P5.021 POOR GONORRHOEA SCREENING IN WOMEN SEEKING STI/REPRODUCTIVE HEALTH ADVICE IN RUSSIAN PUBLIC HEALTH SETTINGS IS THE CHALLENGE FOR GONORRHOEA CONTROL AND PREVENTION OF ITS COMPLICATIONS

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Background Untreated gonorrhoea in women in 20–40% brings to PID and the following tubal infertility. The estimated number of Russian women 15–44y.o. with infertility history around 1.5% due to the tubal factor in 2011. Free access to $4000 in-vitro fertilisation for women with infertility was introduced in Russia to increase national birth rate. Timely diagnosis and treatment of gonorrhoea that can be cost-effective preventive intervention, is however compromised by the low-sensitive microscopy test for gonorrhoea screening in women. In the circumstances of fast spreading of drug-resistant gonorrhoea forms improving gonorrhoea diagnosis and treatment in Russia are urgent priorities. Methods: Desk review and stakeholder interviews were used to review and analyse gonorrhoea trends, policies and guidelines, service delivery, challenges and needs.
Results (1) Free Gs microscopy women can either receive in STI clinic or in women's consultation. Culture is mostly used as the confirmatory method or in women with gonorrhoea infected partners. Sensitive NAAT methods are available in most urban settings on commercial base. Specificity of the Russian NAAT tests remains challenge. (2) Gs prevalence studies are not available (3) Standards are developing by different institutions, there are not leadership on the development of national guidelines or public health interventions on STI. The vertical structures of STI and reproductive health services under the Ministry of Health in combination with complex region-based health financing provide a challenge for the development of cost-effective public health response when multidisciplinary approaches are needed.
Conclusion Gs prevalence studies in STI clinics and women's consultations could provide the knowledge base for the cost-effective public health action. Algorithm of final Gs diagnosis should be developed and used in accordance with local situations. Introduction of free sensitive screening test as NAAT or culture among female populations with greater than 1% Gs prevalence might be recommended for public STI or reproductive health settings.

P5.022 EARLIER HCV DIAGNOSIS BY THE INTRODUCTION OF ROUTINE HCV TESTING FOR HIV POSITIVE MSM AND MSM OPTING OUT FOR HIV IN A LARGE STI OUTPATIENT CLINIC

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Background In October 2007 at a large STI outpatient clinic (SOC), anti-HCV screening was introduced for HIV unaware MSM opting-out for HIV testing (MOH) and HIV-positive MSM. We evaluated whether this screening resulted in additional and earlier HCV diagnosis in HIV-positive MSM also attending HIV treatment centres (HTC).
Methods At first visit, MOH and HIV-positive MSM visiting the SOC in Amsterdam were screened for anti-HCV. During follow-up visits, only those previously HCV negative were tested. Retrospectively, date of new HCV diagnosis at SOC was compared with HCV data provided by HTC.
Results The anti-HCV prevalence at first screening was 0.7% (3/450) among MOH and 6.4% (112/1,742) among HIV-positive MSM of whom 30% (34/112) did not report a history of HCV. In 133 follow-up visits to MOH 0 and in 3,286 follow-up visits to HIV-positive MSM 52 HCV seroconversions were found. These 52 seroconverters and the 34 MSM anti-HCV positive at first screening, excluding 13 MSM who were detected at HTC before SOC started anti-HCV screening, were compared with HTC data. Additional data from HTC was available for 56/73 clients. 29/56 (52%) were first diagnosed at SOC: 7 were concurrently diagnosed with HIV and not in care at HTC; 11 were scheduled for a routine visit at HTC within 1 month; 3 within 3 months; 3 within a year and all 17 were tested and diagnosed with HCV at HTC because of elevated ALT values; 3 HCV diagnoses would have been missed because ALT was low or considered non-HCV related; 2 missed ALT data.
Conclusions The introduction of routine HCV-antibody screening in SOC resulted in additional and earlier diagnoses of HCV in MSM. Testing should focus on HIV-positive MSM especially those newly diagnosed with HIV. Since anti-HCV testing does not identify acute infections, additional testing policies should be evaluated at SOC.

P5.023 NOVEL EMERGENCY DEPARTMENT REGISTRATION KIOSK FOR HIV SCREENING INCREASES ENGAGEMENT OF HIGH RISK PATIENTS AND IS COST-EFFECTIVE

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Background High operating costs challenge sustainability of successful U.S. Emergency Department(ED) HIV screening programmes. Free-standing registration kiosks could potentially reduce the marginal costs of ED HIV screening. We investigated a cost-effectiveness ratio(CER) as cost per new HIV diagnosis for a kiosk-based approach for offering screening, versus a counsellor-based approach.
Methods A rapid oral-fluid HIV screening programme, instituted in a U.S. ED since 2005, had a rate of new HIV diagnosis 0.16% in 2012. A two-phase quasi experimental design, including a counsellor-based approach to offer testing at the bedside (Phase I, August and September 2011) and a kiosk-based approach to offer testing at ED registration (Phase II, December 2011 and January 2012), was performed. CER per new HIV diagnosis was defined as total cost of the screening programme divided by number of newly diagnosed cases. Costs included screening programme personnel (study coordinator, testing staff, and kiosk helpers), diagnostic assays (rapid and confirmatory tests), and kiosks (2 kiosks, software, and IT consulting fees). Sensitivity analyses were performed.
Results Slightly higher rates of newly diagnosed HIV positivity were observed with kiosk approach [I: 0%(0/538); II: 0.47%(2/430; 95% CI: 0.08%, 1.53%)]. Compared to phase I, those tested via kiosk were more likely to be younger and report high-risk sexual behaviours and/or injection drug use(IDU) [phase I vs. II: age: 39 years, 35 years; high-risk sexual behaviours: 30%, 51%; IDU: 1%, 7% (all $p < 0.05$)]. Projected first-year CER for kiosk-facilitated screening was $12,470 versus $18,406 counsellor-based screening(using a new HIV diagnosis rate in 2012). Sensitivity analysis based on 95% CI of positivity(0.08%, 1.53%) estimated the 1-year CER for kiosk-facilitating screening to be $82,847 to $3,814, respectively.
Conclusions Our pilot data demonstrated that use of kiosks for offering HIV screening engaged more high-risk patients, identified more unrecognised infections, and was potentially more cost-effective than a counsellor-based bedside approach.

P5.024 USE OF RAPID HIV TEST IN LOW THRESHOLD CENTRE IN ANTWERP, BELGIUM DURING 2007–2012

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