

Abstract P1-S6.35 Figure 1 Coverage of Syphilis screening by year and service Callao, Peru 2009–2010.

Conclusions Implementation of syphilis rapid test proved feasible, acceptable and effective in improving screening and treatment coverage and can serve as a powerful catalyst for improvements in quality of care.

P1-S6.36 COST-EFFECTIVENESS OF RAPID TESTS TO IMPROVE ACCESS TO SYPHILIS PREVENTION AMONG PREGNANT WOMEN IN PERU

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Background Several recent articles compared the cost and cost-effectiveness syphilis testing strategies to avert congenital syphilis in settings with high syphilis prevalence. Current study contributes analysis in low-prevalence setting. **Methods.** Rapid syphilis testing (RST) was implemented at two different settings, both with syphilis prevalences of around 1%: (a) The Ventanilla-Network of outpatient clinics and a small hospital at a peripheral district in Peru, where the rapid syphilis test was implemented together with the rapid HIV testing (One finger stick, two tests"); (b) The National Maternal and Perinatal Institute (INMP) a tertiary hospital with a high number of patients, and Initially in both settings the only test available was RPR with low coverage. For the costing of RPR we included supplies, capital costs, human resources and costs associated to treatment. For the costing of RST, we included also start up costs (advocacy meetings with authorities, training, supervision, monitoring) and the cost of implementing a quality assurance system. Cost-effectiveness analyses compared the cost of screening and treatment for the joint program to the disability adjusted life-years saved when congenital syphilis was averted.

Results For the Ventanilla-Network the total cost was \$5.98 for RST and \$5.22 for RPR per woman screened and \$580.83 and \$1845.55 respectively per woman treated. In contrast, the total cost was \$2.53 for rapid syphilis test and \$3.15 for RPR per woman screened (the lower costs probably associated to the economy of scale, due to the large number of women seen at the INMP) and \$336.80 and \$1051.59 at INMP. At Ventanilla-Network, the cost per DALY saved from averting cases of congenital syphilis was \$35.23 for rapid syphilis test and \$111.95 for RPR. In incremental analysis, the rapid test was cost-saving. At INMP, the cost per DALY saved was \$20.43

for rapid syphilis test and \$63.79. For the Ventanilla-Network and the INMP the RST was cost-effective by the WHO standard of \$64/DALY.

Conclusion Syphilis screening is cost-effective even in a low-prevalence setting. To the extent that HIV rapid tests are funded by PMTCT programs, the cost of scaling up rapid syphilis tests would be lower than these estimates, because the joint cost of blood sample collection would be borne by the PMTCT program.

P1-S6.37 CAN RAPID SYPHILIS TESTS BE IMPLEMENTED AND IMPROVE SCREENING FOR MATERNAL SYPHILIS IN A THIRD LEVEL HOSPITAL?

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Background Syphilis continues to be one of the most important causes of maternal and child morbi-mortality, frequently being more common than HIV. Ideal diagnostic test should provide rapid and accurate results to provide timely diagnosis and treatment. Rapid syphilis testing is an excellent option. The objective of this study is to determine the feasibility of the implementation of Rapid Syphilis Testing (RST, Syphilis 3.0 BioLine) and the impact on maternal screening for syphilis at a third level hospital in Peru: the National Maternal and Perinatal Institute (INMP).

Methods Between February and December of 2010, RST was implemented in the Antenatal care (ANC), labour and miscarriage services. The National guidelines recommended screening for syphilis in all those services with RPR. Health workers (midwives, nurses and laboratory technicians, depending on the service) were properly trained on the use of RST and their performance was monitored throughout the study.

Results RST was performed on 15 116 women, with a prevalence of syphilis (RPR reactive, TPPA positive) of 1% for ANC, 0.7% for miscarriage services and 0.8% at labour. The coverage of screening for syphilis improved from 82% with RPR to 99% with RST at the ANC services; from 0% to 91% at the miscarriage services and from 79% to 94% at labour. At baseline, at the ANC visit, the results of the RPR were only available 15 days after the visit, resulting in a low coverage for treatment when the test was positive, 39%. With the implementation of the RST, the results and treatment were given immediately at the same visit, resulting on treatment coverage of 95%. The RST was very well accepted by the providers and patients.

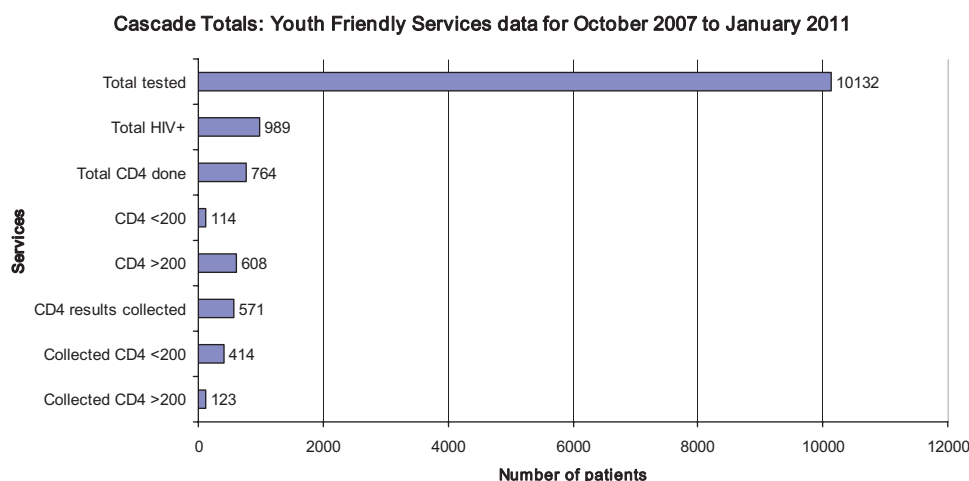
Conclusions This study shows the feasibility, acceptability and improvements on screening associated to the implementation of RST in a third level hospital. In addition of improving coverage and treatment, our results triggered changes in the institutional policies for syphilis control.

P1-S6.38 INTERPRETATION OF ROUTINE DATA FROM A YOUTH FRIENDLY CLINIC IN REGION F, JOHANNESBURG

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Background The Wits Institute for Sexual and Reproductive Health, HIV and Related Diseases (WrHI)'s Youth Friendly Programme aims to engage with young people and make reproductive healthcare accessible and non-threatening. The team educates and informs young people about HIV and has specially sensitised nurses and



Abstract P1-S6.38 Figure 1 Cascade of HIV service bundling for October 2007–January 2011.

counsellors for HIV and STI testing who are skilled in working with youth. This abstract discusses the HIV and STI outputs of the Youth Friendly clinic based on the quantitative reported data.

Methods Routine programme data submitted for the period October 2007–January 2011 was reviewed. Data was collated for the purposes of graphing, and calculating percentage difference and percentage change.

Results The target age for service delivery fluctuated in line with WHO and is currently 15–24 years. There was inconsistent reporting of headcounts for the review period. In 2007 the clinic saw 15–19 year olds (ratio of 1 male: 2 female). From 2008 this changed to a ratio of 30% male: 70% female. The age threshold moved to 24 years and clinic population became 35% of 15–19 year olds: 65% of 20–24 year olds. Total number of HIV tests conducted was 10 132 (3515 males and 6617 females). 10% tested HIV positive. 77% ($n=764$) had blood draws for CD4 count testing. 722 results were received from the laboratory, of which 571 (79%) were collected by patients. 414 results were <200 cells/mm³ see Abstract P1-S6.38 Figure 1. All eligible patients were worked up for ARVs and referred to the initiation facilities. 5176 clients accessed STI services. In 2007 50% males and 50% females were treated for STIs. During the review period this changed to 44% males and 56% females. Both HIV testing and STI services were lowest from October 2007 to February 2008 and peaked from May 2009—to July 2009 and again from September 2009 to November 2009. The reported data did not distinguish between new and repeat clients for HIV testing and STI treatment.

Conclusion The increase in target population age led to more services being accessed by 20–24 year olds. Over time there was an increase in the number of people accessing HIV and STI testing and treatment. There was an increase in males accessing the clinic and a decrease in STI services required by males. Lab reporting of CD4 counts and CD4 results collection needs to be strengthened. Routing data needs to be collected on new and repeat clients as a means of addressing casual factors for STI acquisition.

P1-S6.39 CAN PROFESSIONAL MIDWIVES INTERPRET RAPID SYPHILIS TESTS ACCURATELY?

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Background Congenital syphilis produces miscarriage and severe complications in newborns. Rapid syphilis testing (RST, Syphilis 3.0

Bioline) was introduced in antenatal care and reproductive health services of 16 health centers at Ventanilla (Callao), Peru, aiming to improving access to syphilis screening and treatment in the first contact of pregnant women with professional midwives. We present the results of a quality control assessment evaluating internal (IQC) and external quality control (EQC) of such tests when performed by professional midwives.

Methods We developed quality controls panels consisting of the Dried Tube Specimen (DTS). Open label positive and a negative control DTS were distributed as IQC bimonthly to services performing RST, to evaluate the test performance under the service storage conditions. Additionally, closed label controls (EQC) were distributed biyearly to evaluate the performance of each professional midwife performing RST. The ECC panel was composed of a weak positive, an intermediate and a strong positive DTS, as well as a negative DTS. Midwives were trained in DTS reconstitution, as well as result interpretation and recording.

Results 28 DTS panels were distributed for IQC (16 to antenatal and 3 to emergency services), with 100% concordance. 119 DTS panels were distributed as EQC, with 100% concordance observed in most (95%) of midwives evaluated. Six midwives read the weak positive DTS as negative (75% concordance). These six professionals were retrained in their health centers. IQC and EQC were well accepted by midwives, giving them a sense of confidence with their performance with the test.

Conclusion Excellent IQC and EQC results were observed, with good acceptance of the evaluation by midwives.

P1-S6.40 VCT SITES IN MSM FROM MEXICO CITY: AN OPPORTUNITY TO ACTION

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Background Mexico has a concentrated HIV epidemic (15% HIV prevalence among Male Sex Workers; 11% in MSM; 5% in IDU; and 2% in FSW). Voluntary counselling and testing (VCT) for HIV is a strategy for case detection and deliver prevention messages. This study analyses the HIV prevalence in MSM in two different settings, in order to identify potential opportunities for HIV prevention.

Methods We realised a comparative study between the men that received VCT inside the clinic, and the men reached with VCT in a mobile unit. Both services were offered by the Clinica Condesa in