

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 100 000 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

included demographics, sexual behaviour, sex work characteristics and sexual healthcare and a 28-item STI knowledge scale (Jaworski and Carey, 2007). Adjusted prevalence ratios were estimated using poisson regression to assess the association between STI testing in the past year and standardised STI knowledge scores.

Results Participants were aged 18–55 years (Median: 28; IQR: 23–32), all born in Mexico and had been involved in sex trade a median of 6 years (IQR: 3–9). A majority (69%) reported having an STI test in the past year and 39% reporting three or more tests see Abstract P5-S7.15 table 1. Median STI knowledge score was 63% (IQR: 55–70). Notably, 43% and 33% did not think there were cures for Chlamydia and gonorrhoea, respectively. Among the 31% with no STI test, 87% (N=95) indicated that this was because they “had been careful/always used condoms”. However, of these, only 44% reported consistent condom use for vaginal sex with non-regular clients. In adjusted regression models accounting for education, income, years in sex work, number of clients and self-treatment, higher STI knowledge scores remained significantly associated with STI testing.

Discussion STI knowledge was significantly associated with reporting STI testing in the past year. As women work in bars and brothels outside of the main entertainment district where the majority of FSW interventions are based, STI knowledge may have a greater impact on access and utilisation of testing services. Importantly, misperceptions regarding available treatment and perceptions of sexual risk were prevalent. Incorporation of sexual health education into existing HIV/STI programs is warranted and would be an efficient way to improve sexual healthcare in this population.

Abstract P5-S7.15 Table 1 Prevalence ratios for association of STI testing in past year with standardised STI knowledge score among FSW in Tijuana, Mexico

	STI test past year, N=277 (69%)	No STI test past year, N=126 (31%)	AdjPR (95% CI)
STI knowledge score			
Median % of responses correctly answered	67 (59–70)	59 (52–67)	–
Median standardised score	0.40 (–0.38, 0.79)	–0.38 (–1.16, 0.40)	1.10 (1.03 to 1.19)
Age <25	84 (30%)	40 (32%)	–
Work colonia			
Region A	131 (47%)	53 (42%)	–
Region B	146 (53%)	73 (58%)	–
Lived in TJ whole life	91 (33%)	36 (29%)	–
Education (>6 yrs)	151 (55%)	55 (44%)	1.15 (1.01 to 1.30)
Income (>3500 pesos/mos)	229 (83%)	56 (44%)	1.87 (1.51 to 2.32)
Years of SW	5 (3, 9)	7.5 (3, 11)	0.98 (0.96 to 0.99)
10+ clients/week	158 (57%)	51 (40%)	1.20 (1.06 to 1.37)
Used Antibiotics for STI w/out prescription (ever)	20 (7%)	26 (21%)	0.76 (0.58 to 0.99)

Bold font indicates $p < 0.05$.

P5-S7.16 EASY ACCESS “COMMUNITY-BASED HIV TESTING SERVICES FOR GAY MEN: A SYSTEMATIC REVIEW”

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Background Community-based HIV testing has been widely utilised with the goal of increasing testing opportunities for gay men and decreasing the number of men who are unaware of their HIV status.

Abstract P5-S7.16 Table 1 Summary of community HIV testing services by setting and key outcomes of interest (n=44)

Category	Subcategory	All services n (%)	
Location (n=44)	Australia	3 (6.8)	
	Hong Kong	1 (2.3)	
	Spain	1 (2.3)	
	Switzerland	1 (2.3)	
	The Netherlands	3 (6.8)	
	New Zealand	1 (2.3)	
	UK	6 (13.6)	
	USA	28 (63.6)	
	Target group (n=44)†	Men who have sex with men (only)	15 (34.6)
		Broader population including:	
MSM		6 (13.6)	
Ethnic minority		3 (6.8)	
Young people		3 (6.8)	
Transgender		3 (6.8)	
IDUs		3 (6.8)	
Multiple		11 (25.0)	
Not reported		3 (6.8)	
Service type (n=44)		On-site CBO	8 (18.2)
	Community clinic*	10 (25.0)	
	Outreach Mobile testing facility (MTF)	6 (13.6)	
	Venue-based outreach (bar, club, sauna)	8 (18.2)	
	Multiple sites (venues, MTF, homeless shelter)	5 (11.4)	
	On-site and outreach services (combination of venues)	7 (15.9)	
	Number of sites (n=44)	1–2	29 (65.9)
5–10		2 (4.6)	
Multiple sites—number not reported		12 (27.3)	
Not Specified		1 (2.3)	
Rapid HIV testing offered (n=44)		Yes	30 (68.2)
	Yes in parallel with conventional EIA testing	4 (9.1)	
	No	10 (22.7)	
Type of Rapid Testing (n=28)† ‡	Abbott Determine HIV-1/2 rapid test	12 (42.9)	
	Abbott-Murex Single Use Diagnostic System for HIV-1 [SUDS]	3 (10.7)	
	Inverness Clearview HIV 1/2 STAT-PAK	1 (3.6)	
	OraSure OraQuick Advance Rapid HIV-1/2 Antibody	12 (42.9)	
	OraSure OraQuick Rapid HIV-1 Antibody	10 (35.7)	
	Unigold Recombigen HIV	4 (14.3)	
	Cost to patient (n=32)	Nil - (covered by service/study)	17 (38.6)
		Nil + incentive received for participating	11 (25.0)
		\$10–€20 payment for test	4 (11.4)
	Operating hours (n=16)	2–5 h/week	10 (62.5)
5–10 h/week		1 (6.3)	
>10 h/week		5 (31.3)	
Staff types (n=26) †	Administrative staff	4 (15.4)	
	HIV counselling & testing staff/counsellors	16 (61.5)	
	Nurses/healthcare workers/clinic co-ordinator	8 (30.8)	
	Phlebotomists	2 (7.7)	
	Physicians/medical officers	4 (15.4)	
	Psychotherapists	2 (7.7)	
	Sexual health educators/peer-workers/outreach workers	9 (34.6)	
	Social workers/case managers	2 (7.7)	
No Staff/shift (n=19)	Volunteers	4 (15.4)	
	1	1 (5.3)	
	2–3	13 (68.4)	
	4–7	5 (26.3)	

*Community clinics refer to services that offer direct medical services to clients; for example, STI/HIV testing and treatment, vaccinations, dental services and may have a licensed pharmacies or laboratory on-site.

†Target group, type of rapid test and staffing types are not mutually exclusive, so percentages do not add up to 100%.

‡Some studies reported offering more than type of rapid test, therefore numbers do not add up to n=28.