

vulnerable groups through distribution by community organizations in contact with these groups. This program is conducted among others to increase use of condoms and reduce STDs in Estrie. Recommendations resulting from evaluation will be used to improve the program.

Methods The process evaluation was conducted in two parts: 1. First part was conducted by analysing all relevant documents available at the public health department in charge. 2. Second part was conducted by interviewing all community organizations which participated in the program. Information was collected orally by two interviewers, using a standardised questionnaire.

Results The regional program is based on five components: 1) Annual launch (November) with a letter sent to all community organizations known to work with vulnerable groups. 2) Project submission by community organizations using a standardised form. 3) Distribution of condoms to community organizations. 4) Distribution of condoms to vulnerable groups by community organizations. 5) Annual report of activity by participating community organizations. Eleven community organizations had received condoms within the three years of the program. More than 100 000 condoms have been distributed in various projects. The regional budget allowed to the program has been able to cover the cost of all requested condoms, except for 1 year, where all projects were accepted, but with a somewhat reduced number of condoms per project. Participants were generally satisfied with the program. They confirmed its usefulness but proposed some modifications to it. Thirteen recommendations were made following evaluation. Some of them were about: 1) Favoured methods to approach community organizations. 2) Use more marketing so that more organizations know about the program. 3) Use of reminder for project submission and annual activity report. 4) Offering more kinds of condoms (especially large and without latex). 5) Offer education material to use in organizations along with condoms.

Conclusion Overall, the regional condom access program is considered useful and satisfying by the participating organizations. The recommendations resulting from evaluation will be useful to optimise the implementation of program in the future, adapt it to the needs and therefore increase its efficacy to reach its STDs reduction goals.

Epidemiology poster session 6: Preventive intervention: Counselling

P1-S6.48 IDENTIFYING WOMEN AT RISK: CAN AN STD DIAGNOSIS HELP TARGET WOMEN FOR RISK REDUCTION COUNSELLING? MIAMI-FORT-LAUDERDALE, 2000–2009

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Background The Miami-Fort Lauderdale metropolitan statistical area has one of the highest rates of HIV in the US and 29% of cases are among women. We explored STD history as an HIV risk factor for women.

Objective To determine if reported gonorrhoea (GC), chlamydia (CT), early syphilis (ES) or demographic factors predict the risk of subsequent HIV infection among women.

Methods We linked STD surveillance data (2000–2006) and HIV report data (2000–2009) to identify HIV infection rates among females >10 years of age, who acquired HIV >60 days after an STD diagnosis. Census data were used to estimate HIV infection rates for women without an STD diagnosis. Multivariate analysis was used

to identify correlates of HIV-infection in women with an STD diagnosis.

Results Of 46318 women diagnosed with an STD from 2000 to 2006, 534 (1.2%) were subsequently reported to be HIV-infected by 2009 (median time to diagnosis 3.0 years, mean 3.5 years). Most, 446 (83.5%), were Black. Of the 604 Black women aged 20–24 years diagnosed with HIV, 167 (27.6%) had been diagnosed with at least one STD. However, 9187 Black women aged 20–24 had an STD in 2000–2006, so the risk of HIV following an STD diagnosis was relatively low for these women. Of 371 181 Black female area residents, 6077 with no STD were reported HIV-positive in the time frame (0.16% per person-year). Risks for Black women with STD were: CT 0.23% per person-year; GC 0.54% per person-year; and ES 1.70% per person-year. In multivariate analysis, among women with an STD, HIV risk factors were: Black race (adjusted prevalence rate ratio (PRR) 4.8, 95% CI 3.1 to 7.3); age at STD diagnosis <15 years (PRR 2.1, 95% CI 1.4 to 3.3) or between 35 and 49 years (minimal PRR 1.9, 95% CI 1.4 to 2.5) compared to 20–24 years; residence in a high morbidity zip code (PRR 2.1, 95% CI 1.8 to 2.5); and diagnosis of GC (PRR 2.0, 95% CI 1.8 to 2.5) or ES (PRR 7.9, 95% CI 5.7 to 10.9) compared with CT.

Conclusion STDs are common in young women. However, these data demonstrate that STDs in younger and older women, particularly Blacks with gonorrhoea or syphilis are indicators of increased risk of subsequent HIV infection. These women can be easily identified in clinical settings and targeted for risk-reduction interventions.

P1-S6.49 DEVELOPING AND VALIDATING A RISK SCORING TOOL FOR CHLAMYDIA INFECTION AMONG SEXUAL HEALTH CLINIC ATTENDEES IN AUSTRALIA: A SIMPLE ALGORITHM TO IDENTIFY THOSE AT HIGH RISK OF CHLAMYDIA INFECTION

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Objective To develop and validate a risk scoring tool for chlamydia infection to identify those who are at increased risk of chlamydia infection.

Methods We used demographic, sexual behaviour information and chlamydia positivity results from more than 45 000 individuals who attended Sydney Sexual Health Centre between 1998 and 2009. Participants were randomly allocated to either the development or internal validation dataset. Using logistic regression, we created a prediction model and weighted scoring system using the development dataset and calculated the OR of chlamydia positivity for participants in successively higher quintiles of score. The internal validation dataset was used to evaluate the performance characteristics of the model for five quintiles of risk scores including population attributable risk (PAR), sensitivity and specificity.

Results In the prediction model, inconsistent condom use, increased number of sexual partners in last 3 months, genital or anal symptoms and presenting to the clinic for sexually transmitted infections (STIs) screening or contact of an STI case were consistently associated with increased risk of chlamydia positivity in all groups. High scores (upper quintile) were significantly associated with increased risk of chlamydia infection. A cut-point score of 20 or higher distinguished a “increased risk” group with a sensitivity of 95%, 67% and 79% among heterosexual men, women and MSM, respectively.

Conclusion The scoring tool may be included as part of a health promotion and/or clinic website to prompt those who are at increased risk of chlamydia infection which may potentially lead to increased uptake and frequency of testing.