

05-S4.02 SUCCESSFUL INTERVENTIONS TO INCREASE USE OF PATIENT SELF OBTAINED VAGINAL SWABS FOR CHLAMYDIA/GONORRHOEA TESTING IN WA STATE

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Background Patient Self-Obtained Vaginal Swabs (SOVs) are the most sensitive and specific technology for chlamydia (CT) and gonorrhoea (GC) testing. While SOVs enhance clinic efficiency and client access to testing, uptake of this innovation has been slow. The 10 USPHS Regional Infertility Prevention Projects (IPP) collect CT/GC test data from Family Planning, STD, and other publicly-funded clinics across the U.S. By 2010, only two regional IPPs reported using vaginal swabs. Washington (WA) State has been a leader in SOV promotion and collects common supplemental data to evaluate uptake.

Objectives (1) Describe WA SOV interventions; (2) Describe clinics' adoption and use of SOVs; (3) Explore trends and associations in SOV use vs other specimen sources.

Methods In 2011, key stakeholders were interviewed about SOV interventions. WA IPP data from female patients were compiled from 1/2007 to 6/2010. Clinic and client factors associated with SOVs were explored including visit date, clinic type, client demographics, specimen source, and test results. Multivariate models were developed. An aggregate clinic-level dataset was generated to assess SOV uptake in clinics averaging >25 tests/year. Significant (p<0.05) results are reported.

Results In 2008, WA Department of Health declared SOV promotion a state-wide objective. Interventions included development and dissemination of patient instructions, provider education materials and webinars; direct communication and follow-up with clinic management; and data monitoring. Of 126 IPP clinics, % using SOVs increased significantly from 9.3% in 2007 to 76.8% in 2010. Among clinics using SOVs, mean % of CT/GC specimen obtained by SOVs increased from 1.7% to 27.2%. During the study period, 176,234 total CT/GC specimen were obtained. SOV use rose 16.6% overall (from 0.3% in 2007 to 16.9% in 2010), replacing 12.2% of clinician-obtained and 4.4% of urine-based specimen (Abstract O5-S4.02 table 1). Factors independently associated with SOV use were: client age <20 (AOR=1.55) and clinic type (FP: ref., STD: AOR=0.27, School-Based: AOR=5.44, Women's Health: AOR=0.07). Client race, ethnicity, and CT/GC positivity were not associated.

Abstract O5-S4.02 Table 1 Chlamydia/Gonorrhoea specimen source distribution by year (CT/GC test data)

	2007		2008†		2009		2010		% change, 2007–2010
	N	%	N	%	N	%	N	%	
Clinician—Obtained*	25 076	52.0%	23 231	45.3%	22 814	42.2%	8885	39.8%	-12.2%
Urine	23 024	47.7%	26 785	52.2%	25 257	46.7%	9677	43.4%	-4.4%
SOV	123	0.3%	1290	2.5%	5984	11.1%	3743	16.8%	16.6%
Total	48 223	100.0%	51 306	100.0%	54 055	100.0%	22 305	100.0%	0.0%

*Clinician—obtained method include endocervical and clinician —obtained vaginal swabs.
 †SOV promotion intervention initiated in 2008.
 ‡χ²<0.001.

Conclusions Since 2007, SOV use increased substantially across WA state and within individual clinics. SOVs are replacing clinician-obtained and urine specimens. More work is needed to improve uptake across the variety of clinic types. WA's successful intervention and evaluation activities can be a model for other states.

05-S4.03 HIV TESTING AMONG PATIENTS INFECTED WITH NEISSERIA GONORRHOEAE-STD SURVEILLANCE NETWORK, USA, 2009–2010

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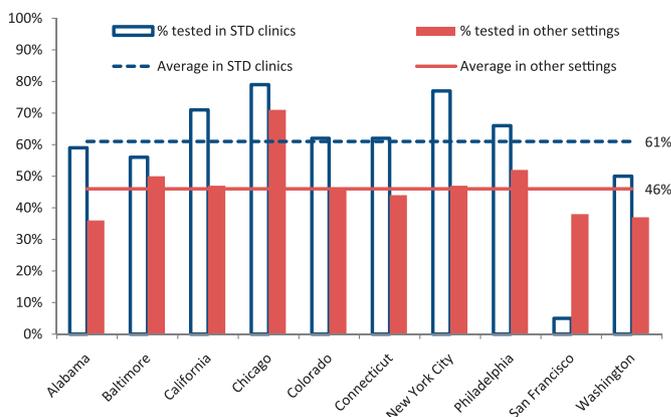
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Background An estimated 21% of 1.1 million HIV-infected US residents do not know they are infected and may unknowingly transmit HIV. Because people with sexually transmitted diseases (STDs) are at increased risk of HIV, CDC recommends HIV screening for patients seeking STD treatment. We investigated whether patients given a diagnosis of *Neisseria gonorrhoeae* during January 2009-June 2010 were concurrently tested for HIV.

Methods We used data from interviews with randomly selected gonorrhoea-infected patients in the 12 state and local health jurisdictions constituting the STD Surveillance Network. We compared the prevalence of HIV testing concurrent with gonorrhoea testing or treatment among patients seeking care in STD clinics and patients in other practice settings (emergency rooms, public and private outpatient facilities, hospitals, and family planning clinics).

Results Of 6658 eligible patients, 3462 (52%) were successfully interviewed. Complete data were available for 1845/3462 (53%). Of these, 51% were tested for HIV when they were tested or treated for gonorrhoea. The proportion of gonorrhoea patients tested for HIV ranged from 22% to 74% by jurisdiction. STD clinic patients were more likely to be tested for HIV than those in other practice settings (61% vs 46%, p<0.01), see Abstract O5-S4.03 figure 1 and women were more likely than men to be tested for HIV in STD clinics (71% vs 58%, p=0.01). HIV testing was more common among black (53%) and Hispanic women (54%) compared with white women (36%, p=0.01). Men who have sex with men (MSM) were generally more likely to be tested for HIV compared with other men (56% vs 48%, p=0.02), though 58% of both MSM and MSW were tested for HIV in STD clinics. We found no association between HIV testing and race (among men), age, or having multiple sex partners.

Conclusions HIV testing among gonorrhoea-infected patients is sub-optimal. While patients are more likely to be HIV-tested in STD clinics than in other practice settings, even STD clinics miss many



Abstract O5-S4.03 Figure 1 Percentage of patients tested for HIV concurrently with gonorrhoea testing or treatment by facility type and jurisdiction.

opportunities to test high risk groups such as MSM, who are less likely than women to be HIV tested in this setting. Interventions are urgently needed to increase HIV testing among STD patients.

05-S4.04 TARGETED STD SCREENING AMONG HIGH-RISK MEN WHO HAVE SEX WITH MEN

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Background Subgroups of men who have sex with men (MSM) are at high risk for HIV infection and other viral and bacterial STDs. Since the mid-1990s, increased rates of early syphilis, gonorrhoea, and chlamydial infection and higher rates of unsafe sexual behaviours have been documented among MSM in the USA and virtually all industrialised countries.

Methods The Gay Men’s Health & Wellness (GMH&W) Clinic is a Tuesday and Thursday evening STD clinic for men at Whitman-Walker Clinic (WWC), a Washington, DC community health center specialising in HIV/AIDS care and lesbian, gay, bisexual, and transgender care. As an outreach of this bi-weekly clinic, WWC, Gilead Foundation, and the local HIV/AIDS, Hepatitis, STD, and TB Administration collaborated to provide STD screening in the Crew Club, the District’s only bathhouse serving MSM, for ~4 h each Tuesday night beginning July 2010. All participating men were offered HIV screening, syphilis screening, and nucleic acid amplification testing (NAAT) for gonorrhoea and chlamydia of urine, pharyngeal, and rectal specimens.

Results During the first 6 months of testing at the Crew Club, 173 unique clients were screened. Of those, five new HIV and 18 new syphilis cases were identified (Abstract 05-S4.04 table 1). In addition, two urethral, six pharyngeal, and two rectal gonorrhoeal infections were identified and five urethral, two pharyngeal, and 14 rectal chlamydial infections were identified. In comparison, during 2010, 2487 unique clients were tested at the GMH&W Clinic. Of those, 37 HIV and 189 syphilis cases were identified. In addition, 115 urethral and 89 rectal gonorrhoeal infections were identified and 139 urethral and 124 rectal chlamydial infections were identified. Pharyngeal results from the GMH&W Clinic were not yet available.

Abstract 05-S4.04 Table 1 Testing results, gay men’s health & wellness clinic (2010) vs STD Screening at the Crew Club (July–December 2010)

Test	GMH&W clinic			Crew club		
	Tests	Positives	% Positive	Tests	Positives	% Positive
HIV	2747	37	1.35%	189	7	3.70%
Syphilis	2969	189	6.37%	191	18	9.42%
Urethral GC	1753	115	6.56%	184	2	1.09%
Pharyngeal GC	2017	N/A	—	189	6	3.17%
Rectal GC	1138	89	7.82%	183	2	1.09%
Urethral CT	1753	139	7.93%	184	5	2.72%
Pharyngeal CT	2017	N/A	—	189	2	1.06%
Rectal CT	1138	124	10.90%	183	14	7.65%

Conclusions A higher percentage of presumably asymptomatic clients tested positive for HIV and syphilis infections during STD screening in this non-traditional venue than during the diagnosis and routine screening that occurred at the clinic. Conversely, a higher percentage of clients, many of whom were symptomatic, tested positive for gonorrhoea and chlamydia during the GMH&W Clinic than during the Tuesday night outreach. This effort allows us to engage hard-to-reach men who may be among the core transmitters driving the HIV and syphilis epidemics in the DC area. Costs

per HIV and syphilis cases detected need to be calculated /estimated for this fruitful outreach endeavour.

05-S4.05 INTRODUCTION OF A SEXUAL HEALTH PRACTICE NURSE INCREASES STI TESTING AMONG MSM IN GENERAL PRACTICE

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Introduction Increased screening among MSM could improve STI control in this population; however published data on interventions that improve screening rates is limited. The aim of this study was to determine if introducing a sexual health practice nurse (SHPN) into a general practice clinic could increase HIV and STI testing among MSM who attend.

Methods In October 2008, Melbourne Sexual Health Centre introduced a SHPN into a Melbourne general practice with a high case-load of MSM. We undertook an observational study comparing the proportion and STI tests undertaken in the 9 months before (Period 1), and after the SHPN was introduced (Period 2). Consistent with Australian national STI testing guidelines for MSM, complete testing was defined as HIV and syphilis serology, urine test and anal swab for chlamydia, pharyngeal and rectal swabs for gonorrhoea, from the same man on the same date. MSM were stratified and analysed according to HIV status. The Qui-Square Test for Independence was used to compare the difference in proportions of tests. In the case of syphilis tests among HIV positive MSM the median number of tests was compared using the Mann–Whitney U Test.

Results Among HIV negative MSM, the proportion of MSM tested, increased from Period 1 to Period 2 as follows; HIV from 57.8% to 66.2%; syphilis from 59.9% to 76.6%; urethral chlamydia from 67.7% to 75.8%; pharyngeal gonorrhoea 62.5% to 69.9%; and rectal gonorrhoea/chlamydia from 58.5% to 69.5% (all $p < 0.001$). The proportion of episodes of complete testing, also increased from 41.1% to 51.9% ($p < 0.001$). Among HIV positive MSM, the proportion of MSM tested, increased from Period 1 to Period 2 as follows; urethral chlamydia from 66.5% to 80.2%, pharyngeal gonorrhoea 58.7% to 77.2% and rectal gonorrhoea/chlamydia from 55.3% to 75.3%, (all $p < 0.001$). Prior to Period 1, the clinic had a policy of testing HIV positive MSM for syphilis with each three monthly routine HIV monitoring blood tests. Therefore, the median number of syphilis tests was the same in both study periods (median 2, range 0 to 6, $p = 0.817$). The proportion of episodes of complete testing, also increased from 32.3% to 56.2% ($p < 0.001$).

Conclusion The introduction of a SHPN into general practice significantly increased HIV and STI testing among MSM. The magnitude of the effect of this intervention may be greater in MSM high case load general practices where the culture of STI testing is less well established.

05-S4.06 IMPROVING HIV SCREENING AT AN URBAN STD CLINIC

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Background At the end of 2006 (the most recent year that data are available), an estimated 1 106 400 persons in the USA were living with HIV infection, with 21% undiagnosed. In September 2006, the Centers for Disease Control & Prevention (CDC) released new