

Abstract P5-S6.19 Table 1 Prevalence of STIs and asymptomatic infections (n=282)

Pathogen	Baseline visit	1st follow-up	Final visit
Cervical infections (GC and/or CT)	27.7% (asymptomatic 35.9%)	16.7% (asymptomatic 60.5%)	21.3% (asymptomatic 76.7%)
TV	29.9% (asymptomatic 27.2%)		46.6% (asymptomatic 82.2%)
Latent syphilis (RPR titre >1:8)	6.8%		2.5%

Conclusions The incidence of GC, CT and TV and the considerable burden of asymptomatic infections indicate the need for periodic presumptive treatment at high STI prevalence sites in India. The current regime of bi-annual syphilis screening is justified. Consistent condom use and partner treatment, particularly for regular partners, need to be re-emphasised.

P5-S6.20 STIS AND HEALTHCARE REFORM. WILL IT REALLY IMPROVE AMERICA'S SEXUAL HEALTH?

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Background The implementation of healthcare reform in the U.S has led to a debate on whether publicly-funded STI clinics will continue to be necessary. A large proportion of STIs are reported from non-STI clinic providers and this proportion will grow with universal access to care. However, STI clinics serve vulnerable populations such as men who have sex with men (MSM) and racial/ethnic minorities who have no other access to STI care. In addition, many prefer the confidentiality and expertise of STI clinics. We studied characteristics of patients reported with gonorrhoea in the City and County of Denver and compared those reported from the Denver Metro Health (STI) clinic (DMHC) with those reported from elsewhere.

Methods As part of the CDC-funded STD Surveillance Network (SSuN), DMHC and the Colorado Department of Public Health and Environment (CDPHE) collect additional risk information for gonorrhoea cases residing in the SSuN catchment area. Of all incident gonorrhoea cases within a given month, 40 are randomly selected for an interview by CDPHE staff to collect demographic, treatment, and risk information. All gonorrhoea cases diagnosed between 1 January 2008 and 31 October 2010 were examined.

Results Of 2933 gonorrhoea cases for the 2-year period, 932 (32%) were diagnosed at DMHC. Cases diagnosed at DMHC were considerably more likely to be male (74% vs 38% $p < 0.0001$), and tended to be slightly older (mean age 27.0 vs 24.9, $p = < 0.0001$) than cases diagnosed elsewhere. CDPHE successfully contacted 41% of selected cases for interviews. A significantly higher proportion of cases diagnosed in the STI clinic were MSM compared to cases diagnosed elsewhere (34.7% vs 14.5%, $p \leq 0.0001$). No differences were found in terms of race/ethnicity, number of reported sex partners, education level, or previous gonorrhoea infection.

Conclusions In the City and County of Denver, heterosexual men and MSM are more likely to be diagnosed with gonorrhoea in the STI clinic than women. The successful transition of STI services to non-STI healthcare systems in the context of healthcare reform, will not only depend on the STI expertise in those settings, but in large part on a shift in health seeking behaviours among men, many of whom may be considered core STI transmitters. The continued need for and utilisation of STI clinics in countries with long-standing universal access to care, should give us pause in abandoning our STI clinical system to soon.

P5-S6.21 ACYCLOVIR FOR MANAGING GENITAL ULCER DISEASE IN SOUTH AFRICA: EXPERIENCES OF GUIDELINE INTRODUCTION, IMPLEMENTATION AND UPTAKE

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Background Herpes simplex virus type 2 (HSV-2) is the leading cause of genital ulcer disease (GUD) worldwide. Treatment with acyclovir has been shown to shorten GUD duration, decrease plasma and genital HIV RNA levels and slow HIV disease progression in several trials. In South Africa, STI management guidelines were revised in 2008 to include acyclovir as first-line GUD therapy. However, acyclovir access appeared to be unequal across various settings. This study attempted to understand acyclovir access in South Africa from both a supply and demand perspective.

Methods The study was cross-sectional and primarily qualitative. Three groups of participants were recruited to reflect acyclovir access and use: policymaker key informants, healthcare providers at public primary healthcare facilities and ART initiation sites in greater Johannesburg, and former HSV-2 treatment trial participants (both genders, HIV-positive and -negative). Information was collected following the WHO/Health Action International two-stage cluster random selection of health units through standardised questionnaires, complemented by in-depth interviews with selected stakeholders.

Results Acyclovir was documented to be widely available. Challenges to access included the initial policy development and implementation process, staff training, accessibility and availability. The updated guidelines appeared to have been introduced with little high-level co-ordination and minimal staff training, although policymakers and staff thought that HSV-2 treatment was both efficacious and useful. Clinics did not experience drug stock outs. The demand for acyclovir appeared to be poor and influenced by limited knowledge of HSV-2 by the general public, negative perceptions associated with HSV-2 infection, adverse logistical factors like long waiting times at clinics and negative experiences with staff at clinics.

Conclusions The South African guidelines were supported by local research evidence in line with WHO recommendations. Although little attention was paid to how the new guidelines had to be introduced, implemented and monitored, both the supply and prescribers' awareness improved rapidly. Access to acyclovir was undermined by poor demand from patients. Individuals possibly did not see herpes as enough of a problem to seek treatment. To ensure the success of new treatment approaches, it is essential to consider user and well as provider issues.

P5-S6.22 SOCIAL-STRUCTURAL FACTORS ASSOCIATED WITH SUPPORTIVE SERVICE USE IN A COHORT OF HIV-POSITIVE INDIVIDUALS ON ARV THERAPY IN BRITISH COLUMBIA, CANADA

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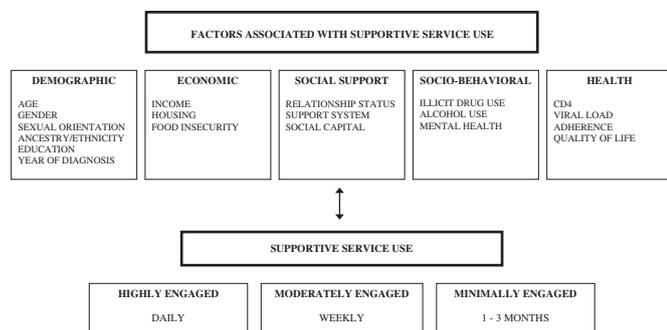
Introduction Medical services are seldom the only assistance required for HIV-positive individuals to lead longer, healthier lives. The clinical complexities of HIV infection and the multiple needs of people living with HIV often require additional assistance to ensure

optimal health outcomes. Supportive services (eg, housing, food, counselling, addiction treatment) are increasingly conceptualised as critical components of care. Our study investigates social and clinical correlates of supportive service use across differing levels of engagement. Abstract P5-S6.22 figure 1 presents the conceptual model of the study.

Methods The Longitudinal Investigations into Supportive and Ancillary Health Services (LISA) is a cross-sectional cohort of HIV-positive persons on antiretroviral therapy in British Columbia, Canada. Interviewer-administered surveys collected information regarding sociodemographic factors, substance use, social support networks, and supportive services. Clinical variables were obtained through longitudinal linkages with the Drug Treatment Program at the BC Centre for Excellence in HIV/AIDS. Participants were stratified by level of service engagement (daily, weekly, and 1–3 months). Bivariate analysis and a logistic regression proportional odds model were used to identify variables significantly associated with supportive service use.

Results Among 915 participants, 742 (81%) reported using supportive services, of which 344 were highly engaged, 280 moderately engaged, and 118 minimally engaged. Food programs, medication support, and counselling and social supports groups were services most accessed. Multivariate results demonstrated that those most engaged in supportive services were more likely to report poor social determinants of health such as low income [adjusted OR (AOR)=1.81]; not having completed high school (AOR=1.97); unstable housing (AOR=1.89); and current illicit drug use (AOR=1.60). After adjusting for social determinants, there were no significant differences in clinical measures across different levels of engagement with supportive services.

Conclusion High service use by those demonstrating social and clinical vulnerabilities reaffirms the need for continued expansion of supportive services to facilitate a more equitable distribution of health among persons living with HIV.



Abstract P5-S6.22 Figure 1 Conceptual model for factors associated with supportive service use.

P5-S6.23 BARRIERS TO ACCESSING HEPATITIS C TREATMENT FOR INDIVIDUALS WHO HAVE EXPERIENCE WITH INJECTION DRUG USE

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In Canada, approximately 10 000 people are living with both hepatitis C and HIV; 20% of individuals living with HIV are co-infected with hepatitis C. Many individuals who inject drugs are at a higher risk for contracting both hepatitis C and HIV because they engage in high risk activities that increase their chances of being in contact with infected blood. Individuals living with hepatitis C are at risk of contracting HIV. Being co-infected with both diseases complicates both hepatitis C and HIV; it is therefore critical to

provide treatment for hepatitis C. Although those living with hepatitis C often report high interest in treatment, uptake remains low. The purpose of this research project is to identify the factors which influence decisions around hepatitis C treatment. A mixed methods approach was used; 60 individuals participated in a cross sectional questionnaire, while 6 engaged in in-depth interviews. All participants were currently accessing methadone maintenance treatment for opioid addiction and had experience with injection drug use. The questionnaires explored characteristics, knowledge, attitude and willingness to access hepatitis C treatment. Interviews delved deeper into the issues uncovered in the questionnaires and explored life experiences and their influence around treatment decisions. Results indicated that 70% of participants were interested in starting hepatitis C treatment within the next 6 months, while 30% were undecided or uninterested. Analysis of the questionnaire results have suggested that it may not be factual knowledge which influences individuals' decisions around treatment, but life conditions (ie, housing, employment) and experiences. The interviews supported this finding through a thematic analysis. The results of this study suggest that efforts to increase interest in treatment should focus on improving life conditions that support accessing treatment (eg, providing supportive housing). Future studies would include a larger sample size and a more refined questionnaire.

P5-S6.24 COMPREHENSIVE, COMPETENT AND COMPASSIONATE CARE FOR PEOPLE LIVING WITH HIV IN COASTAL ANDHRA PRADESH

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Background Districts in coastal Andhra Pradesh, south India have the highest burden of HIV in both rural and urban areas. A comprehensive care program focused on improving clinical care and community outreach, complemented by a computerised management information system (CMIS), was implemented under the USAID supported Samastha project.

Methods Four community care centres covering 19 mandals were chosen as project sites. A mandal covers about 25 villages. Doctors, nurses and other members of the care teams were trained using the adapted "Integrated Management of Adult Illness" package and followed up with clinical mentorship visits every quarter. All on-site staffs were trained on infection prevention procedures. At the community level, people living with HIV (PLHIV) were involved in community outreach focused on treatment adherence, accompanied referrals for management of opportunistic infections and social linkages for livelihood options and basic nutrition. Small support groups of 10–12 individuals were formed at village or cluster level. Minor ailments and illnesses were treated at the local primary healthcare centers. Each community outreach worker maintained individual line-lists and prioritised outreach and follow-up for an average of 125 PLHIV, including children infected or affected by HIV. 6–8 outreach workers were supervised by a counsellor.

Results By the fourth year of implementation, 3257 PLHIV were registered with the project, of whom 1269 (38.9%) were initiated on Government supplied free ART. 2845 (87.3%) received nutrition support through education, supplementation and government schemes. 2085 (64%) were linked to social schemes such as widow pensions, bank loans or alternative livelihood options. Psychosocial support was provided to 2964 (91%) of the individuals registered. Loss to follow-up among those on ART reduced from 17% to <1% and annual death rates among those registered decreased from 21%