

Results The median age of all enrolled participants was 26 (IQR: 23–31), with a median of 3 (IQR: 2–4) partners reported during the previous 30-day period. Among all participants completing follow-up, 111/155 (71.6%) notified at least one partner, with a median of 1 partner notified per participant (IQR: 0–2). For participants randomised to receive PDPT, 69/83 (83.1%) reported notifying at least one partner, compared with 42/72 (58.3%) of participants in the control arm ($p = 0.001$). The proportion of all recent partners notified was significantly greater in the PDPT than the Control arm (53.5% vs. 36.4%; $p = 0.004$).

Conclusions Provision of PDPT led to significant increases in notification among Peruvian MSM diagnosed with GC/CT infection. Additional research is needed to assess the impact of PDPT on biological outcomes of HIV/STI transmission in MSM sexual networks.

011.2 OVERCOMING THE AMBIGUITY OF SEXUAL PARTNERSHIP TYPE: A NOVEL CATEGORISATION USING DATA FROM BRITAIN'S 3RD NATIONAL SURVEY OF SEXUAL ATTITUDES AND LIFESTYLES (NATSAL-3)

¹CH Mercer*, ¹KG Jones, ¹AM Johnson, ²R Lewis, ²KR Mitchell, ¹S Clifton, ¹C Tanton, ¹P Sonnenberg, ²K Wellings, ³JA Cassell, ^{4,5}CS Estcourt. ¹Centre for Sexual Health & HIV Research, Research Department of Infection & Population Health, University College London; ²Department of Social and Environmental Health Research, Centre for Sexual and Reproductive Health Research, London School of Hygiene and Tropical Medicine; ³Division of Primary Care and Public Health, Brighton and Sussex Medical School, University of Brighton; ⁴Blizard Institute, Barts and the London School of Medicine and Dentistry; ⁵Barts Sexual Health Centre, St Bartholomew's Hospital

10.1136/sextrans-2015-052270.138

Background The labels 'casual' and 'regular' partners are routinely used in both research and clinical contexts, yet considerable subjectivity surrounds the definition of different types of partnership in both professional and lay contexts, rendering comparison of audit and research findings problematic. We use national probability survey data to distinguish between different types of partnership, and examine the association between the resulting typology and reported STI diagnosis/es.

Methods 15,162 people aged 16–74y resident in Britain participated in Natsal-3 undertaken 2010–2012. Computer-assisted-self-interview was used for sensitive questions including those relating to participants' (max.) three most recent partners ($N = 12,167$ partners/past year). ANOVA and regression were used to test for differences in partnership duration and perceived likelihood of sex again across 20 'Partnership Progression Types' (PPTs) derived from reported relationship status at first/most recent sex with partners. Multivariable regression examined whether reporting STI diagnosis/es varied by partnership type after adjusting for partner numbers (all past year).

Results Four summary partnership types were identified from the 20 PPTs with median[IQR] durations and likelihoods of sex again (%), respectively, of: (1) 'Long-term' = 175 months [83–323], 96.9% likelihood of sex again; (2) 'Ex-steady' = 38 months [16–90], 44.9%; (3) 'Now steady' = 17 months [6–41], 74.4%; (4) 'Currently casual' = 3 months [0–14], 43.9%. These thresholds neither varied significantly by gender nor sexual identity, but did by age and sexual health clinic attendance. Reporting STI diagnoses varied according to the combination of partnership types experienced, including after adjusting for partner numbers, e.g. AOR for reporting STI diagnoses among men with both 'currently casual' and 'ex-steady' partners: 6.07 (95% CI: 1.41–26.1) vs. men with only 'currently casual' partners.

Conclusion Two survey questions enabled identification of four distinct types of sexual partnership in the British population. This typology is a valuable first step in defining partnership type, benefitting both research and practice, especially given recent moves towards more detailed reporting of sexual risk and partner notification outcomes.

Disclosure of interest statement AMJ has been a Governor of the Wellcome Trust since 2011. The other authors declare that they have no conflicts of interest.

011.3 TRICHOMONAS VAGINALIS RISK AND COFACTORS AMONG PERIPARTUM KENYAN WOMEN: PROTECTIVE ASSOCIATION WITH MALE PARTNER CIRCUMCISION

^{1,2}J Pintye*, ¹AL Drake, ³JA Unger, ⁴D Matemo, ⁴J Kinuthia, ^{1,5,6,7}RS McClelland, ^{1,5,6,8}G John-Stewart. ¹Department of Global Health, University of Washington, Seattle, USA; ²Department of Nursing, University of Washington, Seattle, USA; ³Department of Obstetrics and Gynecology, University of Washington, Seattle, USA; ⁴Department of Research Programs, Kenyatta National Hospital, Nairobi, Kenya; ⁵Department of Medicine, University of Washington, Seattle, USA; ⁶Department of Epidemiology, University of Washington, Seattle, USA; ⁷Institute of Tropical and Infectious Diseases, University of Nairobi, Kenya; ⁸Department of Pediatrics, University of Washington, Seattle, USA

10.1136/sextrans-2015-052270.139

Introduction *Trichomonas vaginalis* (TV) is the most common non-viral sexually transmitted infection (STI) worldwide and has implications for reproductive health in young women. We measured risk and correlates of peripartum TV.

Methods Kenyan women participating in a prospective study of peripartum HIV acquisition were enrolled during pregnancy and attended monthly follow-up visits until 9 months postpartum; HIV-seroconverters were excluded. TV was assessed every 1–3 months using wet mount microscopy and treated per Kenyan national guidelines. Recurrent TV was defined as TV detected ≥ 30 days after treatment or documented TV clearance. Male partner characteristics were reported by women. Andersen-Gill survival models were used to measure correlates of TV adjusting for age, socio-economic status, marital status, male partner circumcision status, and other STIs.

Results 1271 women enrolled at a median of 22 weeks gestation (interquartile range [IQR] 18–26), representing 1223 person-years. Most women were married (78%), reported no prior STIs (94%) and had uncircumcised male partners (69%); median age was 22 years (IQR 19–27). Overall, 196 TV infections were detected (81 prevalent at baseline, 115 incident during follow-up) and 56 (28%) were recurrent; 25% of infections were symptomatic. TV incidence was 9.4 per 100 person-years. In multivariate analyses, women with circumcised male partners had a 36% lower risk of incident TV compared to women with uncircumcised partners (adjusted hazard ratio [aHR] 0.64, 95% CI 0.43–0.94, $p = 0.023$). Having lower education (<8 years) (aHR 1.74, 95% CI 1.18–2.57, $p = 0.005$), being unmarried (aHR 1.75, 95% CI 1.10–2.78, $p = 0.017$), and recent *Chlamydia trachomatis* infection (aHR 2.06, 95% CI 1.24–3.44, $p = 0.006$) were associated with TV. Compared to nonuse, postpartum injectable or oral hormonal contraception use was not associated with TV risk.

Conclusion TV was relatively common in this peripartum cohort. Male circumcision promotion for HIV prevention may confer benefits in preventing TV among women in this setting.

Disclosure of interest statement We have no conflicts of interest to disclose.