(primary outcome) and sex partners treated (key secondary outcome).

Methods We did a cross-over 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 supplementing enhanced PN. Differences in the outcomes were however small, with lower than expected uptake.

018.3 CHARACTERISTICS AND OUTCOMES OF PEOPLE WHO USED ACCELERATED PARTNER THERAPY FOR CHLAMYDIA IN THE LUSTRUM CLUSTER CROSS-OVER RANDOMISED CONTROL TRIAL

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Background Accelerated partner therapy (APT) is a partner notification (PN) method whereby healthcare professionals assess sex partners by telephone, then send or give the index patient antibiotics and self-sampling kits for them. We described characteristics and outcomes of people choosing APT in an RCT.

Methods We did a cross-over cluster-randomised controlled trial comparing APT, additional to enhanced patient referral (2018–2019, ISRCTN Reference 15996256). Clusters were 17 UK clinics, assigned by random permutation. Each period lasted 6 months, with 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 sex partner in the past six months. Analysis is 'per protocol', using random effects logistic regression.

Results 1536 index patients were offered APT. They described 2137 partners and selected APT for 305/2137(14.3%). Of these 166/305(54%) were Committed/steady, 85/305(29%) New, 45(15%) Occasional and 9(3%) One-off partners. Common index reasons for declining APT included: preference for face-to-face conversation 400/1832(21.8%), partner already in clinic 388/1832(21.2%), unwilling to engage with partner 206/1832(11.2%), preferring partner to attend clinic 202/1832 (11.0%), partner overseas 150/1832(8.2%). Of 241 partners sent APT packs, 119/241(49%) returned chlamydia and gonorrhoea testing samples, of which 78/119(65.5%) were positive, but only 60/241(24.9%) HIV and syphilis samples (all negative). Of 106 index patients offered APT which was accepted ≥ 1 partners, and tested for chlamydia at 12–24 weeks, only 2 (1.9%) were positive. This contrasts with 6.6% (53) in the control arm and 5.2%(29) in index patients not selecting APT or whose partners refused.

Conclusion APT may improve PN outcomes but uptake is not universal and varies by partner type. Many index patients preferred face-to-face discussion and/or partners to attend clinic, while many were already attending. The role of APT in optimising PN, index patient care and STI control requires further clarification.

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

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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.