

In order to optimise the opt out policy, and thereby successful interruption of HIV transmission, interventions to motivate “opt-outers” should be studied, since the few clients still refusing an HIV test were linked to higher risk behaviour.

**P1-S6.18** CHARACTERISTICS OF MEN WHO SEEK RESCREENING FOR STIs AFTER ONCE USING THE [HTTP://WWW.IWANTTHEKIT.ORG](http://www.iwantthekit.org) SCREENING PROGRAM

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**Background** The iwantthekit (IWTK) Internet screening program offered an opportunity to study characteristics of men who seek rescreening, as well as determine reported infected status at the previous screening.

**Methods** We determined characteristics of male repeat users from questionnaires. Predictors of repeat users were identified in a matched case-control study by conditional logistic regression analysis. A case was defined as reporting ever having used IWTK before. A control was a user who reported never using the program before. Two controls were systematically sampled for each case by matching the date of use IWTK of the case within 3 months.

**Results** During 2007–2010, 115 (14%) of 852 men who used IWTK for STI testing, indicated that they had used IWTK previously. Among them, 43% used it >2 times. Mean age was 25.8 yr ±8.5 yr, and 90% were currently sexually active. 17% reported having sex with a male; 35% had >5 partners in the past yr; 58% had new partners in last 3 months; 49% currently were having sex >1 person. 63% had been treated for an STI: chlamydia (CT)(74%), trichomonas (TV)(42%) and gonorrhoea (GC)(23%); 6 reported being treated for HIV. By matching time of enrolment, 230 controls were selected. In the multivariate analysis, repeat IWTK users were more likely to be <30 years (OR=2.04, 95% CI 1.04 to 4.02), have health insurance (OR=2.01, 95% CI 1.10 to 3.69), reported ever being tested for an STI (OR=2.01, 95% CI 1.02 to 3.97), ever been treated for an STI (OR=2.20, 95% CI 1.14 to 4.23), particularly TV (OR=5.16, 95% CI 1.80 to 14.81), and less likely to have penile discharge currently (OR=0.24, 95% CI 0.08 to 0.76). Of male repeaters, 80.9% reported previous test results from IWTK as negative and 22/115 (19.1%) reported previous result positive—11 had CT, 4 had GC, 8 had TV; 2 of these were mixed infections. At present test, 24 tested positive—19 had CT, 3 had GC, 5 had TV; 3 were mixed infections. Reported CT positivity in last test was associated with current CT test positivity ( $p<0.05$ ).

**Conclusions** The Internet screening program IWTK attracted a number of previous male users of IWTK, who practiced high-risk sexual behaviours, to use the program for repeat STI testing. IWTK provided an alternate approach for rescreening previously infected men as well as men reporting high-risk behaviours.

**P1-S6.19** COMPARING TWO METHODS OF ESTIMATING CHLAMYDIA SCREENING COVERAGE IN AN URBAN NEIGHBOURHOOD, 2009

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**Background** CDC recommends sexually active females aged <26 be screened annually for *Chlamydia trachomatis* (Ct). Only Ct cases are reported to local health departments. Screening coverage estimates,

defined as the proportion of the sexually active population tested for Ct, are not routinely available. Without such measures it is difficult to interpret increases in Ct case reports.

**Methods** We compared 2 approaches to estimating screening coverage in the New York City neighbourhood of Central Brooklyn (CB) in 2009: The “indirect method” used public health surveillance data, and “back calculated” to get the number of sexually active females that must have been screened to yield the number of reported Ct cases in CB females aged 15–19 and 20–25 years. Data inputs included: reported number of females with  $\geq 1$  Ct case in 2009 (730 cases aged 15–19, 619 cases aged 20–25) population estimates (12 772 aged 15–19, 14 024 aged 20–25), proportion ever had sex (35% aged 15–19), proportion sexually active in last 12 months (76% aged 20–25), and Ct positivity (20% aged 15–19, 8% aged 20–25). The “direct method” used electronic health record (EHR) data from 8 primary care provider practices in CB and adjoining zip codes using a common EHR for >1 year. EHR data were analysed to determine: numbers of unduplicated female clients aged 15–19 and 20–25, proportion sexually active, and number of sexually active females screened for Ct. The sexually active population was measured in 2 ways; group 1 was defined as females that reported ever having sex (18% (246/1340) aged 15–19 and 12% (302/2419) aged 20–25). Group 2 was defined as females meeting >1 of: reported ever having sex; ever prescribed an oral contraceptive by the practice; ever had an STD; ever diagnosed with STD by the practice; ever pap ordered by the practice (38% (514/1340) aged 15–19 and 38% (910/2419) aged 20–25).

**Results** See Abstract P1-S6.19 table 1.

Abstract P1-S6.19 Table 1 Estimated Chlamydia Screening Coverage for Central Brooklyn Females by Method and Age Group, 2009

Method	Age group	Female population	Percent sexually active	Number Ct tested	Estimated screening coverage
Indirect	15–19	12 772	35% (4406)	3632	82%
	20–25	14 024	76% (10 630)	8234	77%
EHR Group 1	15–19	1340	18% (246)	167	68%
	20–25	2419	12% (302)	178	59%
Group 2	15–19	1340	38% (514)	315	61%
	20–25	2419	38% (910)	518	57%

**Conclusion** The indirect approach yielded a higher Ct screening coverage estimate than the direct approach. By both methods, screening coverage was higher in the 15–19 age group than the 20–25 age group. For the direct approach, definitions of sexually active women affected measures of screening coverage, particularly for 15–19 year olds. The indirect method can be easily replicated, with limited resources. The direct method requires more resources and is contingent on consistent and accurate provider documentation of sexual activity.

**P1-S6.20** PERINATAL SCREENING FOR STIS IN THE USA: ADHERENCE TO PREVENTIVE SCREENING RECOMMENDATIONS FOR HIV AND SYPHILIS AMONG THE COMMERCIALY INSURED (2008)

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**Background** Perinatal transmission of sexually transmitted infections is a preventable source of morbidity. In the USA, the incidence