Background Curable sexually transmitted infections (STIs) such as infection with Chlamydia trachomatis (C. trachomatis), Neisseria gonorrhoeae (N. gonorrhoeae), and Trichomonas vaginalis (T. vaginalis) can lead to adverse pregnancy. There are limited data on the prevalence and correlation of STI in Ethiopia, yet pregnant women are not screened for curable STI. Hence in this study, the prevalence of STIs and associated risk factors were assessed.

Methodology A cross-sectional study was conducted on consecu- tive women attending the delivery ward at the Hawassa comprehensive and specialized hospital. Vaginal swabs collected at the time of labor and delivery were tested for C. trachomatis, N. gonorrhoeae and T. vaginalis using GeneXpert. Study participants responded to a questionnaire about their previous and current obstetric history and socio-demographic characteristics. Possible independent factors for curable STIs were assessed by chi-square, bivariable, and multivariable logistic regression.

Results Of the 350 vaginal swabs tested, 51 (14.6%, 95% CI: 10.9–18.3) were positive for one or more curable STIs. The prevalence of C. trachomatis, N. gonorrhoeae and T. vaginalis were 8.3%, 4.3%, and 3.1%, respectively. STIs were assessed for 3 months after chlamydia treatment to identify reinfection. Men and increases the risk of reproductive complications, par-

Reinfection after treatment for chlamydia is com-

10.1136/sextrans-2021-sti.252

Results Rates of retesting within recommended timeframes were low and there were missed opportunities for retesting. Age and sex differences in retesting and clinics highlight the need for processes within clinics and patient focused strategies to promote reattendance and retesting. High reinfection rates further highlight the importance of retesting for timely reinfection detection and treatment.

Background Reinfection after treatment for chlamydia is common and increases the risk of reproductive complications, particularly for women. Australian guidelines recommend retesting at 3 months after chlamydia treatment to identify reinfection. There are limited data about chlamydia retesting in Australia’s mainstream primary care setting, general practice. We investigated retesting patterns among young people treated for chlamydia infection in regional Australian general practice clinics during 2010–2015.

Methods Chlamydia testing and attendance data for 16–29-year-olds attending 128 regional general practices were collected for a chlamydia testing intervention trial. Rates of retesting within recommended timeframes (defined as 6-weeks-6-months after an individual’s first positive chlamydia test) were calculated. We examined factors associated with retesting using logistic regression models adjusting for patient sex and age-group and clustered by clinic.

Results A total of 2357 individuals (68.7% female) with a first positive chlamydia result formed the study population. In the following 6-weeks-6-months, 26.5% (95% CI 24.3–28.7) re-tested and were retested; 11.9% had a positive retest and positivity at retest was higher for males (19.2%, 95%CI 14.1–25.6) than females (10%, 95%CI 9.3–15.0). A further 39.1% (95% CI 36.1–42.2) re-attended but were not retested and 34.4% (95% CI 31.7–37.2) did not re-attend. Multivariable analysis showed that retesting was more likely for women (adjusted odds ratio (AOR) 2.23, 95% CI 1.79–2.79) and in intervention clinics (AOR 1.33, 95% CI 1.07–1.64) and that individuals aged 20–24 years were less likely (AOR 0.73; 95% CI 0.59–0.92) to be retested than 16–19-year-olds.

Conclusions Rates of retesting within recommended timeframes were low and there were missed opportunities for retesting. Age and sex differences in retesting and clinics highlight the need for processes within clinics and patient focused strategies to promote reattendance and retesting. High reinfection rates further highlight the importance of retesting for timely reinfection detection and treatment.