symptomatic cases). An annual register-based Chlamydia screening programme is implemented in three regions since 2008.

**Methods** The number of persons tested and cases detected in the Chlamydia Screening among 16–29 year olds in Amsterdam, Rotterdam and South Limburg, 2008–2010, were compared to consultations and diagnoses in this age group reported in surveillance data from STI centres in the regions and estimates of STI care in general practices in these regions, 2007–2010. Round 3 data are based on the first 6 months of the year.

**Results** The baseline testing rates (at STI centers and by GP’s in year pre-screening) were 10% in Rotterdam, 15% in Amsterdam and 6% in South-Limburg. CSI increased testing rates steeply in the first year to 26–30% in the cities and 17% in Limburg; this decreased to 20–21% and 13% in round 3, still doubling testing rates as compared to baseline. Positivity rates at regular STI-care facilities are higher than in CSI: 12–15% in regular care vs 4–5% in CSI; therefore the addition of CSI to case-finding in the three regions was lower than that to testing; the screening programme added about 41% on top of the cases found in regular care in round 1, but this decreased to 20% in round 3 due to lower participation and positivity rates in consecutive rounds.

**Conclusions** By comparison to regular testing at STI centers and in general practice, the Chlamydia Screening had a major contribution towards case-finding in general practice, the Chlamydia Screening had a major contribution to baseline. Positivity rates at regular STI-care facilities are higher than in CSI: 12–15% in regular care vs 4–5% in CSI; therefore the addition of CSI to case-finding in the three regions was lower than that to testing; the screening programme added about 41% on top of the cases found in regular care in round 1, but this decreased to 20% in round 3 due to lower participation and positivity rates in consecutive rounds.

**Methods** Rapid HIV-tests offered through dedicated clinics were widely advertised in Montréal using free rapid tests with the goal of increasing early diagnosis of HIV. In this study we evaluated the feasibility of and potential impact of facilitated access to rapid HIV-testing.

**Results** Over 9 months 2500 received HIV testing. 98% were men reporting infected status at the previous screening. Mailed IWTK testing rates by 80% and 25% respectively. Using a $20 patient incentive to encourage re-testing.

**Conclusion** Reminders and mailed screening kits can increase re-testing rates by 80% and 25% respectively.

**Background** Repeat infection with *Chlamydia trachomatis* following treatment is common and increases the risk of sequelae. Despite clinical guidelines recommending re-testing within 3 months of treatment, re-testing rates remains low. We undertook a systematic review of studies which evaluated interventions aimed at increasing re-testing for repeat chlamydial infection.

**Methods** We searched Medline, EMBASE, trial registries, and conference websites from 2000 to September 2010 using variations of the terms “chlamydia” and “re-testing” and “intervention” to identify studies which compared rates of re-testing for repeat chlamydial infection between patients receiving and not receiving an intervention. We used meta-analysis methods to calculate the overall RR effect on re-testing rates, as well as undertaking a sub-analysis by strategy type.

**Results** We identified eight studies satisfying the inclusion criteria, including four randomised controlled trials and four controlled observational studies. The studies described 12 intervention strategies. All were conducted in the USA. The overall effect estimate RR for any strategy was 1.45 (95% CI 1.35 to 1.55); RR=1.80 (95% CI 1.65 to 1.97) for four studies using reminders such as postcards, phone calls, letters and emails (individually or in combination); 1.25 (95% CI 1.12 to 1.38) for four studies using mailed screening kits with or without reminders; 2.15 (95% CI 0.92 to 3.37) for two studies using motivational interviewing with or without reminders; 1.55 (95% CI 0.38 to 1.93) for one study using motivational interviewing with or without reminders; 1.55 (95% CI 0.38 to 1.93) for one study using a $20 patient incentive to encourage re-testing.

**Conclusion** Reminders and mailed screening kits can increase re-testing rates by 80% and 25% respectively.
Predictors of repeat users were measured in a matched case-control study by conditional logistic regression analysis. A case (N=304) was defined as reporting having ever used IWTK before. A control was a user who reported never using the program earlier. Two controls (N=608) were systematically sampled for each case by matching date of use of IWTK of the case within 3 months.

**Results**

From 2007 to 2010, 17% of 1747 women who used IWTK for STI testing indicated they had used IWTK previously. Of these, 45% used it >2 times. Mean age was 24.7±5.7 yr; most were African American (69%); single (87%); 57% had 2–4 sexual partners previous yr; 44% had new partners in last 3 months; 32% were currently having sex >1 person; 16% practiced anal sex in the last 3 months; 13% never used condoms; 77% had been treated for an STI; 95% CI 1.50 to 3.58) and reside in Maryland (OR=2.03, 95% CI 1.31 to 3.13). They were more likely to have had a pelvic exam in past yr (OR=2.03, 95% CI 1.56 to 3.03); be treated for an STI (OR=2.32, 95% CI 1.57 to 3.44); to perceive internet screening as confidential (OR=1.98, 95% CI 1.32 to 2.97); report results from self-administered swabs as accurate (OR=2.49, 95% CI 1.61 to 3.87); be less likely to drink alcohol before sex (OR=0.63, 95% CI 0.44 to 0.91); and to never use condoms with vaginal sex (OR=0.43, 95% CI 0.27 to 0.69). Of repeat users, 84.2% reported having a negative prior test and 48/504 (15.8%) reported last test positive; 11 had CT, 24 had TV, 3 had GC; 6 were mixed vaginal sex (OR 2.97; report results from self-administered swabs as accurate previously infected women.

**Results**

Recruitment began in July 2010 and 282 GPs in 69 clinics in 24 postcode have been recruited to date in the States of Victoria, New South Wales and Queensland. Four clinics have refused so far and these postcodes have been excluded. To date, 615 16 to 29 year olds have been tested during the baseline prevalence survey with a participation rate of 70%. Overall chlamydia prevalence is 4.0% (95% CI 2.5% to 6.0%). Prevalence is slightly higher among males (4.5%, 95% CI 2.0% to 8.7%) than females (3.7%, 95% CI 2.0% to 6.3%, p=0.7) and in rural (6.9%, 95% CI 3.8% to 11.2%) compared with metropolitan areas (2.2%, 95% CI 0.9%, 4.4%, p<0.01).

**Conclusions**

This study shows high participation rates by GP clinics and by individuals invited to take part in the prevalence survey. Results will determine whether annual chlamydia testing is effective at reducing transmission and morbidity and will inform the optimal design of a chlamydia testing program in Australia.

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**Poster Sessions**

**P1-S6.17 OPTING OUT TESTING FOR HIV IN DUTCH STI CLINICS: DOES IT WORK?**


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**Background**

In 2005, STI centres in the Netherlands started provider-initiated HIV testing policy, in order to decrease the proportion of people unaware of their positive HIV status and to enable interruption of transmission and create more opportunities for timely treatment. This policy gradually evolved towards opt-out HIV testing and in January 2010, this became the official policy within all Dutch STI centres. The effects of the change in HIV test policy were studied and factors associated with opting out for HIV testing were identified.

**Methods**

Data from January 2004 to June 2010 from 488 727 consultations registered in the Dutch national surveillance in the STI centres were used to characterise current practices on HIV testing. Known HIV positives were excluded from analyses. Logistic regression analyses were done separately for men having sex with men (MSM) and heterosexuals, to identify factors associated with refusing an HIV test.

**Results**

Since 2004, the percentages of HIV testing within an STI consultation have increased significantly from 56% up to 92% in 2009, and further to 97% in the first half of 2010 when opting out was implemented nationally (both p<0.001). STI were significantly more often diagnosed in clients not tested on HIV during their consultation (p<0.001), except in 2010. Using 2010 data, MSM being older than 25 years (OR: 1.8, 95% CI 1.2–2.6), those having STI symptoms (OR 2.2, 95% CI 1.7 to 2.8) and those with a previous STI (OR: 1.5, 95% CI 1.2 to 2.0) more often refused an HIV test. For heterosexuals, having had a previous STI (OR: 1.6, 95% CI 1.3 to 2.0), being female (OR: 1.2, 95% CI 1.0 to 1.4) and being younger than 25 years (OR: 1.2, 95% CI 1.0 to 1.4) were independent factors associated with refusing an HIV test.

**Conclusions**

Although provider-initiated HIV testing already increased HIV testing rates, national implementation of opting out for HIV testing increased this uptake even more. Standard testing on HIV in every STI clinic is shown to be highly feasible and effective.