Predictors of repeat users were measured in a matched case-control study by conditional logistic regression analysis. A case (N=304) was defined as reporting having ever used IWTK before. A control was a user who reported never using the program earlier. Two controls (N=608) were systematically sampled for each case by matching date of use of IWTK of the case within 3 months.

**Results** From 2007 to 2010, 17% of 1747 women who used IWTK for STI testing indicated they had used IWTK previously. Of these, 45% used it >2 times. Mean age was 24.7±5.7 yr; most were African American (69%); single (87%); 57% had 2–4 sexual partners previous yr; 44% had new partners in last 3 months; 32% were currently having sex >1 person; 16% practiced anal sex in the last 3 months; 13% never used condoms; 77% had been treated for an STI; (5 HIV+). In multivariate analysis, repeat IWTK users were more likely to be ≥20 yr. (OR=2.10, 95% CI 1.30 to 3.38) and reside in Maryland (OR=2.03, 95% CI 1.31 to 3.13). They were more likely to have had a pelvic exam in past yr (OR=2.03, 95% CI 1.36 to 3.05); be treated for an STI (OR=2.32, 95% CI 1.57 to 3.44); to perceive internet screening as confidential (OR=1.98, 95% CI 1.32 to 2.97); report results from self-administrated swabs as accurate (OR=2.49, 95% CI 1.61 to 3.87); be less likely to drink alcohol before sex (OR=0.63, 95% CI 0.44 to 0.91); and to never use condoms with vaginal sex (OR=0.43, 95% CI 0.27 to 0.69). Of repeat users, 84.2% reported having a negative prior test and 48/304 (15.8%) reported last test positive; 27 had CT; 24 had TV; 3 had GC; 6 were mixed infections. At present test, 40 (13.2%) were positive: 14 had CT, 2 had GC, 28 had TV; 4 were mixed infections. Previous TV was associated with current TV positivity (p<0.05).

**Conclusions** IWTK attracted many previous participants who practiced high-risk sexual behaviours to use IWTK for repeat STI testing. IWTK may offer an alternate approach for rescreening previously infected women.

## P1-S6.16 AUSTRALIAN CHLAMYDIA CONTROL EFFECTIVENESS PILOT: PRELIMINARY RESULTS FROM A TRIAL OF CHLAMYDIA TESTING IN GENERAL PRACTICE

doi:10.1136/sextrans-2011-050108.240

[1]J Hocking, [1]M Temple-Smith, [1]S Poznanski, [2]R Guy, [3]N Low, [2]B Donovan, [1]J Gunn, [2]M Law, [2]J Kaldor, [1]C Fairley. *[1]University of Melbourne, Carlton, Australia; [2]University of New South Wales, Australia; [3]University of Bern, Switzerland*

**Background** While opportunistic chlamydia screening is conducted in several countries, debate remains about the effectiveness of population-based screening programs for reducing chlamydia transmission and its morbidity. The Australian Chlamydia Control Effectiveness Pilot (ACCEPt) aims to assess the feasibility, acceptability, efficacy and cost-effectiveness of annual chlamydia testing in general practice.

**Methods** ACCEPt is a cluster randomised controlled trial targeting sexually active 16–29-year old women and men for annual chlamydia testing. 54 postcodes (towns) are being randomised and all GP clinics within each area invited to participate. A multifaceted intervention to maximise testing includes: a computer alert prompting GPs to test; incentive payments for GPs and payments for employing practice nurses; a recall system to encourage annual testing; partner notification, and; information/support with regular feedback on testing performance. Clinics in the control group are encouraged to continue their usual practice. The intervention will be in place for up to 4 years. The primary outcome is change in chlamydia prevalence among a consecutive sample of 80–100 patients attending participating clinics in each postcode (total sample size about 4500) measured at the beginning and end of the trial. Secondary outcomes include pelvic inflammatory disease and chlamydia testing rates.

**Results** Recruitment began in July 2010 and 282 GPs in 69 clinics in 24 postcodes have been recruited to date in the States of Victoria, New South Wales and Queensland. Four clinics have refused so far and these postcodes have been excluded. To date, 615 16 to 29 year olds have been tested during the baseline prevalence survey with a participation rate of 70%. Overall chlamydia prevalence is 4.0% (95% CI 2.5% to 6.0%). Prevalence is slightly higher among males (4.5%; 95% CI 2.0% to 8.7%) than females (3.7%; 95% CI 2.0% to 6.3%, p=0.7) and in rural (6.9%; 95% CI 3.8% to 11.2%) compared with metropolitan areas (2.2%; 95% CI 0.9%, 4.4%, p<0.01). Recruitment will be completed by December 2011 with the intervention period running till end of 2014.

**Conclusions** This study shows high participation rates by GP clinics and by individuals invited to take part in the prevalence survey. Results will determine whether annual chlamydia testing is effective at reducing transmission and morbidity and will inform the optimal design of a chlamydia testing program in Australia.

## P1-S6.17 OPTING OUT TESTING FOR HIV IN DUTCH STI CLINICS: DOES IT WORK?

doi:10.1136/sextrans-2011-050108.241

[1]F Koedijk, [2,3]J van Bergen, [4,5]N Dukers, [4,5]C Hoebe, [3,6]M van der Sande, [7]on behalf of the Dutch STI centres. *[1]National Institute of Public Health and the Environment, Bilthoven, Netherlands; [2]STI AIDS Netherlands, Amsterdam, the Netherlands; [3]Centre for Infectious Diseases and Control, National Institute for Public Health and the Environment, Bilthoven, the Netherlands Netherlands; [4]Department of Infectious Diseases, Public Health Service South Limburg; [5]Department of Medical Microbiology, Maastricht University Medical Center, Maastricht, the Netherlands Netherlands; [6]Academic Medical Centre Utrecht, Utrecht, the Netherlands Netherlands; [7]A van Daal, P van Leeuwen, F de Groot, A Niekamp, M Langevoort, A van Camerijk, J van de Sande, E van der Veen Netherlands*

**Background** In 2005, STI centres in the Netherlands started provider-initiated HIV testing policy, in order to decrease the proportion of people unaware of their positive HIV status and to enable interruption of transmission and create more opportunities for timely treatment. This policy gradually evolved towards opt-out HIV testing and in January 2010, this became the official policy within all Dutch STI centres. The effects of the change in HIV test policy were studied and factors associated with opting out for HIV testing were identified.

**Methods** Data from January 2004 to June 2010 from 488 727 consultations registered in the Dutch national surveillance in the STI centres were used to characterise current practices on HIV testing. Known HIV positives were excluded from analyses. Logistic regression analyses were done separately for men having sex with men (MSM) and heterosexuals, to identify factors associated with refusing an HIV test.

**Results** Since 2004, the percentages of HIV testing within an STI consultation have increased significantly from 56% up to 92% in 2009, and further to 97% in the first half of 2010 when opting out was implemented nationally (both p<0.001). STI were significantly more often diagnosed in clients not tested on HIV during their consultation (p<0.001), except in 2010. Using 2010 data, MSM being older than 25 years (OR: 1.8, 95% CI 1.2–2.6), those having STI symptoms (OR 2.2 95% CI 1.7 to 2.8) and those with a previous STI (OR: 1.5, 95% CI 1.2 to 2.0) more often refused an HIV test. For heterosexuals, having had a previous STI (OR: 1.6, 95% CI 1.3 to 2.0), being female (OR: 1.2, 95% CI 1.0 to 1.4) and being younger than 25 years (OR: 1.2, 95% CI 1.0 to 1.4) were independent factors associated with refusing an HIV test.

**Conclusions** Although provider-initiated HIV testing already increased HIV testing rates, national implementation of opting out for HIV testing increased this uptake even more. Standard testing on HIV in every STI clinic is shown to be highly feasible and effective.