

these data are from one of the largest U.S. laboratories, with representation by insurance type and geography of the U.S. population, they can be useful for monitoring testing trends. Laboratory testing data also might be a valuable adjunct for national surveillance of chlamydia positivity trends that would not be dependent on provider or health department reporting nor small sample size from national surveys.

**P1-S6.23 IMPACT EVALUATION OF PERFORMANCE-BASED FINANCING (PBF) FOR HIV TESTING AND COUNSELLING FOR INDIVIDUALS AND COUPLES IN RWANDA**

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**Background** The Government of Rwanda has nationally implemented performance-based financing (PBF) to improve the satisfaction and motivation of health workers, as well as access and quality of HIV/AIDS services in the context of scaling-up services. The scheme pays for 10 HIV/AIDS indicators (two related to HIV testing and counselling (HTC), which is believed to be a core strategy for decreasing HIV incidence and improving prevention and care). We present the effect of Rwanda's PBF program on individual and couple/partner testing as an entry point to other HIV services and in the context of scale up.

**Methods** Taking advantage of a prospective quasi-experimental design, an impact evaluation was conducted during phase-in of the Rwanda's PBF program in 2006 and 2008. Individual HTC was measured by whether or not the individual has ever been tested for HIV (371 treatment individuals (61.1% female), 378 control (56.6% female)), and partner testing was assessed by whether or not the sexual partners they had in the 12 months prior to the survey had ever been tested for HIV (208 treatment individuals (57.2% female), 202 control (52.0% females)). To evaluate the outcomes, a difference-in-difference fixed effects model was used with SEs clustered by district\*year.

**Results** PBF increased HTC at the individual level by 9.45% from baseline ( $p=0.07$ ). This effect was mainly found among married individuals (10.87% increase,  $p=0.02$ ), specifically males (15.75% increase,  $p=0.06$ ). PBF also increased testing among couples by an estimated 16.14% ( $p=0.034$ ) increase from baseline, as reported by one of two partners.

**Conclusion** Our work provides evidence that PBF might be a useful tool to increase access to HTC for both individuals and couples. This is a remarkable result since couple testing has previously been difficult to encourage.

**P1-S6.24 ESTIMATION OF PRENATAL SCREENING RATES FOR CHLAMYDIA, SYPHILIS, AND HIV AMONG LOW-INCOME WOMEN, CALIFORNIA, 2007**

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**Background** Prenatal screening for chlamydia (CT), syphilis, and HIV infection is recommended to diagnose and treat infection that

might otherwise be transmitted to the neonate and result in perinatal complications. Assessment of screening is important for programs serving low-income women who may be more likely to initiate care late in pregnancy and may be at higher risk for adverse perinatal outcomes.

**Methods** We analysed Medi-Cal program claims to identify low-income California female clients who delivered an infant in 2007 with  $\geq 9$  months Medi-Cal eligibility,  $\geq 1$  prenatal and family planning claim in the 42 weeks before delivery. Test claims in Medi-Cal and family planning claims during this period for CT, syphilis (including obstetric panels), and HIV were identified based on Common Procedural Terminology-4 codes. We estimated the percent of women screened for CT, syphilis, and HIV, and stratified by trimester screened, age ( $\leq 25$  years;  $> 25$  years), and race/ethnicity. Results of 181 390 Medi-Cal clients who delivered in 2007, the percent with  $\geq 1$  prenatal test for all 3 STDs was 62% and for CT, syphilis, and HIV was 73%, 77%, and 62%, respectively, with little variation by age and race/ethnicity. Among 125 444 women who initiated care in the first trimester the percent tested for CT, syphilis, and HIV was 78%, 83%, and 68%, respectively. Among 11 802 women who initiated care in the third trimester the percent tested for CT, syphilis, and HIV was lower at 43%, 48%, and 31%. Among women who were tested in the first trimester, the percent re-tested in the third trimester for CT, syphilis and HIV was 21%, 30%, and 5%, respectively.

**Conclusions** These lower than expected STD prenatal screening rates should be considered minimum estimates. Estimates have not included testing from all other healthcare programs accessed by women prior to delivery in the Medi-Cal program and have not been validated against medical records. Nevertheless, the lower rates of testing among women with late prenatal care initiation and the relatively low rates of HIV testing as compared with syphilis testing despite legislative mandate are concerning and further studies are needed to understand reasons for these differential rates.

**P1-S6.25 THE MALE REPRODUCTIVE HEALTH PROJECT: USING RESEARCH-BASED INTERVENTIONS TO INCREASE MALE CLIENTS AND STI TESTING AT FAMILY PLANNING CLINICS**

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**Background** Women comprise  $>95\%$  of US family planning (FP) clinic clients. The Male Reproductive Health Project (2008–2013) is a national research demonstration effort implementing empirically-based interventions to increase male FP clients and male testing for sexually transmitted infections (STI).

**Methods** In 2009 interventions at 5 FP grantees included: male outreach via FP clinics' female clients and other agencies serving men, clinic efficiency assessments, FP staff training, and modifying clinic environments. Study population currently includes male FP client visit records (2004–2009) from 2 grantees. In separate analyses for Montana (MT) (2891 visits) and San Diego (SD) (7008 visits) grantees we analysed chlamydia (CT) testing (urine/NAAT) and positivity (CT+) by clinic, age, race/ethnicity, intervention status (pre: 2004–2008; post: 2009), insurance status, new/returning client, and federal Title X FP funding. Multivariate models developed.

**STI**

## **P1-S6.24 Estimation of prenatal screening rates for chlamydia, syphilis, and HIV among low-income women, California, 2007**

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