Introduction Despite the evolution in STI prevention strategies, US racial and ethnic minority populations continue to share a disproportionate burden of disease. Race and ethnicity are frequently correlated with other determinants of health status such as poverty, income inequality, unemployment, and educational attainment. However, differences among race groups in prevalence of STI for levels of lifestyle have not been evaluated for the US military, where these determinants of health may be less influential. We analysed data from the 2008 Survey of Health-Related Behaviours (SHRB) among US military personnel to determine racial differences in STI rates and associations with other lifestyle risks behaviours.

Methods Our analysis of the 2008 SHRB included data from 28,546 US military personnel. STIIs were dichotomized as ‘yes’ or ‘no’ if self-report as ‘ever’ or ‘in the last 12 months’. Demographic variables, regular exercise, tobacco use, alcohol use, other lifestyle variables were considered. Weighted binary logistic regression model, and Bonferroni adjustment for pairwise comparison were used.

Results Significant differences were found in proportions of reporting STI in African American (24%) Hispanic (12%) White (10%) and other (9%) racial groups within the military. For males, higher significant STI prevalence rates were found in blacks versus any of other 3 race groups separately for each level of regular exercise, tobacco use and alcohol use respectively. However, similar results were not applicable to females.

Conclusion Despite universal access to healthcare, standardised income and required educational attainment, differences in STI rates by ethnicity were maintained among those in military service. In addition, STI risk in some racial groups was higher at all levels of other lifestyle risks suggesting that risk taking behaviour beyond STI risk is variable by ethnicity. Population health programs target to risk reduction should address ethnicity beyond the historical confounders of income, educational attainment, and educational attainment.

Disclosure of Interest Statement: The content of this publication is the sole responsibility of the authors and does not necessarily reflect the views, assertions, opinions or policies of the Uniformed Services University of the Health Sciences (USUHS), the Department of Defense (DoD), or the Departments of the Army, Navy, or Air Force. Mention of trade names, commercial products, or organisations does not imply endorsement by the U.S. Government.
the acceptability and preferences for STI screening among a sample of pregnant, HIV-infected women at two clinics near Pretoria, South Africa.

Methods We approached potentially eligible HIV-infected pregnant women at their first antenatal care visit to invite them to receive STI screening that was integrated into the appointment. Trained staff collected data on STI screening preferences. Following enrollment, women were requested to provide two self-collected vaginal swabs for STI testing (GeneXpert, Cepheid, Sunnyvale, CA, USA).

Results Of the 171 women eligible for enrollment, 168 (98.2%) agreed to participate in the STI study, including STI testing and self-collected vaginal swabs. Of the 167 complete responses, 15.6% (n=26) preferred a urine test for STI screening, 41.1% (n=69) vaginal swab, and 42.9% (n=72) had no preference. Of those who preferred the urine test, the most common reasons were “easier” of the test (n=20, 12.0%), followed by anticipation of the test being “less painful” (n=3, 1.8%), “less uncomfortable” (n=2, 1.2%), “less embarrassing” (n=1, 0.6%), and more familiar (n=1, 0.6%). However, when given directions on the vaginal swab collection procedures, all 168 (100%) women complied and received successful test results.

Conclusion Integration of an STI screening protocol, including self-administered vaginal swabs, into first antenatal care visits appeared to be highly acceptable in this setting among HIV-infected pregnant women. Despite variability in preferences, all women adequately and satisfactorily self-collected vaginal samples, allowing for the timely detection and treatment of infections that may have been otherwise missed.

P3.71 CORRELATES OF HIV INFECTION AMONG KENYAN WOMEN SCREENED FOR A INTRA-VAGINAL CONTRACEPTIVE RING STUDY IN KISUMU KENYA, 2015

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Introduction Women in Sub-Saharan africa continue to be disproportionately affected by the HIV epidemic. Correlates of HIV infection need to be better understood, and prevention strategies adapted, to account for risk patterns linked to particular settings or situations.

Methods We assessed prevalence and correlates of HIV infection among women 18–34 years of age screened for a contraceptive vaginal ring study. Women provided socio-demographic, medical information, and underwent real-time parallel rapid HIV testing and medical evaluation and sexually transmitted infections (STI) testing.

Results Of the 459 women screened, the median age was 25 (IQR: 21–28). Majority of whom were married (69%), and more than a half (69%) had primary or less level of education. Overall, HIV prevalence was 14.5%, with the married and widowed recording a significantly higher burden of HIV (25% and 50%) respectively. Slightly more than a half (55%) of HIV positive women perceived their health to be good. Women who tested positive for herpes simplex and gonorrhoea had significantly higher prevalence of HIV (6% vs. 21%, p<0.001% and 14% vs. 39%; p=0.003) respectively.

Women ages 25–29 years old had a 3 fold increased odds of HIV acquisition compared to 18–24 year olds (aOR=3.61; 95% CI:1.23–10.49, p=0.019), while those aged 30–34 had a 5 fold increased risk (aOR=5.36; 95% CI:1.23–19.60, p=0.011). Widowed had nearly 6 times risk of HIV acquisition compared to single women (aOR=5.85; 95% CI:1.39–24.51, p=0.016), whereas women reporting to have had sexual intercourse with partners of unknown HIV status in the last 3 months were four times more likely to test positive for HIV than those who did not (OR 4.10 95% CI: 1.47–11.41).

Conclusion Behavioural, biological and structural factors continue to put women at risk of HIV. There is need for multi-pronged prevention strategies including female controlled multipurpose technologies to reduce their HIV burden.