Mexico City (January, 2010). We described and analysed the population demographics, HIV prevalence, condom use, and sexual practices. All data were considered to identify the MSM and the factors associated with their HIV prevalence.
Results 956 men were HIV tested in January 2010 (401 in VCT site, and 555 in mobile unit). The percentage of MSM was 57.9 vs 47.9%, respectively; however, the HIV prevalence in MSM from the VCT site (27.6%), was seven times great than HIV prevalence in MSM from mobile unit (3.8%).
Conclusions Results suggest that the MSM attending the VCT site are different than the one attending the mobile unit. MSM tested in VCT site have the self-selection bias. However, due to higher HIV prevalence, the VCT site is an excellent place to develop intensive prevention programs in MSM.

Epidemiology poster session 6: Preventive intervention: Vaccination

P1-S6.41 DETERMINANTS OF HUMAN PAPILLOMA VIRUS VACCINATION (HPVV) AMONG QUEBEC (CANADA) TEENAGERS

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Background In 2010, 76% of Quebec female students aged 14 and 15 received complete HPVV through a publicly funded school-based program where teenagers can elect to be vaccinated (parental consent not mandatory). Quebec's free HPVV program also targeted female teenagers up to age 18 in various settings (mostly public clinics and schools). A study was conducted to identify the determinants of HPVV among Quebec teenagers targeted by the program.
Methods A mailed and electronic survey was conducted in 2010 of a random sample of 3000 females (aged 14 to 18) listed in the public health insurance data registry. The survey questionnaire was based on a model elaborated following an extensive literature review and upon an adaptation of the Health Belief Model and the Walsh and McPhee model. The model developed takes into account the mutual influence of teenagers and their parents, as well as interactions with health professionals, on the vaccination decision. Prior to the survey, two focus groups were conducted with vaccinated and non-vaccinated teenagers to improve the model, and the questionnaire reliability was tested on 110 students aged 14 and 15. The final questionnaire had 38 Likert scale and multiple-choice questions. Bivariate and multivariate analyses were done.
Results The response rate was 46%. Generally, teenagers have a good knowledge of HPVV and the virus transmission. However, 68% thought that men cannot catch the virus. The HPVV coverage for one dose decreases with age: from 94% for teenagers aged 14 to 68% for those aged 17–18 ($p<0.001$). HPVV was significantly associated with better knowledge, HPVV perceived benefits, vaccination habits, encouragement from the school nurse or a teacher, relatives? Encouragement and parental approval (adjusted OR: 1.1–4.3). Not having HPVV was significantly associated with concern about HPVV side effects, family discouragement, and media promotion of HPVV (adjusted OR: 0.27–0.50).
Conclusions School-based HPVV is more effective in reaching high vaccine uptake. Information on the virus transmission has to be improved; by targeting girls, the program suggests that only females can be infected. Even if their consent is not mandatory for teenager HPVV, parents play a major role in their daughter's vaccination decision. The media influence on unvaccinated teenagers must be deepened as it has a paradoxical impact.

P1-S6.42 HPV VACCINE AND SEXUAL BEHAVIOUR AMONG US ADOLESCENT AND YOUNG ADULT WOMEN

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Background Monitoring HPV vaccine uptake can identify potential disparities in coverage and guide vaccine implementation efforts. While there are several national estimates of HPV vaccine uptake among US women, there are few data on vaccination status in relation to sexual behaviour. We analysed receipt of HPV vaccine and intent to get vaccinated by demographic and sexual behaviour data from a nationally representative US survey.
Methods In 2007–2008, 1243 females aged 15–24 years in a nationally representative US survey answered questions about receipt of at least one dose of HPV vaccine. Unvaccinated women were asked about their intent to get vaccinated in the next 12 months. Demographic and sexual behaviour correlates were evaluated in bivariate and multivariable analyses by age for (a) receipt of HPV vaccine and (b) intention to receive HPV vaccine.
Results Overall, 23.1% of respondents reported receiving HPV vaccine; significantly more 15–19 year olds were vaccinated compared to 20–24 year olds (30.3% vs 15.9%, $p<0.001$). There was no difference in receipt of vaccine by race/ethnicity for 15–19 year olds, but 20–24 year old non-Hispanic blacks were less likely than non-Hispanic whites to have received vaccine [aOR=0.2 (0.1, 0.4)]. Women who had insurance were more likely to have received HPV vaccine. HPV vaccination was not associated with being sexually active or lifetime number of sex partners. Among sexually active 15–19 year olds, those who received HPV vaccine were more likely to report always wearing a condom [aOR=3.0 (1.1, 7.9)] than those who had not received vaccine. A majority of unvaccinated women in both age groups are not likely to get vaccinated in the next 12 months (62% of 15–19 year olds and 58.0% of 20–24 year olds). Sexually active women were more likely to intend to get vaccinated [15–19 year olds: aOR=2.6 (1.2, 5.5); 20–24 year olds: aOR=2.2 (1.1, 4.3)].
Conclusions These nationally representative data from the US highlight disparities in HPV vaccine uptake by insurance status among 15–24 year old women and by race/ethnicity among women above age 19. Our data do not suggest that HPV vaccination results in more sexually-risky behaviour, however, further data on timing of vaccination and sexual initiation are needed. Continued efforts are needed to encourage vaccination before initiation of sexual activity when the benefit of vaccination would be greatest.

P1-S6.43 HPV VACCINE COVERAGE AMONG HIGH-RISK WOMEN: RACIAL AND SOCIOECONOMIC DISPARITIES AND BARRIERS

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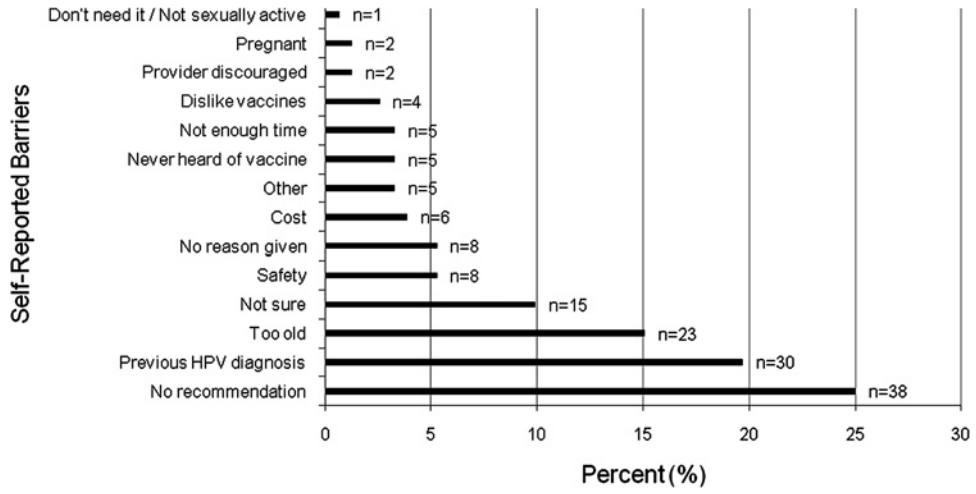
Background Human papillomavirus (HPV) is a necessary cause of cervical cancer and two vaccines are recommended for routine use among females ages 11–12 years with catch-up through age 26. Reducing disparities in cervical cancer will depend on achieving adequate vaccine coverage among racial and ethnic minorities and low-income women. The purpose of this analysis was to describe racial, ethnic, and socioeconomic differences in HPV vaccine coverage and identify barriers to catch-up vaccination.



Abstract P1-S6.43 Figure 1 Self-reported barriers to hpv vaccination among women with precancerous cervical lesions (n=152).

Methods Telephone interviews were conducted among women diagnosed with precancerous cervical lesions and reported to the CT Department of Public Health for routine surveillance during 2008–2010. The sample consisted of 269 women ages 18–27 years (age-eligible for catch-up vaccination after licensure) including 77% white, 15% black, and 17% Hispanic; median age was 23 years.

Results Overall, 43% of women reported having received ≥1 dose of HPV vaccine (mean age at vaccination 22 years). Publicly insured and uninsured women were significantly less likely than privately insured women to have received vaccine (23% and 15% vs 52%, $p<0.05$ for both), and black women were marginally less likely to receive vaccine compared to white women (31% vs 48%, $p=0.06$). There was no significant difference for ethnicity. The most common self-reported barrier to vaccination was lack of provider recommendation (25%). Other common self-reported reasons were previous HPV diagnosis (20%) and being too old (15%). Women who did not discuss HPV vaccine with a provider were more likely to have not received vaccine compared to women who discussed vaccine (95% vs 44%, $p<0.001$) see Abstract P1-S6.43 Figure 1.

Conclusions Provider interventions may be necessary to assure catch-up vaccine is offered to eligible women. A common reported barrier was being too old, yet all women in this sample were age-eligible for vaccination. Previous HPV infection was another common barrier, yet this is not a contraindication for vaccination to protect against infection from other HPV types. In particular, greater efforts are required to administer catch-up vaccine to low-income and black women. Providing vaccine for underinsured women in this age group will be a challenge because they are not eligible for some state or federal vaccination programs (eg, Vaccines For Children).

P1-S6.44 HIV VACCINE CLINICAL TRIAL ADHERENCE AND RETENTION: HIGH-RISK DRUG-USING WOMEN

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Background Clinical trial protocol adherence and retention are often considered challenges that are especially difficult to achieve among certain high-risk populations. The HIV infection rate among heterosexual African-American women is increasing, making their participation in clinical trials of HIV behavioural and biomedical prevention interventions more important. We identify drug use and sex risk factors associated with adherence to protocol and study retention among this population during the course of an HIV vaccine trial.

Methods Data from participants at the Philadelphia, PA site for the HIV Vaccine Trials Network (HVTN) 502 study testing the Merck Adenovirus 5 gag-pol-nef HIV vaccine were used to examine factors associated with adherence (receipt of three vaccines) and retention (present for 12-month appointment). Enrollees included 123 HIV-negative women 18–45 years of age reporting regular use of crack cocaine and frequent unprotected sex, who were randomly assigned to receive three injections of either the study vaccine or a placebo vaccine.

Results Study participants had a mean age of 37 years and 91% were African–American. Overall adherence to study protocol was 89% and study retention at one year was 93.5%. Analyses found no association between drug use and high-risk sex behaviours and poorer rates of adherence and retention. In fact, participants who used recreational drugs at baseline were more likely than those who did not to adhere to study protocol (92% vs 75%, $p<0.10$). Participants who reported use of injectable contraceptives at baseline were less likely than those who did not to be retained in the study at 1 year (57% vs 96%, $p<0.01$). Other measures of drug use (whether injected recreational drugs, and used crack cocaine, speed and other drugs) and sex risk (whether had a STI, exchanged vaginal, oral or anal sex for money, drugs or services, used different methods of birth control, the number of male sex partners, whether aware of partner's HIV status and whether had protective and unprotected vaginal, anal or oral sex with them) were not associated with adherence and retention.

Conclusions Factors commonly assumed to interfere with trial participation were not associated with adherence to study protocol or retention. These findings suggest that drug use and sexual risk behaviours do not impede completion of vaccinations and protocol required visits in clinical trials of experimental HIV vaccines.

Epidemiology poster session 6: Preventive intervention: Community action

P1-S6.45 IMPACT OF A COMMUNITY LEVEL, DIFFUSION BASED HIV/STI INTERVENTION ON HETEROSEXUALLY-IDENTIFIED, SOCIALLY MARGINALISED MEN IN URBAN, COASTAL PERU

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