Reasons for eventual condom initiation included: concern about infection/pregnancy (53%), partner insistence (32%), and condoms being available (15%). Compared with men who used condoms at first intercourse, men initiating use afterwards were significantly more likely to report their first condom experience was negative (62% vs 35%, aOR=2.8, 95% CI 1.1 to 7.2), and were less inclined to use condoms subsequently based on this first experience (34% vs 14%, aOR=3.4, 95% CI 1.2 to 8.8). However, measurement of condom use during most recent coitus did not differ significantly between men who initiated condom use after vs at their first intercourse both at last sex (43% vs 55%) and for both consistent use during the last month (43% vs 39%) and year (26% vs 20%).
Conclusions Public health efforts should emphasise the importance of condom use at first intercourse. Counselling should be provided to help prepare men for a positive first experience with condoms, given that this experience may affect immediate subsequent condom use following sexual debut.

P2-S1.12 PROJECT PREPARE TANZANIA: ENGAGING MULTIPLE STAKEHOLDERS TO DEVELOP A SCHOOL-BASED SEXUAL HEALTH CURRICULUM FOR ADOLESCENTS

doi:10.1136/sextrans-2011-050108.290

[1]R McCree-Hale, [2]L Kajula-Maonga, [2]Tatizo Ramatu Sheya wa Mnyakaya, [2]J Joachim, [2]K Mrumbi, [2]E John, [2]S Kaaya. *[1]Management and Development for Health, Dar es Salaam, United Republic of Tanzania; [2]Muhimbili University, Dar es Salaam, United Republic of Tanzania*

Background The objective of this formative research was to engage multiple stakeholders to identify specific factors that may influence program development for Project Prepare Tanzania- an innovative, school-based sexual health curriculum for young adolescents in Tanzania.
Methods Focus group discussions (FGDs) and structured interviews were used to elicit data for program development from students, teachers, parents, and healthcare workers. 12 FGDs were conducted with male and female adolescents (n=90) from 6 randomly selected schools in Dar es Salaam, Tanzania. Individual interviews (n=16) were conducted with boys (n=8) and girls (n=8). Key informant interviews were conducted with teachers (n=12) and parents (n=12). Community social workers (n=6) and healthcare workers (n=4) also participated in key informant interviews. Interview and FGD guides were designed to elicit data on: sexuality communication, self-efficacy, parenting and sexuality, inclusion of sexual health education in schools and knowledge, attitudes, and perceptions related to peer-education and skills-building for sexual health. NVivo 8 software was used to analyse data and help develop salient qualitative themes.
Results Salient themes were related to sexuality communication, attitudes towards skills building for condom use and negotiation of safe sex, access to correct information for sexual health, and partnership building to strengthen links between stakeholders. Factors that may influence communication about sexual health among adolescents include: fear associated with talking to parents, fear of being perceived as immoral, and inadequate opportunities to discuss sexuality including puberty. Parents and teachers reported needing skills to discuss puberty, sexually transmitted infections and sexual health. Teachers indicated that curricula should be expanded to include a sexual health component. There is a need for values clarification between parents and teachers regarding teaching about condoms and healthy sexual scripts for negotiation of safe sex. All participants suggested strengthening links between stakeholders to promote more communication.
Conclusions Project Prepare Tanzania will address the facilitators and barriers identified in this formative research to develop a culturally acceptable, innovative and sustainable sexual health curriculum for adolescents.

P2-S1.13 WHY INDIVIDUALS DO NOT RETURN THEIR REQUESTED *CHLAMYDIA TRACHOMATIS* (CT) HOME COLLECTION KIT: RESULTS FROM A QUALITATIVE STUDY

doi:10.1136/sextrans-2011-050108.291

R KoekenbierL Kalma, F Zuure, U Davidovich; On behalf of the Chlamydia Screening Implementation CSI project group. *Amsterdam Public Health Service Amsterdam, Netherlands*

Background A systematic and selective screening programme for CT was set up in the Netherlands, in which adolescents were invited by a personal letter to request a home collection kit online (http://www.chlamydiatest.nl). After collection, the kit could be returned to the laboratory by mail. In the first screening round (2008/2009), 20% (52 346/261 053) of the adolescents requested a kit. Of those, 22% (11 317/52 346) did not return the kit (non-testers). Here, we describe a qualitative study examining motives of non-testers for requesting a home collection kit, and their barriers for using it.
Methods Semistructured telephone interviews were conducted with non-testers from the second screening round (2009/2010) until data saturation was reached (n=25). They were invited for participation by email. Transcribed interviews were analysed qualitatively using Flexible Content Analysis, and interpreted using health behavioural theories that is, the Health Action Process Approach (HAPA).
Results Motives of participants to request a kit related to perceived risk for CT were: for certainty/reassurance, having complaints, or to take responsibility for one's own health. Motives related to specific features of the screening procedures were: it avoids invasive screening at STI-clinic or GP, procedures are simple, or because the screening is anonymous. Barriers for using a kit related to perceived risk for CT were: recently being tested, worries about the consequences of a positive test-result on the relationship, having no time, giving testing no priority, or laziness. Barriers related to specific features of the screening were: making wrong assumptions about the term of preservability of an unused test kit or about the term of the screening round, the user manual is unclear, being afraid to make mistakes during the collection procedures, the method of collection is unpleasant, or worries about privacy.
Conclusions Motives to request the CT home collection kit were related to the participants perceived risk of acquiring CT, and to advantages of the screening procedures compared to conventional testing. Barriers for using the test kit were related to low personal risk perception, unclear procedures of the screening, and fear for a positive test result. To overcome these barriers, the ease of contracting CT, and consequences of an untreated infection, should be emphasised. Furthermore, screening procedures should be optimised according to the users experiences.

P2-S1.14 THE ACCURACY OF PERCEPTIONS ABOUT SEXUAL CONCURRENCY AMONG PREGNANT ADOLESCENTS AND THEIR PARTNERS AND THE INFLUENCE OF SELF-REPORTED CONCURRENCY

doi:10.1136/sextrans-2011-050108.292

[1]A Swartzendruber, [2]L Niccolai, [3]J Zenilman, [3]J Jennings, [2]H Sipsma, [2]A Arnold, [2]T Kershaw. *[1]Johns Hopkins Bloomberg School of Public Health, Baltimore, USA; [2]Yale School of Public Health, USA; [3]Johns Hopkins University School of Medicine, USA*

Background Inaccurate perceptions about sexual partner concurrency are associated with current STI status. While high STI rates are reported among pregnant adolescents, studies have not investigated the accuracy of perceptions about sexual concurrency among young expecting couples nor explored factors related to inaccurate perceptions. Without open communication, individuals may inaccurately assume their partner's behaviour is like their own. The

objectives of this analysis were to assess the accuracy of perceptions about sexual concurrency among pregnant adolescents and their partners and whether self-reported concurrency is related to the accuracy of perceptions.

Methods Pregnant adolescent couples (N=258) were recruited from antenatal clinics as part of a larger study. Couples included pregnant women, 14–21 years, romantically involved with the father of the baby, ≥14 years. Sociodemographic, psychosocial and sexual behaviour data were collected from each member of the couple via ACASI. κ statistics assessed the accuracy of perceptions about partner concurrency during the relationship. Respondents who were uncertain about their partner's concurrency (n=58) were excluded from the kappa calculations. Multivariable logistic regression using generalised estimating equations assessed the associations between the respondent's self-reported concurrency and the accuracy of their perceptions about partner concurrency.

Results A total of 162 (81%) males and 146 (85%) females accurately reported their partner's nonconcurrency, but only 40% of males and 43% of females accurately reported the partner's concurrency (Abstract P2-S1.14 table 1). Overall, the accuracy of perceptions about concurrency was moderate (κ 0.41 for males, 0.49 for females). Adjusting for age, gender and partnership duration, respondents who self-reported non-concurrency were 54% less likely to accurately report their partner's concurrency (p=0.061). Respondents who self-reported concurrency were 81% less likely to accurately report their partner's non-concurrency (p<0.001).

Abstract P2-S1.14 Table 1 Agreement between respondent's perceptions about sexual concurrency during the relationship and partner-reported concurrency

	Female partner's self-reported concurrency # (% of total)		
Male's perception	**No**	**Yes**	**Total**
No	162 (63)	31 (12)	193 (75)
Yes	12 (5)	23 (9)	35 (14)
Uncertain	25 (10)	4 (2)	29 (11)
Total	199 (77)	58 (23)	257

	Male partner's self-reported concurrency # (% of total)		
Female's perception	**No**	**Yes**	**Total**
No	146 (57)	33 (13)	179 (69)
Yes	13 (5)	37 (14)	50 (19)
Uncertain	12 (5)	17 (7)	29 (11)
Total	171 (66)	87 (34)	258

Conclusions Among pregnant adolescents and their partners, there were many inaccurate perceptions about partner sexual concurrency. More than half did not accurately report their partner's sexual concurrency, which may increase their STI risk. Respondents' personal concurrency was associated with inaccurate perceptions about their partners' concurrency, reinforcing the need to improve sexual communication among young expecting parents.

P2-S1.15 CRIMINAL JUSTICE INVOLVEMENT IN ADOLESCENCE AND SEXUALLY TRANSMITTED INFECTION IN ADULTHOOD IN USA

doi:10.1136/sextrans-2011-050108.293

[1]M Khan, [2]D Rosen, [3]M Epperson, [4]A Berger, [4]K Smyrk. *[1]University of Maryland, College Park, College Park, USA; [2]University of North Carolina, Chapel Hill, Chapel Hill, USA; [3]University of Chicago, USA; [4]University of Maryland, College Park, Department of Behavioural and Community Health, Maryland, USA*

Background Criminal justice involvement (CJI) may influence a former offender's sexually transmitted infection (STI) risk by, for example, disrupting sexual networks thereby increasing sex partnership exchange or increasing links to high-risk networks and thus STI-infected sex partners. If CJI increases STI risk, juvenile CJI may be a particularly important determinant of subsequent STI, because experiences and behaviours during the adolescent period have been shown to influence risk trajectories into adulthood and because adolescent CJI that continues into adulthood would result in greater CJI exposure. No study, to our knowledge, has measured associations between juvenile CJI and adult STI risk.

Methods We used Wave III (2001–2002: young adulthood) of the National Longitudinal Study of Adolescent Health (N=14 322) to estimate cross-sectional associations between reported history of juvenile justice involvement and adult biologically-confirmed infection with chlamydia, gonorrhoea, or trichomoniasis.

Results In analyses adjusting for age, race, gender, socio-economic factors, drug use, delinquency, and depression/suicidality, indicators of 1 juvenile arrest and 2–5 juvenile arrests were not associated with adult STI. Those who had been arrested 6 or more times as a juvenile had 8 times the odds of adult STI as those with no juvenile arrest history (adjusted OR 8.58, 95% CI 2.94 to 25.1). History of juvenile conviction and serving a sentence of juvenile detention or probation also was associated with STI (adjusted OR: 2.07, 95% CI

Abstract P2-S1.15 Table 1 ORs and 95% CIs for the association between juvenile justice involvement and adult biologically-confirmed sexually transmitted infection (Assessed at Wave III)*, among young adults aged 18–28 years in the USA†

	Adult biologically-confirmed sexually transmitted infection	
Juvenile criminal justice involvement	**Unadjusted OR (95% CI)**	**Adjusted OR (95% CI)‡**
Number of times arrested as a minor		
0 times	Referent	Referent
1 time	1.23 (0.73 to 2.07)	1.24 (0.73 to 2.11)
2–5 times	1.30 (0.59 to 2.84)	1.17 (0.49 to 2.78)
6+ times	7.58 (3.00 to 19.17)	8.58 (2.94 to 25.1)
Ever convicted or plead guilty in a juvenile court		
No	Referent	Referent
Yes	2.14 (1.26 to 3.63)	2.07 (1.16 to 3.70)
Persistent Offending		
Never arrested as a juvenile or an adult	Referent	Referent
Arrested as a juvenile, not as an adult	1.19 (0.64 to 2.22)	1.35 (0.71 to 2.56)
Arrested as an adult, not as a juvenile	1.11 (0.78 to 1.56)	1.22 (0.82 to 1.81)
Arrested both as a juvenile and an adult	1.98 (1.26 to 3.10)	1.72 (1.06 to 2.80)
Timing of First Arrest		
Never arrested as a juvenile or an adult	Referent	Referent
Arrested for the first time as a minor	1.58 (1.09 to 2.29)	1.53 (1.02 to 2.29)
Arrested for the first time as an adult	1.10 (0.78 to 1.55)	1.21 (0.81 to 1.79)

*Overall, 6.1% of the analytic sample was confirmed to have a positive test result with *Chlamydia trachomatis*, *Neisseria gonorrhoeae,* or *Trichomonas vaginalis*.

†Use of survey commands to account for stratification, clustering, and unequal selection probabilities yielded nationally representative estimates of white and black young adults.

‡Adjusted for age; gender; race/ethnicity; age at first sex; high school education status of mother/primary caretaker; high school education status of respondent; poverty level measured at Wave III, defined as difficulty affording housing/utilities in past year; adolescent history of getting drunk or marijuana, cocaine, or injection drug use; high levels of delinquency in adolescence, defined as a score of 7 on a 7 point delinquency scale; and indicators of hopelessness in adolescence, including respondent report that he/she would be killed by the age of 21 year and report that he/she would get HIV/AIDS.