

positivity among this population also demonstrated variance across geographic regions ranging from 13.2% (Aberdeen) to 4.6% (California). Among >26-year-old women, similar levels of screening were seen ranging from 34.4% (Alaska) and 5.7% (Bemidji); however, significantly less positivity was identified (1.4%–5.6%) (Abstract P5-S7.10 table 1).

Abstract P5-S7.10 Table 1 Chlamydia screening coverage among AI/AN women (≤ 25 & ≥ 26) by geographic regions, Stop Chlamydia Project—2009

Geographic Regions	# of Tests	≤ 25	% Positive	≥ 26	% Positive
Aberdeen (IA, NE, NS, SD)	8590	31.70%	13.20%	19.00%	3.80%
Alaska (AK)	12 185	50.80%	8.60%	34.40%	2.50%
Bemidji (MI, MN, WI)	190	10.90%	5.00%	5.70%	5.60%
Billings (MT, WY)	2630	28.70%	9.20%	18.70%	1.40%
California (CA)	173	6.80%	4.60%	6.10%	1.90%
Oklahoma (KS, OK)	2211	14.70%	11.60%	10.90%	2.80%
Portland (ID, OR, WA)	2063	28.80%	9.20%	23.80%	2.40%
Southwest (AZ, CO, NM, NV, TX, UT)	15 506	29.30%	9.40%	27.70%	4.00%
Nashville (AL, AR, CT, DE, FL, GA, IL, IN, KY, LA, MA, MD, ME, MO, MS, NC, NH, NJ, NY, OH, PA, RI, SC, TN, VA, VT, WV)	No participating sites				
Overall Total	43 548	31.50%	10.00%	23.80%	3.30%

Conclusions This is the first time screening coverage for American Indian/Alaska Native women has been evaluated by geographic regions. These data can help inform program improvement activities to maximise screening outcomes by expanding testing among women <25 years old and limiting routine screening efforts in older women (>26 years old) in order to better utilise testing resources to expand coverage among those at greatest risk for chlamydia (<25 years old).

P5-S7.11 CHLAMYDIA AND GONORRHOEA POSITIVITY AMONG FEMALES AGED 15–25 YEARS TESTED IN COMMUNITY HEALTH CENTERS IN 12 COUNTIES IN CY2009, REGION II INFERTILITY PREVENTION PROJECT, USA

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Background The US Centers for Disease Control and Prevention (CDC) recommends annual chlamydia screening for sexually active females aged <26 years. Community health centers (CHCs) have been a focal point for Health Care Reform in the US and have traditionally served as safety-net providers, however little is known about CT screening practices in CHCs or CT prevalence among CHC clients. The Region II Infertility Prevention Project (IPP) supports chlamydia and gonorrhoea (CT/GC) prevalence monitoring in participating facilities throughout New Jersey, New York, Puerto Rico and the US Virgin Islands, including a small number of CHCs.

Methods We reviewed Region II IPP CT/GC prevalence monitoring data for females aged 15–25 years tested in CY2009 attending CHCs for non-prenatal visits by age, test result, and laboratory test type, and compared with data for females attending family planning (FP) clinics for non-prenatal visits in the same counties. A total of 3103 CT and 2890 GC test records were associated with 18 CHCs in 12 counties in New Jersey, New York, and the US Virgin Islands; 35 FP clinics in the same counties reported 32 905 CT and 19 882 GC tests.

Results CT positivity among females aged 15–19 and 20–25 years in CHCs was 11.4% (n=640) and 5.7% (n=2463), respectively,

compared with 8.5% (n=10 946) and 4.6% (n=21 959) in FP clinics in the same counties. GC positivity in CHCs was 1.3% (n=594) and 0.2% (n=2296) among females aged 15–19 and 20–25 years, respectively, compared with 1.0% (n=6548) and 0.3% (n=13 334) in FP clinics (Abstract P5-S7.11 table 1). Over 99% of tests in CHCs were performed using highly sensitive nucleic acid amplification tests (NAATs), vs 55% of tests performed in FP.

Abstract P5-S7.11 Table 1 Chlamydia and gonorrhoea testing and positivity among females aged 15–25 years attending community health centers and family planning clinics for non-prenatal visits, CY2009, Region II Infertility Prevention Project, USA

Test type	Age Group (Years)	Community health centers		Family planning clinics	
		# Tests	% Pos	# Tests	% Pos
Chlamydia	15–19	640	11.4%	10 946	8.5%
	20–25	2463	5.7%	21 959	4.6%
	Total	3103	6.9%	32 905	5.9%
Gonorrhoea	15–19	594	1.3%	6548	1.0%
	20–25	2296	0.2%	13 334	0.3%
	Total	2890	0.4%	19 882	0.6%

Conclusion The burden of chlamydia and gonorrhoea among females aged 15–25 years attending CHCs is comparable to that observed in FP clinics, and highest among teens. As state and local health departments face mounting budget deficits and impending cuts to public health infrastructure—including cuts to the delivery of direct clinical services, CHCs may play an increasingly integral role in providing screening to the most at risk populations. CHCs are required to report to HRSA (the federal agency that funds the CHC program) on their performance using the measures defined in the Uniform Data System (UDS); however, the UDS does not currently include a measure for the proportion of clients screened for CT/GC. State and local health departments should consider opportunities to partner with CHCs in high morbidity areas to ensure and expand access to CT/GC screening and treatment for at risk populations, and leverage existing infrastructure to incorporate CHCs into ongoing prevalence monitoring efforts.

P5-S7.12 STD TESTING IN EMERGENCY DEPARTMENT: A NOVEL METHOD TO PROVIDE TEST RESULTS

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Background Realising the potential of broad based STD testing depends on treatment of those with positive results. Because emergency department (ED) physicians expressed reluctance to test for STD's because they had no mechanism for giving test results, we devised a system to provide results to patients tested for STD's at the county's public hospital by calling Bell Flower, the health department's STD program, to determine whether patients tested for STD's in the ED would call for their results.

Methods An electronically generated individually modified referral note with instructions for calling Bell Flower for STD test results was given to all patients tested for STD's including gonorrhoea (GC), Chlamydia (CT) or syphilis, in the Wishard Hospital Emergency Department. The Bell Flower results clerk was given access to the hospital's electronic medical record system containing laboratory results. The clerk's access to a specific patient's results was recorded electronically by the system. Patient records accessed by

the clerk were extracted and matched to patients given the discharge note. A patient was judged to have called if the clerk accessed that patient's test results. Continuous variables were compared using student t tests and proportions compared using χ^2 analysis. Because Hispanic patients used a different call mechanism, their data were excluded.

Results From 1 January 2010 to 30 April 2010, 503 patients were given the STD referral note. Of these, 447 were >14 years old, not Hispanic and had complete medical record information. Of the 447 patients with analysable data, 146 (32.7%) called for test results. Age, race, sex, Chlamydia results or treatment and high risk zip codes were unrelated to whether or not a patient called for results. Of 65 patients infected with CT 33 (52.3%) were not treated in the ED of which 10 called. Of 45 patients with GC, 6 (13.3%) were not treated for it in the ED, of which 2 called. Patients infected with GC, were less likely to call for their results than those not infected ($p=0.019$), particularly those who were adequately treated in the ED ($p=0.039$).

Conclusions Roughly one third of patients in one public hospital ED instructed to call for STD results called for them. Most of those infected with GC but not CT were treated appropriately with empiric antibiotics while in the ED. Infected patients calling in for test results could facilitate prompt treatment.

P5-S7.13 ROYAL PERTH HOSPITAL EMERGENCY DEPARTMENT SCREENING PROJECT FOR CHLAMYDIA TRACHOMATIS

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Background Western Australian (WA) rates of Chlamydia are consistently higher than the national average and continue to rise. Chlamydia screening programs often miss hard-to-reach populations, including young men, indigenous peoples, and the homeless. The objective of this pilot study was to determine if screening patients for genital Chlamydia in the Emergency Department (ED) of a large metropolitan hospital is: feasible, able to access the hard-to-reach populations, and follow-up for treatment is possible. **Methodology** Urinary screening for Chlamydia was offered to asymptomatic people aged 18–25 years who attended the Royal Perth Hospital (RPH) including visitors. Recruitment via a nurse-led strategy was compared to a patient self-initiated strategy. A resource package (including brochure and DVD) was designed to facilitate recruitment and screening, as well as to provide information on Chlamydia to those choosing not to participate. Options for notifying patients of their results have been evaluated (including text messaging and e-mail). Statistical analysis was performed using SAS. **Results** 823 people (male 532, female 291, aboriginal 58) were recruited. Of these 10% were homeless and 35% had moved residences in the last 3 months. The indigenous population of 7.1% was greater than that of the State (1.9% 2006 Census). The recruited asymptomatic population had a Chlamydia prevalence of 5.4%. When the nurse-led vs patient self-initiated strategies were compared there was a 23.8 to 1 ratio of recruitment.

Conclusions This study was able to access the hard-to-reach population. The nurse-led recruitment was the most successful strategy to gain access to this group. This cohort engaged in many risk taking behaviours including higher than expected rates of current smoking (45.7%), binge drinking (72.1% male and 42.8% female), never using condoms (26.3%) and recreational drug use (62.4% ever). Most people preferred to get their results by mobile phone (54.1%). This was a feasible ED screening method with respect to notification success. Less than 7% of this hard-to-reach population with Chlamydia could not be informed of their infection. A quarter of the

cases of Chlamydia required augmented efforts to notify them of their infection. The analysis of the data indicates that for every day there is a delay in attempting contact there is a 7.7 times increased chance of not having a successful contact.

P5-S7.14 HIGH CHLAMYDIA AND GONORRHOEA INCIDENCE, REINFECTION AND HIV INFECTION AMONG WORKERS IN THE ADULT FILM INDUSTRY: TIME TO REGULATE AND PROTECT WORKERS

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Background Adult film industry (AFI) workers engage in prolonged and repeated unprotected oral, vaginal, and anal sex with multiple partners over short periods of time, creating ideal conditions for acquisition and transmission of sexually transmitted infection (STIs). Workers are often required to perform without condoms to maintain employment. Our objective was to estimate the annual cumulative incidence rate of chlamydia (CT) and gonorrhoea (GC), assess the rate of reinfection with CT and GC and describe past HIV outbreaks in the AFI.

Methods CT and GC cases in AFI workers reported to the Los Angeles, California health department surveillance registry between 2004 and 2008 were retrieved. Using 2008 data, CT and GC annual cumulative incidence rates were calculated based on estimates of the worker population. For cases reported between 2004 and 2007, the CT and/or GC reinfection rates within 1 year were determined; all reported HIV cases from 2004 to 2010 were investigated.

Results From 2004 to 2008, 2633 cases were reported among 1849 AFI workers. Lower bounds for the annual cumulative incidence rate of CT and GC among AFI workers were estimated to be 14300 and 5100 per 100000 workers, respectively. Reinfection within 1 year was 26%. Female workers were 27% more likely to be reinfected than males (Prevalence Ratio=1.27, 95% CI 1.09 to 1.48). Between 2004 and 2010, 10 HIV cases were reported. In April 2004, 3/14 female workers were infected (attack rate 23%) as a result of workplace exposure. In October of 2010, an acute HIV infection was diagnosed in a male who worked over an 8-week period with 14 performers, including two later found to be HIV infected.

Conclusions CT and GC infection rates among AFI workers are high and repeat infection is common. Transmission of HIV in the workplace has been documented. This industry is not sufficiently regulated to protect workers from serious health risks.

P5-S7.15 STI KNOWLEDGE AND TESTING PRACTICES AMONG FSW WORKING OUTSIDE OF THE MAIN ENTERTAINMENT DISTRICT IN TIJUANA, MEXICO

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Background Regular sexual healthcare among FSW is important to reduce transmission and susceptibility of STIs and to enable earlier intervention and treatment for HIV and cervical cancer. Test and treat programs may improve access to sexual health services; however, low STI knowledge and risk perceptions may impede use of available services. We assessed the relationship between STI knowledge and testing among FSW in Tijuana, Mexico.

Methods Proyecto Amantes de la Salud (Lovers of Health) conducted baseline surveys among 403 FSW working in bars outside of Tijuana's red light district using time-location sampling. Surveys