association between the difference in FSW HIV prevalence between rounds (R2−R1)(D.FSW HIV) and different classes of factors (Abstract P1-S6.07 table 1). Intervention factors included differences between rounds in consistent condom use (CCU) with occasional clients, difference in STI prevalence, or fraction of FSW in contact with the intervention at R1, and others (see Abstract P1-S6.07 table 1). Baseline contextual factors included FSW HIV or STI prevalence, fraction of FSW ever asked for anal intercourse (AI), weekly client number per FSW etc at R1, estimates of CCU in 1998, and increase in CCU before R1. Design factors (date of R1, time between R2−R1, differences in response rate between R2 and R1), and differences in contextual factors between rounds as listed Abstract P1-S6.07 table 1 were also explored. Pearson correlations, univariate and multiple linear regression analysis were performed.

Results In univariate analyses, D.FSW HIV prevalence was negatively associated with R1 FSW HIV prevalence (r=−0.53), R1 HSV-2 and Tp prevalence, difference in response rate, % asked for AI at R1 (Abstract P1-S6.07 table 1). D.FSW HIV prevalence was positively associated with differences in syphilis (r=0.36) or in HSV-2 prevalence or in % asked for AI. In multivariate analysis, R1.FSW HIV prevalence (slope=−0.57) and estimated CCU in 1998 (slope=0.29) (R=0.73), or R1.FSW HIV (slope=0.19) and D. FSW HSV-2 (slope=−0.83) prevalence (R=0.66) were significantly associated with D.FSW HIV prevalence ($p<0.01$).

Conclusion Contemporary time trends in HIV prevalence are influenced by epidemic stages and historical condom use for many years. HIV prevalence is more (less) likely to decline after effective interventions introduced in mature (early) epidemics. R2 was conducted too early after R1 to expect large decline in HIV. Without control group, mathematical modelling is required to simulate counterfactuals and estimate intervention impact.

Epidemiology poster session 6: Preventive intervention: Screening

P1-S6.08 A MULTIFACETED INTERVENTION TO INCREASE CHLAMYDIA TESTING IN AUSTRALIAN GENERAL PRACTICE

doi:10.1136/sextrans-2011-050108.232

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Background The Australian Government has funded the Australian Chlamydia Control Effectiveness Pilot (ACCEPt), a randomised controlled trial of a chlamydia testing intervention to assess the feasibility, acceptability and cost-effectiveness of chlamydia testing in general practice clinics. There are well documented barriers to increased chlamydia testing in general practice including time, cost, and clinicians' knowledge and awareness of chlamydia. If an intervention is to successfully increase chlamydia testing, it must minimise these barriers and take the uniqueness of each general practice into consideration. This paper describes the chlamydia testing intervention being implemented in ACCEPt.

Methods Clinics in the intervention group are being provided with a multifaceted evidence-based intervention designed to increase annual chlamydia testing for sexually active 16−29 year olds. The intervention includes: a computer alert prompting GPs to test; incentive payments for GPs and practice nurses to conduct testing; an annual recall system involving SMS, phone or mail reminders; a comprehensive education pack; and regular feedback on testing performance. The intervention will be in place for up to 4 years, and will be tailored to the resources and needs of each clinic. Prior to implementation, clinic staff are engaged and given the opportunity to identify methods for improving chlamydia testing within their clinic, using an evidence-based practice assessment tool.

Results To date, 69 clinics in 24 areas have been recruited across three Australian states. Four of these areas (9 clinics) have been randomised: two areas (7 clinics) are in the intervention group, and two areas (2 clinics) in the control group. The intervention has been customised to each clinic with two thirds of clinics receiving the computer alert, 4 clinics using SMS reminders for recall, others using a mail recall and some using practice nurses to initiate chlamydia testing. Where possible, doctors and practice nurses have been given one on one education and training about chlamydia and pelvic inflammatory disease.

Conclusions Given that each Australian general practice is unique, it is vital that the intervention is tailored to individual clinic needs to achieve sustainable system changes. This enables maximum staff engagement to ensure the effective uptake of increased chlamydia screening in the Australian general practice setting.

P1-S6.09 AN AUDIT OF MANAGEMENT OF PRENATAL SYPHILIS SEROLOGY IN THE STI CLINIC, CALGARY, AB, CANADA

doi:10.1136/sextrans-2011-050108.233

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Background Outbreaks of syphilis have been occurring across Canada since 2001, with the province of Alberta having the 2nd highest incidence in 2007. As a result, there has been a national increase in the number of reported congenital cases. Current Canadian guidelines recommend performing syphilis serology at the 1st prenatal visit with rescreening at 28−32 weeks gestation, and at delivery in high-risk women. In our center, any positive syphilis serology is referred to the Calgary STI Clinic for staging and treatment recommendations. This is an internal audit of positive prenatal syphilis serologies from 2009 to 2010.

Methods Charts from pregnant women with a positive prenatal syphilis serology, defined as a positive or indeterminate syphilis EIA, from 1 January 2009 to 31 December 2010 were retrospectively reviewed. Syphilis staging was performed by the Medical Director according to national criteria.

Results 48 charts were reviewed: 9 were staged as biological false positives, 22 were previously adequately treated women with low or negative RPR titres not suggestive of reinfection, 13 were late latent (LL) treated with 7.2 μ of benzathine penicillin (PCN), and 4 were early latent (EL) treated with 2.4 μ of benzathine PCN. The mean number of days it took from receipt of a positive serology to contacting the patient were 9.8, 10.2, 2.3, and 1.8, respectively. The mean time to 1st dose of PCN was 8.8 for EL and 17.8 for LL (see Abstract P1-S6.09 table 1). There was 1 case of congenital syphilis in an infant whose mother presented in labour with no prenatal care-her RPR was 1:256. 1 woman with an RPR titre of 1:128 was treated with benzathine PCN 1 week before her estimated date of delivery. She went into preterm labour the afternoon post-injection; it is unclear whether or not the injection induced preterm labour. Her twins were treated with iv PCN with no adverse outcomes.

Abstract P1-S6.09 Table 1

Syphilis Stage= (N)/48	Range (days) from Start of Investigation to First Contact	Mean Number of Days to First Contact	Mean Number of Days to 1st Dose
Biological False Positives=9	1−29	9.8	N/A
Previously Treated=22	1−31	10.2	N/A
Early Latent=4	0−4	1.8	8.8
Late Latent=13	0−7	2.3	17.8 (5.2 if outliers removed)*

*3 patients were difficult to contact or noncompliant, taking 44, 54, and 68 days.

Conclusions Routine prenatal syphilis screening has identified 14/48 women who required PCN treatment, all of whom received PCN prior to delivery with only 1 woman experiencing a possible adverse event. The only congenital case occurred in a mother with no prenatal care, suggesting a need for a strategy to identify marginalised women with syphilis early in pregnancy. Although the average time to contact these patients was short, the time to administration of 1st dose of PCN was longer, reflecting the need to educate women about the importance of prompt and complete therapy in preventing congenital syphilis.

P1-S6.10 ACCEPTABILITY OF ANAL PAP SELF-SCREENING IN HIGH-RISK WOMEN: FINDINGS FROM ENGLISH AND SPANISH FOCUS GROUPS IN NORTHERN CALIFORNIA

doi:10.1136/sextrans-2011-050108.234

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Background HPV has a causative role in anogenital malignancies. During 2003–2007, the rate of anal cancer for women of all races in California was 2.2/100 000 compared to a national rate of 1.8/100 000. There are no national screening measures for preventing anal cancer, a rare disease that affects more women than men annually. Screening approaches have mainly been studied in men. In preparing for an anal cancer self-screening pilot study in high-risk women, we conducted focus groups in English and Spanish to assess HPV knowledge and acceptability and comprehension of anal Pap instruction materials. Qualitative data regarding acceptability and feasibility of anal pap screening in women have not previously been reported.
Methods Women who were biological females >18 years of age and fluent and literate in English or Spanish were recruited from a public HIV or STD clinic for participation in focus groups conducted by two English and Spanish speaking moderators. Participants were asked a structured list of open ended questions on HPV knowledge, and the acceptability of study forms including an illustrated anal PAP instruction sheet. Qualitative data was collected and reviewed for common themes and emphasis.
Results Two focus groups included 6 English speaking (ES) women and 8 Spanish speaking (SS) women. Knowledge gaps identified for SS women included: basic anatomical terms, HPV can infect both women and men, HPV is a STI, HPV can cause cancer, and the existence of a preventive HPV vaccine. Stigma was identified as an issue associated with STI education for SS women only. Shared knowledge gaps for ES and SS women included: asymptomatic nature of HPV, symptoms potentially caused by HPV, and that warts can turn into cancer. Both groups agreed public health HPV campaigns should target both men and women. Whereas ES women encouraged a more media based approach to HPV education, SS women commented current campaigns are too vague and emphasised a more personal, interactive approach to HPV education in public venues. Self-sampling was viewed positively by participants, along with self-sampling instructions; some modifications to collection materials were suggested.
Conclusions Focus groups revealed significant knowledge gaps in HPV associated malignancies and cancer screening in high-risk females. Anal PAP self-screening appears to be an acceptable approach; however, the large scale implementation of such strategies may require targeted educational campaigns particularly in underserved communities.

P1-S6.11 PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV (PMTCT) PROGRAM IN BURKINA FASO: HOW HIGH IS THE COVERAGE OF VOLUNTARY COUNSELLING AND HIV TESTING (VCT) SERVICES WITHIN A CLINICAL TRIAL SUPPORTING ENVIRONMENT?

doi:10.1136/sextrans-2011-050108.235

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Background Since 2003, Burkina Faso has set up a national PMTCT program. Programme monitoring 2009 annual report showed high health districts and facilities coverage. But at beneficiaries' level, how many women and children in need of PMTCT interventions have really access? The objective of our study was to measure the uptake of VCT with a comprehensive set of data collected in the recruitment process in a clinical trial evaluating postnatal chemoprophylaxis to reduce MTCT.
Methods We carried out a cross-sectional study from 1 January 2010to 31 December 2010 in 26 out of 35 PMTCT sites in five health districts in Ouagadougou city. Weekly data collection in PMTCT registers and semi-structured interviews with the personals in charge of MCH departments.
Results Among the 44 484 new recorded Antenatal care (ANC) attendees, 37 539 received HIV counselling and 37 489 were tested for HIV (results returned immediately), an acceptance rate of 99, 86%. 6,945 new ANC did not profit from the HIV counselling equalling 15.61% of the participant population. This miss opportunity for VCT was related to test supplies out of stock (78%), lack of VCT offer due to opt in strategy still in place in many facilities (17%) and structural problems (no trained staff, lack of infrastructures) in the remaining cases.
Conclusion Our results underline the overall good performance of the PMTCT program in the context of a clinical trial facilitating environment. However, a better organization of the supply procurement would allow improving VCT coverage rate. With this high coverage of VCT in research context, we can assume that the low VCT coverage at program (75%) level is mainly due to health-care system problem.

P1-S6.12 THE CONTRIBUTION OF A CHLAMYDIA SCREENING PROGRAMME TO TESTING AND CASE-FINDING IN ADDITION TO REGULAR STI-CARE IN THREE REGIONS OF THE NETHERLANDS

doi:10.1136/sextrans-2011-050108.236

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Background The impact of a Chlamydia screening programme can be measured by the incremental amount of Chlamydia tests performed and cases detected as compared to the throughput in regular care. In the Netherlands, regular STI care is provided by specialised STI-centres (aimed at high-risk groups) and General Practitioners (GP's, basic opportunistic screening and care for