(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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10.1136/sextrans-2021-sti.154

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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10.1136/sextrans-2021-sti.155

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.

Results Among 431 participants across 1,258 visits, 9.3% (40/431) of participants were MSMW and 90.7% MSM. 30% of MSMW were living with HIV (12/40) compared to 52.4% (205/391) of MSM ($p=0.007$). In adjusted analysis, MSMW had higher odds of: not discussing sexual orientation/behavior with healthcare providers (AOR 2.19; 95% CI 1.10–4.35), unknown last partner HIV serostatus (2.19; 1.23–3.89), transactional sex (4.35; 2.27–8.36) and last partner also being MSMW (2.10; 1.10–4.02), compared to MSM.

Conclusion Despite riskier behaviors for HIV/STI transmission, MSMW had lower odds of discussing these behaviors with their healthcare providers, representing potentially missed opportunities for HIV/STI screening and prevention. Additionally, MSMW had higher odds of having MSMW sexual partners, suggestive of high-risk MSMW sexual networks that may not be uncovered in routine patient-provider discussions and should be prioritized in HIV/STI interventions designed to reduce barriers and facilitate linkages to care.

018.5

COMPARISON OF INTIMATE PARTNER VIOLENCE PRIOR TO AND DURING THE COVID-19 PANDEMIC: FINDINGS FROM THE I-SHARE CROSS-SECTIONAL MULTI-COUNTRY STUDY

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10.1136/sextrans-2021-sti.156

Background Shelter-in-place and related COVID-19 physical distancing measures may influence the risk of intimate partner violence (IPV). The current study aims to (1) describe perceived changes in IPV experienced during and prior to the COVID-19 outbreak, (2) identify social correlates of IPV.

Methods The International Sexual Health and REproductive Health (I-SHARE) study collected data on sexual and reproductive health during the COVID-19 pandemic (10,717 respondents in 16 countries between July 26th and December 1st 2020). The sample comprises participants in 7 HICs, 5 UMICs, 2 LMICs, and 2 LICs: 6,643 (62.3%) participants identified as women, 3,650 (34.2%) as men, and 178 (1.7%) as another gender. The median age was 30 (IQR 24; 39). Adults (≥ 18 yrs) were recruited online (social media, panel,

or population-representative). IPV was a primary outcome measured using an adapted six-item version of the WHO IPV scale. Mixed effects modelling was used to assess participants' experience of IPV in the three months prior to, and during, the COVID-19 physical distancing measures; participants were also asked about informal and formal reporting of IPV.

Results Preliminary analysis indicated that 1,864 (17.4%) of the 10,717 participants reported experiencing at least one form of IPV before the introduction of COVID-19 control measures; 1,346 (12.6%) participants reported IPV during COVID-19 physical distancing measures. Among participants experiencing IPV when physical distancing measures were in place, 691 (37.1%) told either a friend, the police, social services or other organization. Participants with a reduction in household income during the COVID-19 measures (aOR 1.48, 95% CI 1.29–1.69) and increased consumption of alcohol during COVID-19 (aOR 1.51, 95% CI 1.26–1.81) had higher odds of experiencing IPV.

Conclusion IPV may have decreased during COVID-19 measures, but remained common overall. Structural interventions are necessary to mitigate the impact of IPV.

018.6

RACIAL-ETHNIC MIXING PATTERNS IN THE UNITED STATES, 2006–2019

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10.1136/sextrans-2021-sti.157

Background Racial-ethnic mixing patterns have been associated with STIs in the U.S.; recent national data are lacking.

Methods We used data from the National Survey of Family Growth (NSFG), a national probability sample, from 2009–2019 (response rate: 63–77%). Analyses were limited to those 15–44 years who had a current, opposite-sex partner. Respondents reported the race-ethnicity of their most recent partner (not spouse or cohabiting partner) ($n=20,640$). We coded partner race-ethnicity as concordant-discordant with the respondent's race-ethnicity. We examined differences by race-ethnicity and sex and, within sex, by race-ethnicity, age, education, poverty, residence, and U.S. nativity (Wald F). Variables $p<0.25$ in bivariate analyses were entered into separate logistic regression models by sex. Adjusted prevalence ratios (aPR) were calculated.

Results Race-ethnicity concordance significantly differed ($p<0.001$) among women and men among non-Hispanic (NH) whites (77.7% vs 84.4%, respectively) and NH blacks (92.1% vs. 70.3%). Significant bivariate analyses ($p<0.25$) included race-ethnicity, education, poverty, and residence for women and race-ethnicity, education, residence and U.S. nativity for men. Among women, Hispanic (aPR=0.75; 95% CI:0.69–0.82), NH white (aPR=0.84; 95%CI:0.80–0.88) and NH other (aPR=0.32; 95%CI:0.25–0.42) were less likely than NH black to have a race-ethnicity concordant partner. Women who lived in major cities (aPR=0.90; 95%CI:0.84–0.97) or suburbs (aPR=0.92; 95%CI:0.86–0.99) were less likely than women who lived in rural areas to have a race-ethnicity concordant partner. Among men, residence findings were similar to women. NH other (aPR=0.42; 95%