C Mercer, 3F Flowers, 2,7R Nandwani, 3M Symonds, 3T Roberts, 4A Althaus, 4C Ogwuolu, 11Brice, 1A Comer, 1A Tostevin, 1A Johnson, 1MacQueen, 12Cas de Beaucourt, 1Glasgow Caledonian University, Glasgow, UK; 2NHS Greater Glasgow and Clyde, Glasgow, UK; 3University College London, London, UK; 4University of Bern, Bern, Switzerland; 5Public Health England, London, UK; 6University of Strathclyde, Glasgow, UK; 7University of Glasgow, Glasgow, UK; 8Public Health Scotland, Edinburgh, UK; 9Western Sussex Hospitals NHS Foundation Trust, Worthing, UK; 10University of Birmingham, Birmingham, UK; 11Barts Health NHS Trust, London, UK; 12Development Media International CIC, London, UK; 13Brighton and Sussex Medical School, Brighton, UK

Background Differences in sexual networks and risk behaviors between MSM and MSMW have important implications for HIV/STI transmission networks and bridging to other populations. As most HIV/STI programming is directed toward MSM, understanding risk behaviors, healthcare provider discussions, and network factors differentially experienced by MSMW are critical toward developing targeted, efficacious HIV/STI prevention paradigms.

Methods This is an analysis of a longitudinal cohort of predominantly Black/Latinx MSM in Los Angeles, California, half with substance use and half with HIV. Every 6 months from 8/2014–1/2019, respondents completed surveys evaluating the following: discussion of sexual orientation/behavior with healthcare provider in last 6 months, transactional sex, and last partnership characteristics (type, gender of partner’s sexual partners, HIV serostatus). MSMW was defined as self-reported sexual intercourse with a woman during last 6 months on two separate visits. Generalized estimating equations evaluated differences between MSM and MSMW associated with healthcare provider discussions, transactional sex, and last partnership characteristics, controlling for HIV and demographics.

UNCOVERING RISKY NETWORKS: RISK BEHAVIORS, SEXUAL PARTNERSHIPS, AND PROVIDER DISCUSSIONS AMONG MEN WHO HAVE SEX WITH MEN AND WOMEN (MSMW)

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10.1136/sextrans-2021-sti.155