

Our aim was to assess whether routine screening for TV in females is indicated in an urban Australian setting.

**Methods** Females attending a sexual health clinic from July 2013–February 2014 who were tested for *Chlamydia trachomatis* (CT) and *Neisseria gonorrhoeae* (NG) were eligible to have a TV test on the same specimen. Testing was performed by transcription-mediated amplification on female genital specimens using the Aptima *Trichomonas vaginalis* assay (Hologic Inc., United States). Characteristics of the study population were examined.

**Results** During the study period, 393 women were tested for CT/NG on 471 occasions. TV tests were performed 347 (73.7%) of CT/NG specimens. There were no significant differences between women who had (n = 294), and did not have (n = 99), a TV test during the study period, except that women who had recent overseas sexual contact were less likely to be tested. Of the 347 tests, two TV infections were diagnosed, a positivity rate of 0.6% (95% CI 0.07–2.1%). Both cases were Australian-born with a history of injecting drug use in the past 12 months. Neither were sex workers and one identified as Aboriginal. One presented with post-coital bleeding, and TV was identified on wet film. The other reported pelvic symptoms, but was tested on outreach and no wet film microscopy was performed. Neither had concurrent CT/NG infections detected.

**Conclusion** We found a low positivity rate of TV among female attendees. Both TV infections were in women who had symptoms suggestive of a sexually transmitted infection. Our findings are in accord with those from previous urban Australian studies and do not support routine TV screening for asymptomatic women in metropolitan Sydney.

**Disclosure of interest statement** Aptima *Trichomonas vaginalis* assay testing kits were provided free by Hologic (Australia) Pty Ltd.

#### P12.07 DELIVERING INCREASED SERVICE PROVISION: IPPF EXPERIENCE OF PROVIDING TARGETED TECHNICAL SUPPORT WITHIN EXISTING SRH SERVICE DELIVERY POINTS FOR STRENGTHENED STI-SPECIFIC SERVICE PROVISION

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**Introduction** In 2013, the International Planned Parenthood Federation (IPPF) set out a strategy for increasing service provision across the IPPF Member Associations (MAs). A key service area identified for rapid scale-up was sexually transmitted infections (STIs). As a global service provider of sexual and reproductive health (SRH), the prevention and management of STIs has long been an integral part of IPPF's mission. However, the provision of services for STIs, other than HIV, has been a lower priority among many IPPF MAs in recent years.

**Methods** To support the strengthening of STI-specific services, small seed grants were provided to eight MAs covering all six of IPPF's geographical regions to conduct a rapid assessment of existing service delivery points. This action-oriented process enabled MAs to set their own goals and directions, and to prioritise interventions to address STIs through existing service delivery points. Specific assessments determined the current service capacity and identified technical assistance needs for increasing STI-specific service delivery.

**Results** The assessments of existing service delivery points gathered information on key issues affecting access, utilisation, and quality of care services for STIs, and identified staff training needs. Overall analysis led to the identification of specific deficiencies affecting service delivery and need for improving programme-level interventions including training and updating guidelines for STIs. Some key opportunities included the scaling-up of both syndromic management and etiological diagnosis in all service delivery points, strengthened integration with other SRH-related services, rollout of rapid diagnostic syphilis testing, and prioritising interventions for young people including vaccination, prevention and screening.

**Conclusion** With commitment and support, targeted technical assistance with limited resources enabled the development of strategic recommendations for scaling-up effective STI-specific services. A number of existing simple, effective, and cost-effective services were identified for implementation towards increasing quality STI services at existing service delivery points providing SRH services.

**Disclosure of interest statement** Nothing to declare.

#### P12.08 STI MANAGEMENT IS HIV PREVENTION: IMPROVING ACCESS TO A COMPREHENSIVE PACKAGE OF STIGMA-FREE SRH AND HIV SERVICES FOR KEY POPULATIONS BY IMPLEMENTING THE LATEST WHO GUIDELINES

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**Introduction** "Shadows and Light" is a three-year project implemented by four IPPF Member Associations and funded by the German BACKUP Initiative. The project developed service capacity that addressed the linked sexual and reproductive health (SRH) and HIV needs of four key populations: transgender people (India); sex workers (Uganda); people who use drugs (Kenya); and men who have sex with men (Cameroon). Often at increased risk of STIs, screening, diagnosis and treatment of STIs are crucial parts of a comprehensive response to HIV.

**Methods** The initial activities focused on preparing clinic sites, including training of service providers to provide stigma-free services. This involved consultations with key population networks and peer educators to inform development of a full continuum of HIV services, including other STIs, as part of SRH services. Recommended interventions were guided by available WHO guidelines for key populations, and included an assessment of implementation in line with current recommendations.

**Results** The project contributed to the development of stigma-free SRH services that offered safe access for key populations in each clinic site. The assessment of available STI services found that while syndromic management for all key populations was available, there was limited availability of targeted screening for asymptomatic STIs. While serological testing for syphilis infection was available in some sites, none were screening for gonorrhoeal or chlamydial infections. No periodic presumptive treatment for asymptomatic STIs was undertaken.

**Conclusion** The inclusion of SRH-related recommendations in the WHO consolidated HIV guidelines for key populations were a critical advancement. By creating a strong link that STI management is HIV prevention enables a greater possibility of addressing within programmes funded by the Global Fund to

fight AIDS, Tuberculosis and Malaria. However, additional implementation tools are required to support strengthening of STI-specific services for key populations.

**Disclosure of interest statement** Nothing to declare.

#### P12.09 HIV CASCADE OF CARE: IMPROVEMENTS IN LINKAGE TO CARE AT THE STI CLINIC OF THE PUBLIC HEALTH SERVICE ROTTERDAM-RIJNMOND, THE NETHERLANDS

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**Background** The hiv cascade of care includes steps from testing to treatment. Once diagnosed, there are several steps determining the time between testing and linkage to care: Algorithm of hiv tests, communication of test results, way of referral to hiv treatment centre, and confirmation of being in care. In the course of 2010–2015 processes have been changed in the STI clinic to improve linkage to care.

**Objectives** To evaluate the efficiency of referral to the HIV treatment centres in Rotterdam we investigated the time between date of hiv test, date of referral to and first consultation at the hospital.

**Methods** We followed newly diagnosed patients from January 2010–March 2015 until linkage to care and collected data on time of HIV testing, discussing diagnosis, referral to and first consultation in care. Median time was calculated between testing, referral and first consultation in care, and regression analysis performed.

**Results** We identified 227 newly diagnosed patients, of which six refused referral, nine were referred to hospitals outside Rotterdam, and 212 were referred to an hiv-treatment centre in Rotterdam. 41 patients (19%) were lost to follow up, 37 (43%) between 2010 and 2012 vs. 4 (5%) between 2013 and 2015. Of the 171 persons in care, the mean time between hiv test and arrival in hospital was 32 days, and decreased significantly ( $p = 0.004$ ); median time was 39 days in 2010 and 14 days in 2015. The mean time between testing and referral was 18 days and decreased significantly ( $p < 0.001$ ); (range median 22 – 9 days). There was no decrease in time between referral and arrival in hospital.

**Conclusion** Time to entry into care can be improved in cooperation between STI clinic, laboratory and HIV treatment centre. Active follow-up for those referred is needed to facilitate interventions for entry into care.

**Disclosure of interest statement** No grants were received in the development of this study.

#### P12.10 CHALLENGES IN IMPLEMENTING A PARTNER NOTIFICATION WEBTOOL IN GP PRACTICES IN THE NETHERLANDS: PRELIMINARY RESULTS OF A PILOT STUDY

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**Introduction** After evaluation of an internet-based partner notification (PN) system for verified diagnoses of STI/HIV, that uses an index-chosen method per partner (email, text messaging; (non-)anonymous) in STI clinics,<sup>1</sup> we started a pilot project with General practitioners (GP) with [www.partnerwaarschuwing.nl](http://www.partnerwaarschuwing.nl). The webtool includes training tools for GPs and practice assistants performing STI consultations and video instructions for patients.

Our aim was to evaluate the use of the webtool by GP practices as compared to STI clinics.

**Methods** We evaluated use of the web tool by GPs in the pilot project from April 2014 – March 2015. Numbers of created codes per professional, and numbers/method of sent notifications as well as login's by notified partners were extracted from the notification database.

**Results** 18/78 (23%) professionals in GP practice who had applied for the pilot project during the year actually used the webtool. Also the Rotterdam and Amsterdam Public Health STI clinics used the webtool. 137 index-clients received a code by 18 professionals in GP practice (11 GPs, 7 practice assistants); mean number of codes provided 7.6/0.75 year. 80% of the codes were provided by practice assistants. Of the GP's patients who received a code, 15% (21) notified contacts and sent 48 notifications (mean 2.3), 73% by text messaging and 27% by email. For 1010 STI clinic patients these numbers were 30% (300), 961 notifications (mean 3.2), 95% by text messaging. Of all notifications 86% was sent anonymously. Sixty-four percent of the partners notified checked their notification at the website (GP patient: 52% [25/48] versus STI clinic 65% [622/961]).

**Conclusion** PN in GP practice is challenging. Improvement of PN in GP practice can be assisted by this webtool, especially in STI consultations by practice assistants. Further analysis of constraints for PN are ongoing to develop a multifaceted implementation strategy and strengthen PN in general practice.

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