and 30.1%, 38.5% for men and 22.2% for women, in 2006 and 2012 respectively. Always using condom with any sexual partners in the last 12 months was 3.5% and 5.1% in 2006 and 2012, respectively. Using drug was 1.4% in both rounds. HIV testing and knowing the result were 1.1% and 31.8% in 2006 and 2012, respectively. Among aged 15–24 groups, the correct knowledge on HIV prevention was increased from 21.0% (2006) to 52.9% (2012); always using condom with any sexual partners in the last 12 months was increased from 5.9% (2006) to 12.0% (2012) and syphilis prevalence was decreased from 3.1% (2006) to 1.6% (2012).

Conclusion High syphilis prevalence combined with high sexual risk behaviour such as multiple sex partners and low consistent condom use suggests high potential risk for HIV/STI transmission among Dao ethnic people. In addition, low-level knowledge on HIV/AIDS prevention and STI treatment warrants extra attention. HIV prevention effort needs to ensure reaching this remote and vulnerable ethnicity with focus on young in Viet Nam.

Disclosure of interest None.

P01.11 UNDERSTANDING THE GREATER BURDEN OF STIS AMONG BLACK CARIBBEANS IN THE UK: EVIDENCE FROM A SYSTEMATIC REVIEW

[1]S Wayal*, [1]C Griffiths, [1]C Mercer, [1]M Gerrussu, [2]G Hughes. *[1]Centre for Sexual Health and HIV Research, University College London, UK; [2]Public Health England, Colindale, UK*

10.1136/sextrans-2015-052270.221

Background In the UK, Black Caribbeans are disproportionately affected by STIs. We conducted a systematic review of attitudinal, behavioural and contextual risk factors of this inequality.

Methods Ten electronic databases were searched for studies on risk factors and drivers of STI among UK Black Caribbeans from 1948 to 30/11/2014. Two independent reviewers screened all identified abstracts and extracted data from selected studies using standardised forms.

Results Of 3220 abstracts identified, 165 were included in the review. STI risk among Black Caribbeans is higher compared to other ethnic groups and varies by gender and age. Being single and reporting first intercourse aged <16, >1 new sex partner in the past year, concurrency, and assortative sexual mixing were identified as risk factors. STIs were considered of lower priority than HIV/unplanned pregnancy. Barriers to condom use, especially among women with older and regular partners, were reported. Compared to other ethnic groups, Black Caribbeans were more likely to have ever attended a STI clinic and tested for HIV, but Black Caribbean women were more likely to report delays in seeking care and be sexually active whilst symptomatic. Perceived negative attitudes of clinic staff of the same ethnicity towards young women negatively affected care-seeking.

Conclusion Sexual behavioural risk factors or access to care did not fully explain the disproportionate STIs burden among Black Caribbeans highlighting the need for further evidence on contextual drivers of STIs. STI reduction interventions should be gender-specific, informed by partnership patterns and address attitudes to STIs and sexual health care-seeking.

Disclosure of interest statement Nothing to declare.

P02 - New media in STI prevention

P02.01 SYSTEMATIC REVIEW AND META-ANALYSIS OF RANDOMISED CONTROL TRIALS OF INTERACTIVE DIGITAL INTERVENTIONS FOR SEXUAL HEALTH PROMOTION

[1]S Wayal*, [1]JV Bailey,[1]E Murray,[1]G Rait, [1]RW Morris,[2]R Peacock, [1]I Nazareth. *[1]University College London, UK; [2]Middlexex University, London, UK*

10.1136/sextrans-2015-052270.222

Background Sexual ill-health is a global concern. Digital technology offers enormous potential for health promotion. This systematic review assessed effectiveness of interactive digital interventions (IDI) for sexual health promotion.

Methods IDI are interactive programmes providing information, decision support, behaviour-change support and/or emotional support. We searched 40 electronic databases for randomised controlled trials (RCT) of IDI for sexual health promotion. Cochrane Collaboration methods were used to determine the effectiveness of IDI vs. minimal interventions (e.g. waiting list) (comparison1); face-to-face interventions (comparison 2); and different designs of IDI (comparison 3). Separate meta-analyses were conducted for comparisons 1, 2, and 3, by type of outcome (knowledge, self-efficacy, intention, sexual behaviour and biological outcomes). Results were pooled using a random effects model to calculate standardised mean differences (SMDs) and odds ratios (ORs). Subgroup analyses tested the following prespecified factors: age, risk grouping, and settings (online, healthcare, educational).

Results We identified 34 RCTs (10,758 participants). Comparison 1: IDI had beneficial effect on knowledge (SMD 0.43, 95% CI 0.14 to 0.71); safer sex self-efficacy (SMD 0.11, 95% CI 0.03 to 0.18) and intention (SMD 0.13, 95% CI 0.05 to 0.22). There was no effect on sexual behaviour (OR 1.15, 95% CI 0.97 to 1.36) or biological outcomes (OR 0.81, 95% CI 0.56 to 1.16). Comparison 2: IDI improved knowledge (SMD 0.36, 95% CI 0.1 to 0.58), and intention (SMD 0.46, 95% CI 0.06 to 0.85), but not self-efficacy (SMD 0.38, 95% CI 0.01 to 0.77). Comparison 3: Tailoring showed a beneficial effect on sexual behaviour (OR 2.64, 95% CI 1.45 to 4.80). No subgroup differences were noted. No data were available for cost-effectiveness.

Conclusions IDIs can effectively enhance knowledge, self-efficacy, intention, and tailored IDIs can improve sexual behaviour. Further evidence is needed to understand how to translate these positive effects of IDIs into improved sexual health, and how IDIs work.

Disclosure of interest Nothing to Declare.

P02.02 ANOTHER DIGI-GAP! INTEGRATING MULTIFACETED TRIAGING APPROACHES TO ASSIST AND SPEED TECHNOLOGICAL TRANSITION TO ELECTRONIC MEDICAL DOCUMENTATION AND BOOKING SYSTEMS

[1]MM Florance*, [1]A Cheshire, [1]B Hadlow, [1,2]A Ubrihien. *[1]North Shore Sexual Health Service, Northern Sydney LHD, Sydney, Australia; [2]HIV and Related Programs Unit, Western Sydney Sexual Health Centre, Western Sydney Local Health District*

10.1136/sextrans-2015-052270.223