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Background Men who have sex with men (MSM) and transgender persons are disproportionately affected by sexually transmitted infections (STIs), including HIV, in Guatemala. Access to integrated sexual health prevention and treatment services is limited. The purpose of this study was to identify barriers to accessing sexual health services among gay, bisexual, and non-gay identified MSM and male-to-female transgender persons in Guatemala City to inform the development of high quality and population-friendly services that are sensitive to the needs of this population.
Methods Semi-structured in-depth interviews were conducted with 27 purposively sampled participants, including 7 transgender, 11 gay, 5 bisexual, and 4 non-gay-identified participants, in Guatemala City. Interview topics included experiences with sexual health services, perceived barriers to access, social and sexual network characteristics, and HIV risk behaviours. Topical codes were developed based on readings of interview transcripts and codes were applied to the data using the qualitative software Atlas.ti. Data were compared between study sub-groups using thematic matrices and analytic memos.
Results Across all participants, public clinics were the most commonly used sexual health services due to their lower cost and greater accessibility, but many participants provided examples of discrimination, violation of confidentiality, and distrust in the quality of services offered. Transgender and gay participants preferred clinics where they felt a sense of belonging while non-gay identified participants preferred clinics that were not associated with the MSM community. The most prominent barriers to sexual health services described by participants included fear of discrimination related to sexual identity and/or behaviour, fear of having HIV and the associated stigmatisation, cost, and lack of social support.
Conclusions Findings highlight the need to strengthen and expand existing public STI clinics to improve access to services among MSM and transgender populations in Guatemala City. These services must address the multiple layers of stigma and discrimination that MSM and transgender persons experience related to identity, behaviour, and STI/HIV. Insights from this study are currently being applied to the implementation of two public clinics in Guatemala City that seek to provide a discrete, non-judgemental environment where individuals can seek affordable services without fear.

P5-S6.18 COST-EFFECTIVENESS OF INTRODUCING RAPID SYPHILIS TESTING IN THE AMAZON REGION, BRAZIL

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Background This study aims to estimate the costs-effectiveness of introducing a universal syphilis screening and treatment package with an enhanced quality assurance system among isolated indigenous populations in the Amazon region of Brazil.
Methods In three indigenous health units (Umariacu II, Vendaval and Betania), incremental financial and economic costs of the full programme were collected including start-up, training and quality assurance, supervision and implementation. These units were chosen because of their different geographic access levels (easy to very difficult) so that results can be extrapolated to other health districts of the Amazon state. Unit cost per person screened and treated was estimated as well as the cost-effectiveness per adverse outcome and DALY averted. This study also provides the first data on prevalence rates in this population.
Results Using rapid syphilis tests, the prevalence of syphilis was 1.56% and 2.2% in the sexually active population and in pregnant women respectively at the three health units. The total financial cost of syphilis screening 4173 people was $277 853. The total economic cost was $285 995.67. The economic cost per person screened was US$68.53 and treated was US$4028.11. The cost per DALY saved was US$484.31 (including stillbirth). Personnel costs contributed the largest input category consisting of 87.5% of the total costs, due to the high cost of labour of FUNASA (National Health Foundation) personnel. Training costs are also high due to the frequency of staff turnover and thus the need for repeated trainings.
Conclusions Although the cost per person screened and per person treated for syphilis could be considered high by international standards, the only alternative to screening in the health units for this population would be transporting people to the nearest larger town for screening in the nearest health facility with a laboratory. This would clearly exceed the costs of treating the cases locally by far. This therefore makes rapid syphilis testing the most cost-efficient alternative for testing these remotely located populations. Additionally, because of cultural behaviour of the indigenous populations and the fact that some of them are located near border regions of Brazil, the prevalence scenario can change quickly, increasing the number of syphilis and HIV cases in the absence of prompt identification and treatment.

P5-S6.19 PREVALENCE AND INCIDENCE OF SEXUALLY TRANSMITTED INFECTIONS AMONG FEMALE SEX WORKERS IN TWO CITIES IN INDIA: IMPLICATIONS FOR STI CONTROL STRATEGIES

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Background India is a large country with marked heterogeneity in prevalence of sexually transmitted infections (STIs) which has implications for STI control strategies. The study objective was to measure the prevalence and incidence of common bacterial STIs in a cohort of female sex workers (FSWs) in known high STI prevalence cities in response to a package of standardised interventions under Avahan, the India AIDS Initiative of the Bill & Melinda Gates Foundation.
Methods FSWs attending clinics were followed up periodically over 6–9 months. At every visit, vaginal swabs were tested for *Neisseria gonorrhoeae* (GC) and *Chlamydia trachomatis* (CT) by Gen-Probe APTIMA Combo II. During the baseline and final visits, vaginal swabs were tested for *Trichomonas vaginalis* (TV) by PCR and blood was tested for syphilis using Rapid Plasma Reagin (RPR) with confirmatory *Treponema pallidum* Haemagglutination Assay (TPHA). All participants received presumptive treatment for gonorrhoea and chlamydia at the baseline visit and syndromic STI management at all subsequent visits.
Results A total of 417 FSWs were recruited, 360 returned for at least one follow-up visit, and 282 completed the final visit. The total follow-up period was 109.4 person years (median 0.18 years, maximum 1.07 years). Self-reported consistent condom use with commercial and regular partners was 70% and 17%, respectively. A substantial proportion of cervical and trichomonal infections were asymptomatic (see Abstract P5-S6.19 table 1). The incidence of GC/CT and TV was 1.0 and 2.0 per person year respectively. Three new cases of latent syphilis were detected at the final visit.