

Conclusions Although scapegoats (in the form of sex workers) were increasingly identified by the community, stigma towards those with HIV appeared to have reduced significantly. Despite increased knowledge and positive changes around stigma, fear of change to cultural mores was apparent, with unwillingness to embrace openness and discuss sexuality. Young and educated respondents appeared to be the most regressive thinkers, reflecting a cultural inertia that mirrors studies of other threats to traditional societal values. More effort is required to educate young people about healthy sexuality, openness and safe sex.

Social and behavioural aspects of prevention oral session 2—Innovative STI and HIV preventive interventions: intended and unin- tended consequences

O2-S2.01 THE PROJECT CONNECT HEALTH SYSTEMS INTERVENTION: STD SCREENING AND HIV TESTING OUTCOMES FOR FEMALE ADOLESCENTS

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Background Access to STD screening and HIV testing are important components of sexual and reproductive health care for adolescents. However, few youth have ever had an STD or HIV test, suggesting a need for new approaches to linking adolescents to care. Project Connect is an 8 year, quasi-experimental study of a multi-level intervention to prevent STD, HIV, and teen pregnancy. The Health Systems Intervention component was designed to provide an effective conduit to link youth to available health care services. Community health care providers who offered adolescents high quality care were identified and recruited for a referral system implemented through school nurses.

Methods Six intervention and six control high schools in a public school district in the Los Angeles, California area participated in the study. Analyses included survey data from 6623 sexually experienced (ever engaged in sexual intercourse) and 4703 sexually active (engaged in intercourse in the past 3 months) female high school students across 5 years (T1–T5). Both samples were 78% Latino and 13% African American; the mean age was 16.6. A mixed model logistic regression analysis was used to test for intervention effects. Random effects on the student level were included to control for repeated measures.

Results Statistically significant intervention effects were observed overall among both samples (see Abstract O2-S2.01 table 1 for adjusted OR and 95% CIs for sexually experienced sample) for receiving STD testing or treatment in the past year and ever being tested for HIV. At T1, for example, 18% of sexually experienced intervention females reported being tested/treated for an STD in the past year; at T5, 29.2% reported having done so. In the control condition, 17% reported STD testing/treatment in the past year at T1, which remained relatively stable by T5, at 19.9%. Among sexually experienced females statistically significant increases were also found for ever being tested for an STD.

Abstract O2-S2.01 Table 1 Adjusted OR for the change between time points in sexually experienced females

Time point paired difference	AOR (95% CI)		
	STD test/Tx past year	Ever STD test	Ever HIV test
T2-T1	1.12 (0.66 to 1.98)	1.06 (0.57 to 1.97)	1.16 (0.59 to 2.26)
T3-T1	1.73 (1.02 to 2.95)*	1.44 (0.77 to 2.70)	1.42 (0.73 to 2.28)
T4-T1	1.67 (0.965 to 2.87)	1.97(1.03 to 3.77)*	2.20 (1.10 to 4.39)*
T5-T1	1.93 (1.14 to 3.26)*	1.28 (0.68 to 2.41)	1.94 (0.99 to 3.81)
T3-T2	1.55 (0.93 to 2.56)	1.36 (0.75 to 2.45)	1.23 (0.65 to 2.32)
T4-T2	1.49 (0.88 to 2.51)	1.86 (0.99 to 3.48)	1.90 (0.97 to 3.71)
T5-T2	1.72 (1.04 to 2.85)*	1.21 (0.66 to 2.22)	1.67 (0.86 to 3.24)
T4-T3	0.96 (0.57 to 1.62)	1.36 (0.74 to 2.50)	1.55 (0.81 to 2.96)
T5-T3	1.11 (0.67 to 1.84)	0.89 (0.49 to 1.61)	1.37 (0.72 to 2.59)
T5-T4	1.16 (0.70 to 1.91)	0.65 (0.36 to 1.18)	0.88 (0.47 to 1.65)

*p<0.05.

Conclusions Project Connect was successful in linking female adolescents to sexual and reproductive health care through high school nurses. Rather than attempting to change provider behaviour, this structural intervention capitalises on existing, adolescent-focused expertise among local medical providers. It is a low-cost, sustainable strategy for linking (or ensuring access for) adolescents to care and could be widely implemented.

O2-S2.02 SEX WITH STITCHES, THE RESUMPTION OF SEXUAL ACTIVITY DURING THE POST-CIRCUMCISION HEALING PERIOD IN ZAMBIA

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Background As male circumcision (MC) programs are scaled-up for HIV prevention, it is critically important to measure the prevalence of risk behaviours post-MC. Of particular concern is the potential risk of increased HIV-1 transmission and acquisition as a result of premature resumption of sexual activity during the 6-week healing period post-MC, when clients are instructed to abstain from sex. The presentation will review the prevalence of sex post-MC, highlight risk factors for the early resumption of sex and model the impact of such behaviour at the population level.

Methods The study was conducted in four provinces of Zambia in which male circumcision services are being scaled-up. A sample of 248 males aged 15–29 were interviewed via ACASI immediately prior to and 6 weeks after their circumcision; the study follow-up rate was 90%. At baseline, participants were asked about risk behaviours, as well as their knowledge and attitudes about MC. At follow-up, participants were asked about sexual activity in the previous 6 weeks, the timing of resumption of sex post-MC, and other sexual risk behaviours. To evaluate the impact of the study results at the population level, a model was used to estimate the number of new infections that are attributable to the early resumption of sexual activity and the number of infections averted due to the MC program.

Results Preliminary findings indicate that of the men who were followed up, 24% reported resuming sexual activity prior to 6 weeks. The prevalence of early sex is higher (30%) for men who were already sexually active at baseline. Of men who resumed sex prior to 6 weeks, 46% did so in the first 3 weeks post-MC; 22% initiated sex within the first week. Further, 82% reported at least one unprotected sex act, and 26% reported multiple sexual partners. Data also suggest these men had higher risk behaviours at baseline. Modelling the impact of such behaviour indicates that the benefits of the MC

program, in terms of HIV infections averted, far out-weigh the costs from the number of new infections generated from the early resumption of sex see Abstract O2-S2.02 table 1.

Conclusion The resumption of sexual behaviour during the wound healing period poses increased risk for the transmission and acquisition of HIV-1 for individuals. The early resumption of sex is of particular concern for programs that circumcise HIV+ men or a large proportion of men who are not HIV tested. However, at the population level, such behaviour seems less of a concern.

Abstract O2-S2.02 Table 1 Sexual behaviour with 6 weeks post MC

Percent having sex within 6 weeks post-MC	
Among all MC clients	24%
Among all MC clients who were sexually active by baseline survey	30%
Among all MC clients who had sexual partners at baseline	28%
For those having sex...	(N=54)
Mean number of sex acts in last 4 weeks	2 (min=1, max=12)
Mean number of partners	1.6 (min=1, max=4)
Reported at least one unprotected sex act	82%
Reported 2 or more sexual partners in period	26%
Report sex with a commercial sex worker or bar girl	4%
Resumed sex within first week of MC	22%
Resumed sex within first 2 nd and 3rd weeks of MC	24%
Resumed sex 4+ weeks of MC	41%

O2-S2.03 FEASIBILITY OF GIVING HSV SEROLOGICAL TEST RESULTS BY MAIL AND PHONE

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Background Accurate serological tests for the herpes simplex virus have been commercially available since 1999. Despite this availability, they are offered infrequently. Concerns about the resources required for testing including time spent on counselling and follow-up are among the barriers to testing. The purpose of this study was to determine the feasibility of using letters and phone calls to give HSV-1 and HSV-2 serological test results and to document the resources used to deliver results and respond to subjects' concerns.

Methods Subjects were recruited from an urban STD clinic and tested for HSV-1 and HSV-2 as part of a multi-site study of HSV serological test performance (N=612). Subjects were offered the option of having an investigator mail or call with test results. Result letters included a one page hand-out on HSV-1 and HSV-2 and the phone number of an investigator who could address concerns. Number of phone calls received, time spent on the phone, level of subject distress, and request for referrals were documented. Descriptive statistics were calculated for all variables and data was examined for bivariate relationships using SPSS.

Results Sixty-seven per cent of the subjects requested that their results be mailed (n=410) and 33% requested that their results be given by phone (n=202). Approximately 6% of the subjects who received letters called for additional information. Seventy-one per cent of the calls took less than 5 min and only 2% required more than 10 min. A total of approximately 6.4 h were spent on the phone to give results and respond to questions. <1% of the subjects required multiple phone calls and less than 1% requested a referral to a clinician. Investigators rated 55% of subjects spoken to on the phone as not at all distressed, 31% as somewhat distressed, and 12% as very distressed. Distress was significantly associated with longer time on the phone, but not with testing positive for HSV-2 vs HSV-1.

Conclusions Delivery of HSV serological test results by phone or mail is feasible and requires minimum time on the part of providers.

O2-S2.04 TARGETING HIV PREVENTION EFFORTS ON HIV-INFECTED MEN USING CONDITIONAL CASH TRANSFER (CCT): DOES IT WORK?

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Background Preventing HIV infections in female spouses of HIV-infected men is limited by low HIV testing rates among these women who are at an increasingly high risk for HIV acquisition. We explored the effect of conditional cash transfer (CCT) on HIV-infected men for spouse testing and HIV status disclosure to their spouses.

Methods Using medical charts we identified all eligible HIV-infected married men receiving care at the PIMS HIV clinic, Islamabad. Selection criteria for CCT were sexually active married men receiving care >6 months including at least two counselling sessions whose spouses had never been tested for HIV (HIV status unknown). CCT was cash given to cover travel/accommodation (US \$14 for out-town and US\$ 5 for in-town) costs for bringing the spouse to the HIV clinic for testing. All study participants underwent a brief study questionnaire looking at patient demographics, visit history, factors influencing spouse testing, barriers to care and self-disclosure. The CCT acceptance rate was 90% among HIV-infected men. Outcome of interest was spouse testing and status disclosure to spouse at 6 months post CCT.

Results Of the 230 married men, 138 men (60%) had spouses' never tested/unknown status. Baseline disclosure of HIV status to wife was 29%, and median duration of receiving care was 14.3 months. From these 138 men we were able to contact and enrol 94 (68%) men for CCT; 53 (56%) brought their spouses for HIV testing within 4 months; 19 (20%) self-reported getting their wives tested elsewhere, and only 22 (24%) did not comply with the CCT conditionality. CCT improved disclosure of HIV status from baseline 29% to 62% (p <0.05). Factors associated with spouse testing were men <50 years, high ART compliance score, and prior self-disclosure of status to one family member (p <0.05).

Conclusions Even within the context of a socially conservative society CCT can significantly improve HIV testing rates for female spouses and self-disclosure of HIV status by HIV-infected men. Using CCT for timely prevention of HIV infection in wives and children of HIV positive men reduces risk and can be an effective strategy to overcome socio-cultural and financial barriers. Further studies are needed to explore cost-effectiveness of this approach in preventing new infections.

O2-S2.05 START WITH THE SOCIAL DETERMINANTS OF HEALTH TO TAILOR SEXUAL HEALTH PROMOTION FOR FIRST NATIONS, INUIT AND MÉTIS YOUTH IN CANADA

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Background Sexual health promotion and approaches for the prevention of sexually transmitted and blood-borne infections (STBBI) should be tailored to the needs and realities of youth. Engaging youth and building their capacity is an important step in health promotion and has proven to be critical in the development of a promising initiative aimed at engaging First Nations, Inuit and Métis youth in Canada.