

Asian/Pacific Islander, 2 were other/unknown; 4 were Hispanic and 14 non-Hispanic. Both GC positive female students were asymptomatic; one was 19, and one was 25 yrs old. Both were non-Hispanic with one being Asian and one White.

Conclusions This ongoing screening program of male and female students from the Johns Hopkins University Student Health and Wellness Center demonstrated a low prevalence of CT and GC among students, attending the Center. Targeted, innovative screening programs may improve outreach to populations with higher prevalences.

Epidemiology poster session 2: Population: Ethnic minorities: aboriginal population

P1-S2.68 TARGETED INTERVENTIONS FOR REMOTE AUSTRALIANS; TRENDS IN CHLAMYDIA AND GONORRHOEA NOTIFICATIONS IN ABORIGINAL AND NON-INDIGENOUS AUSTRALIANS 2005 – 2009

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Background Higher rates of chlamydia and gonorrhoea notifications have been reported in Aboriginal and Torres Strait Islander than non-Indigenous people in Australia since the early 1990s.

Methods Chlamydia and gonorrhoea notification data from the National Notifiable Disease Surveillance System were analysed by age, sex, remoteness and Aboriginal status in jurisdictions where complete data were available. Population rates and χ^2 test for trend were calculated using STATA version 10.

Results In the study period, there were 14 000 (1303 per 100 000) chlamydia notifications in Aboriginal people and 111 947 (242 per 100 000) in non-Indigenous people. In both populations the highest rates were in females aged 15–19, with Aboriginal females reporting a rate four times that of the non-Indigenous females. There was a significant increasing trend in the chlamydia notification rate in Aboriginal people over the 5 years (10%, p-trend $p < 0.001$) and also in non-Indigenous people (59% p-trend $p < 0.001$). Over the 5 years there were 17 336 (964 per 100 000) gonorrhoea notifications in Aboriginal people compared to 14 771 (22 per 100 000) in non-Indigenous people. The highest notification rates were in Aboriginal people aged 15–19 years who lived in very remote areas while in non-Indigenous people the highest notification rates were in males aged 30–39 years. Gonorrhoea notification rates in Aboriginal people over the 5 years decreased over the time period (18%, p-trend $p < 0.001$), but there was no significant trend in non-Indigenous people (19% p-trend $p = 0.667$). Although the rate of gonorrhoea decreased in Aboriginal people the rate was 26 times greater than the rate in non-Indigenous people. The female to male ratio for gonorrhoea of 1.1:1 in Aboriginal people suggests mainly heterosexual transmission, while in non-Indigenous people the female to male ratio was 0.29:1 suggesting predominantly homosexual transmission. The reported rates of gonorrhoea in Aboriginal people resident in very remote areas were 19 times Aboriginal people resident in urban areas.

Conclusion Chlamydia is a generalised epidemic among both Aboriginal and non-Indigenous peoples. In contrast gonorrhoea is predominantly a disease of Aboriginal people in remote areas and urban gay men. We are undertaking a range of trials in quality improvement interventions with Aboriginal communities to address the continued higher burden of STIs notified among Indigenous people in Australia.

P1-S2.69 PREVALENCE OF HPV INFECTIONS IN METIS AND FIRST NATIONS LIVING IN MANITOBA, CANADA

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Background Information on human papillomavirus (HPV) prevalence among Aboriginal populations (First Nations, Métis, Inuit) in Canada remains scarce but is needed for informed public health programming. This need is reinforced by the rapidly changing rates of cervical cancer screening in these populations and the introduction of prophylactic vaccines.

Method In 2008, 52 clinics across the province of Manitoba, Canada participated in a Pap Week initiative during which left over tissues from conventional Pap tests were used for HPV typing using the Lumindex method (developed by the National Microbiology Laboratory). A risk-behaviour survey was also administered to consenting women. Chi-square was used to compare frequencies and logistic regression was used to model the data. The most significant factors were included in the multivariate logistic model.

Results Of 592 women recruited, 113 self-reported being Meti or First Nations (M/FN); 70 did not report their ethnic background and were excluded from the analysis. M/FN participants were younger than the non-M/FN participants (mean age: 39 vs 45, $p < 0.0001$). HPV infection prevalence was 2.3 times higher in M/FN than in other participants (32.7% vs 14.2%, $p < 0.0001$). This increase was mainly due to the higher prevalence of HPV 32, 35, 51, 58, and 62. The prevalence of HPV 16 and 18 in the M/FN population was comparable to that of the non-M/FN ($p = 0.64$), although HPV 18 slightly higher in M/FN (5.6% vs 3.8%). Compared to their non-Aboriginal counterparts, M/FN women participating in the study were more often smokers ($p < 0.0001$), had a higher number of sexual partners in the last year ($p = 0.0004$), and were more often in an unstable relationship ($p = 0.03$). The strongest predictors for HPV infection in the study population were the number of sexual partners over the last year (OR 5.71; 95% CI 3.08 to 10.58) and having reported a M/FN identity (OR 2.17; 95% CI 1.28 to 3.69).

Conclusion Certain types of HPV may be more prevalent in M/FN than in the non-Aboriginal population. Although it is clear that the HPV vaccine has the potential to lower the prevalence of HPV 6, 11, 16, and 18 infections and related diseases in the M/FN population living in Manitoba, its impact could be mitigated by the relatively high prevalence of other HPV types.

P1-S2.70 THE DETECTION AND MANAGEMENT OF PELVIC INFLAMMATORY DISEASE IN ABORIGINAL WOMEN IN CENTRAL AUSTRALIA: CHALLENGES OF A REMOTE HIGH PREVALENCE SETTING

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Background In many remote Aboriginal communities in Australia, the prevalence of gonorrhoea and chlamydia is very high. Client mobility, frequent staff turnover and delays in laboratory results hamper timely treatment. Untreated gonorrhoea and chlamydia can lead to pelvic inflammatory disease (PID). In Central Australia, current remote health guidelines recommend three levels of criteria for diagnosing PID in women with lower abdominal pain: (1) cervical excitation or adnexal tenderness or uterine tenderness; or (2)