Methods STIPU has an advisory group and three working groups for projects dedicated to GP, PFSHS and community STI social marketing. Multidisciplinary groups including academic researchers created work plans to identify needs; develop baseline, process and outcome indicators; develop, promote and disseminate resources and training activities.

Results Identified needs include population health skills, priority population triage, local priority population estimations; resources and training developed include, for GP, STI testing and partner notification tools, practise nurse chlamydia testing card, online and in person STI training modules for doctors and nurses; for PFSHS, priority population calculator and target estimator, state-wide standard operating procedures and triage training. In consultation with academic and corporate health marketers, a social marketing plan includes working with young people's music festivals using online and festival activations. Cross government and non-government youth agencies are now receiving consistent sexual health messaging for local youth work further supporting current school-based sexual health curriculum. External academic evaluation has been undertaken to refine GP project activities.

Conclusion Coordinating three key aspects of the NSW STI Strategy implementation has allowed programme knowledge, practise and outcomes to be considered concurrently. Partner engagement remains strong and early operations and systems research integration has stimulated programme management.

P6.034 POTENTIAL IMPACT OF A PROVINCIAL ELECTRONIC HEALTH RECORDS ON STI/HIV TESTING AT STI CLINICS

doi:10.1136/sextrans-2013-051184.1188

¹G Ogilvie, ¹D Taylor, ¹M Gilbert, ²M Achen, ¹R Lester, BCCDC Provincial STI clinic clericalnursing team. ¹University of British Columbia, Vancouver, BC, Canada; ²BC Centre for Disease Control, Vancouver, BC, Canada

Background Clients who choose to attend sexually transmitted diseases clinics for care express a desire for anonymity and non-judgmental care. We surveyed a convenience sample of clients attending the BC Centre for Disease Control (BCCDC) Provincial STI clinic to assess the acceptability of electronic health records (EHR) containing sensitive sexual health information which may be available to healthcare professionals external to the BCCDC STI clinic.

Methods All clients attending the BCCDC STI clinic between July-October 2012 were offered a 16-item questionnaire to determine if it was acceptable for their sexual health information to be made available to their family physician, pharmacist, medical specialist, and nurses at other STI clinics through the provincial EHR. Demographic information was also collected. Frequency analysis was conducted using SPSS-14

Results At total of 378 (227 [60%] male) individuals completed the survey. Seventy-four percent were 19–39 years old (range 14yrs - > 59yrs). Sixty-seven percent (n = 254) were Caucasian and 55% (n = 209) had a university degree. The majority (86%) of respondents stated they were satisfied with the current computer health record with closed access to external healthcare professionals. One hundred and one (27%) respondents stated it would not be acceptable for their family physician (n = 101 [27%]), pharmacist (n = 197 [52%]), medical specialist (n = 106 [28%]), and nurses in other STI clinics (n = 112 [30%]) to have access their BCCDC STI clinic record. 133 respondents (30%) stating they would be less likely to get tested for HIV and STIs and if their BCCDC STI clinic record were made available as part of the provincial EHR.

Conclusion The introduction of a provincial EHR for STI/HIV care information is not acceptable to a significant proportion of clients and may result in reduced screening, posing a threat to the

control of sexually transmitted infections in British Columbia. Further monitoring and safeguards should be considered.

P6.035 THE ROAD TO PROJECT OWNERSHIP; THE EXPERIENCE OF SUB GRANTING IN 27 DISTRICTS OF UGANDA

doi:10.1136/sextrans-2013-051184.1189

J M Matovu, E Tumuhimbise, J Opigo, A Kekitiinwa. *Baylor Uganda, Kampala, Uganda*

Many donor funded HIV/AIDS programmes have been known to crumble when the donor pulls out. This has largely been attributed to poor sustainability plans by most projects. Since 2008, Baylor Uganda has been implementing an HIV/AIDS programme through sub granting in 27 districts of Uganda. We describe the sub granting experience as a sustainability implementation approach to HIV/AIDS programmes.

Methods Under Sub granting we provide cash subventions to 27 districts health offices, 267 health facilities and 27 district network of people living with HIV/AIDS (PHA) to implement their own HIV/AIDS priority activities. These funds supplement the meagre government primary health care (PHC) conditional grant. Baylor-Uganda together with the partners hold annual planning meetings to identify priority areas for HIV/AIDS for funding in line with ministry of health requirements. Funds are released on a quarterly basis to the partners based on their approved work plans and budgets. Baylor staff monitors project implementation on a monthly basis. Supported districts submit technical and financial reports quarterly. Accountability of the district is reviewed and districts are annually categorised according to performance. The size of the grant in subsequent quarters is dependent upon the performance of the partner.

Results Today all the partners able to identify their priorities, develop work plans and implement their own activities hence fostering ownership and sustainability. Sub granting has helped to create a strong sense of ownership by both the project implementers and the target beneficiaries. Ranking of districts has brought in competition which has improved service delivery as well as accountability. Late implementation and late submission of accountability are still the major challenges.

Conclusion Whereas sub granting faces some challenges, it is a fundamental step towards creating ownership and sustainability of HIV programmes in low resource settings.

P6.036 STIGMA & DISCRIMINATION AMONG HIV-INFECTED MSM POPULATION IN THE SUB-SAHARAN AFRICA

doi:10.1136/sextrans-2013-051184.1190

A Mohanty. *Kissito Healthcare, Roanoke, VA, United States*

People Living with HIV/AIDS (PLWHA) in Sub-Saharan Africa face stigma and discrimination including significant health challenges. Social, religious and cultural contexts most often contribute to various forms of stigma and discrimination among PLWHA. They pose extra challenges for HIV-infected Men having Sex with Men (MSM) by hindering early interventions among these groups. Although the MSM population affected with HIV are not considered to be a high HIV infection risk group in Sub-Saharan Africa, recent studies have revealed the widespread existence of MSM groups across the region and high rates of HIV infection and HIV risk behaviour among MSM population.

This paper provides a systematic literature review about the stigma and discrimination faced by the MSM population in Sub-Saharan Africa. The literature review was conducted through the systematic search of several online databases including Pub Med, Medline and Google.com.

The review found that there have been few strategic interventions that specifically address stigma and discrimination among MSM population despite their high HIV positive serostatus. Men having sex with Men are illegal in 31 Sub-Saharan African countries, potentially attracting the death penalty in four. There has been a disproportionately small amount of governmental funding allocated for targeted interventions among these populations in the region. The MSM populations usually have no access to relevant HIV/AIDS information and services, and many countries have not begun to recognise or address the needs of these men in the context of national HIV/AIDS prevention and control programmes.

We propose that the national governments may consider prioritising context-specific and culturally appropriate strategies and allocate budgets in their National AIDS Policies to address stigma & discrimination faced by the MSM population and protect their rights in Sub-Saharan Africa.

P6.037 MISSED OPPORTUNITIES FOR HIV TESTING IN CLINICAL SETTINGS: A SYSTEMATIC REVIEW OF COMPLIANCE WITH NATIONAL 2008 GUIDELINES IN THE UK

doi:10.1136/sextrans-2013-051184.1191

R Elmahdi, S Gerver, H Ward. Imperial College London, London, UK

Background In 2011 there were 6,280 new HIV diagnoses in the UK, of which 47% were diagnosed late (CD4 cell count 2/1,000 adult population). We evaluated compliance with BHIVA-guidelines on HIV testing outside of STI and antenatal settings.

Methods We carried out a systematic review searching MEDLINE, EMBASE and conference abstracts using variations of "HIV", "testing" and "UK" to identify relevant studies, and used meta-analysis to calculate an overall HIV testing prevalence.

Results Thirty-three UK studies measuring HIV testing in BHIVA-guideline recommended settings were identified. Overall, 37.9% of eligible patients had HIV tests. Thirteen studies reported levels of HIV test offer and uptake: in 10 studies < 50% of eligible patients were offered a test; of those offered, uptake ranged from 47.9%–100%, with 11 reporting > 65% uptake. Twenty-one studies reported seropositivity (range: 0.0%–11.8%).

Conclusion There appears to be poor compliance with the 2008 BHIVA-guidelines for testing outside of STI and antenatal clinics. Over 60% of eligible patients remained untested. Test offer rates were lower than uptake, suggesting clinician-barriers may be stronger than patient-barriers to increasing testing. Greater clinician training in routine HIV testing and improved HIV testing surveillance in clinical settings may be required to further encourage increased HIV testing in the UK.

P6.038 TECHNICAL SUPPORT FOR CLINICAL SERVICES OF A LARGE SCALE HIV PREVENTION PROGRAMME FOR KEY POPULATIONS IN INDIA

doi:10.1136/sextrans-2013-051184.1192

A Das, M Parthasarathy, P Narayanan, T Wi, S Kumta, G Dallabetta. *FHI 360, New Delhi, India; WHO, Geneva, Switzerland; Bill & Melinda Gates Foundation, New Delhi, India*

Background Avahan was a focused HIV prevention programme implemented across six states in India by seven lead agencies through 129 local NGOs, providing services to 321,000 individuals from key populations. Clinical services for STIs were an important component of Avahan's intervention package.

Methods Technical support was provided by a centralised agency to lead agencies' STI staff who directly supervised NGO clinical services. The approach during the first phase (2005–2009) of 'build and operate' included developing standardised guidelines, training,

quality assurance and quality improvement, and using monitoring data to improve the programme. During the final phase (2009–2013) of transitioning to government support, the strategy was to ensure that services were restructured to align with national guidelines, generate and provide evidence towards advocacy for improvement of the national programme.

Results In 2005–2009, 431,434 individuals made 2.7 million clinic visits. The annual average number of clinic visits by individuals increased from 1.6 to 3.5, and the proportion of visits for STI syndromes decreased from 52.5% to 11.8%. Verbal screening for tuberculosis (TB) identified 6,879 TB suspects of whom 1,565 were diagnosed with active TB. The quality monitoring of Avahan clinics showed an increased score from 2.21 to 3.82 (on a scale of 0–5). The introduction of a point of care test for syphilis doubled the proportion of clinic attendees screened from 2007 to 2009. In the transition phase, revised operational guidelines were developed to align with national guidelines and a nurses' training was conducted to address 'task shifting'. The national programme adapted the Avahan guidelines for STI management among key populations.

Conclusion A centralised technical support agency has a pivotal role in ensuring standardised and high quality services. Large scale and national programmes would benefit from collaborating with independent technical units to outsource some of the work of implementation.

P6.039 WHY DID PLAUSIBLE RESEARCH EVIDENCE FAIL TO INFORM POLICY? A LESSON FROM MALE CIRCUMCISION EVIDENCE ON EFFICACY FOR THE PREVENTION OF HIV IN MALAWI

doi:10.1136/sextrans-2013-051184.1193

C A David. UNC Project, Kamuzu Central Hospital, Lilongwe, Malawi

On the basis of three randomised controlled trials showing that male circumcision (MC) is effective in reducing HIV transmission, WHO/UNAIDS recommend that high HIV prevalence countries include MC in their HIV prevention programmes. Malawi delayed to adopt such a policy.

This study examines evidence-to-policy processes in Malawi, using MC as a case study. Separate but similar semi-structured interviews were conducted with national health policy decision-makers, researchers, politicians and traditional leaders regarding the decision-making processes concerning the adoption of MC and, as a comparison, to the adoption of acyclovir for management of STIs and nevirapine for PMTCT.

We observed that although policy-makers are aware of the evidence in Sub-Saharan Africa that MC reduces the risk of HIV acquisition among circumcised men, the adoption of a MC policy is resisted. Policy-makers and international actors are embroiled in policy controversies that have historical resonance in Malawi; MC is perceived as something that comes from outside—a Western 'imposition' is being forced onto Malawians. Malawi was settled by Muslims and by non-circumcised Christians; ethnic and religious rivalries have characterised politics since Independence. Thus, politicians have framed MC in-terms of tribal and religious identities. In contrast, acyclovir and nevirapine were perceived as culturally neutral, and were accepted without debate.

The call for evidence-based policy is likely to be received as unproblematic when, as with acyclovir and nevirapine, the issue does not touch controversies especially those related to religion and ethnic politics. But, when a core issue that identifies ethnicities is at the centre of controversy and it threatens what powerful local actors consider being in their best interest – there is invariably opposition. Thus *reframing* a new policy to minimise controversy – and in the case of MC, from "MC" to "voluntary medical MC" might result in actors' reflection and thus provide a path towards resolution.