resort community with an international, transient and disproportionally large young adult population. A local sexual health clinic operates at capacity. There is no provincial or national outreach CT screening campaign.

Methods Series of 15 outreach CT screening sessions, each 2–3 h duration, held in Whistler, BC, Canada in 2009 & 2010. Sessions were held at resort staff-housing dinners, staff-housing lounge, entertainment, educational and sport events. Men and women <30 years were offered free CT nucleic acid amplification tests on urine. Positive cases were notified, with treatment and partner notification per standard of care. Primary outcome measures were age, gender and infection rates of outreach participants compared to <30 age cohort tested for CT at the sexual health clinic during same calendar years. Anonymous, post-test survey queried interval since last CT test, intention to test, health insurance, and satisfaction with the outreach experience. Unpaired t test & χ^2 analysis.

Results 112 tests for CT were obtained through outreach; 87.5% response rate to post-test survey. Mean outreach age of 23.3 years was 14.4 months younger than comparison age cohort tested at clinic (p=0.0001). Males were tested at outreach in greater proportion than at clinic (57.1% vs 46.5%, p=0.04). Proportion of asymptomatic cases was greater at outreach than clinic (90% vs 46.6%, p=0.01), yet positive test rates at outreach (8.9%, 10/112) and clinic (8.5%, 58/686) were comparable (p=0.87). On survey, 43.9% had never previously tested for CT, 53.7% were not already considering a test, 61.7% would not have gone for a test within the next 2 months. Only 27.6% had Canadian health insurance. 93.9% were satisfied or very satisfied with CT screening in an outreach setting.

Conclusions Intermittent, free, event-based outreach CT screening was operationally feasible, effective at increasing case detection, and highly acceptable to participants. Outreach attracted a younger age and more men than clinic. A large proportion of participants were first-time testers, over half were without prior intent to test or likelihood to test in near future, and most would have had to pay up-front for CT testing in a clinic setting. This study demonstrates both need and benefit of expanded CT screening efforts in the international resort setting.

P5-S7.06 CHLAMYDIA SCREENING IMPLEMENTATION IN THE NETHERLANDS IS NOT COST-EFFECTIVE

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Background *Chlamydia trachomatis* is the most common sexually transmitted infection in western countries. Most infections are asymptomatic and may cause severe complications. In the Netherlands, 3 years of Chlamydia screening implementation (CSI) have been performed. Here, we model its cost-effectiveness after 10 years.

Methods A cost-effectiveness analysis compares the relative costs and effects of two or more scenarios, and is usually expressed as the incremental cost-effectiveness ratio (ICER). The costs of the CSI program included those for hospital care, antibiotics, testing, and productivity loss. We measured the effects as either Major Outcomes Averted (MOA) or Quality Adjusted Life Years (QALY) gained. In the Chlamydia literature, MOAs usually consist of symptomatic pelvic inflammatory disease, chronic pelvic pain (CPP), ectopic pregnancy, infertility, and neonatal pneumonia. We calculated the ICER, the ratio of the above-mentioned costs and effects, for four scenarios: the default screening scenario (annual invitation of all 16–29 year olds), screening for women 16–29 only, for all 16–24 year olds, and biennial screening of all aged 16–29. To account for uncertainty in model parameters, we conducted a probabilistic sensitivity analysis (PSA).

Results If we compare the results of the four different scenarios presented in the abstract P5-S7.06 table 1, the default scenario has the most favourable ICER. This is probably due to the fact that the total number of invitations (and thus people tested) per year is the largest in the default scenario, implying that the fixed annual program costs are spread over more tests (and outcomes), which improves the ICER. The cost per QALY of all four scenarios seems acceptable if we include CPP in our QALY estimate. However, the evidence base for CPP forming nearly 90% of all QALYs lost is extremely weak. Therefore, we prefer the cost-per-QALY estimate excluding CPP, which is 30 000–70 000. Considering previous decisions on population screening programs, this ratio is relatively high and cannot be regarded as cost-effective. However, these results should be interpreted with caution due to the weak evidence base for the disease progression model. Because of this, the PSA showed variability of the four ICERs of up to 50%.

Abstract P5-S7.06 Table 1 Results from the economic CSI model

Scenario:	Total costs (M EUR)	MOAs averted	QALYs gained	QALYs gained [w/o CPP]	Costs/ MOA (k EUR)	Costs/ QALY (k EUR)	Costs/ QALY [w/o CPP] (k EUR)
Default	6.9	1200	1600	210	5.6	4.3	32
Women only	6.2	670	900	130	9.2	6.9	49
16-24	6.6	660	860	92	10	7.6	72
Biennial	6.4	820	1100	140	7.9	6.0	47

Conclusions We conclude that the evidence base for cost-effectiveness of Chlamydia screening is less strong than appeared from previous Dutch and foreign research, because of the much higher costs per MOA.

P5-S7.07 CHLAMYDIA SCREENING IN CORNWALL: HOW OFTEN DO YOUNG PEOPLE GET RETESTED?

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Aim To analyse the uptake of screening and rescreening in Cornwall, UK within the National Chlamydia Screening Programme (NCSP).

Methods We tested for any association between gender, age, test result and the probability of retesting. The time between tests was estimated using a Cox proportional hazards model and we tested whether the result of first test or gender influenced whether or not individuals were retested.

Results Between 2003–2009, 66 513 tests in 46 950 individuals were analysed. Most people were tested once. During this period the number of tests increased dramatically and the positivity declined (shown in Abstract P5-S7.07 table 1). Compared with those negative at the first test, positive cases were more likely to be retested and were retested sooner. Abstract P5-S7.07 table 1 Positivity among those tested in Cornwall 2003–2009.

Abstract P5-S7.07 Table 1

	2003–2004	2004–2005	2005–2006	2006–2007	2007–2008	2008–2009	*Total*
Tests	4794	6153	11 158	12 864	14 443	17 101	66 513
Positive	589	805	1086	1103	1213	993	5789
Positivity	0.1287	0.1376	0.1019	0.0901	0.0874	0.0604	0.0910