engaged in substance abuse and sexual behaviours that increase their risk of HIV transmission, and STD transmission and acquisition. Such patients were more likely to want to discuss their mental health concerns than those who did not engage in these behaviours. These findings underscore the importance of interventions to decrease risky sexual behaviour and to promote clinical assessment of mental health needs for this patient population. A mental health assessment can identify patients who might need greater psychosocial support or referral for treatment of substance abuse and underlying mental illness.

P5-S1.03 HIV STATUS DISCLOSURE IN FAMILY AND DETERMINANTS OF STIGMATISATION IN A CONSERVATIVE SOCIETY

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Background National AIDS control of Pakistan and its development partner Canadian Government CIDA is seeking for effective AIDS surveillance. However, prevailing illiteracy and conservative societal norms are challenging factors in preventing HIV spread. Factors which lead to behavioural changes among people if they have been told of their HIV positive status are complicated and directly related to self-esteem and personal liberation.
Methods We evaluated this complex phenomenon with an aim to identify factors that prevent a person to disclose his/her HIV status to family members. Effort was also made to characterise determinants of prevailing stigma at society level for HIV positive and PLHA. Self structured questionnaire with binary and multiple response items was used for data collection. Multivariate logistic regression was used to identify significant predictors of stigma at family and societal level.
Results A total of 412 subjects (178 females and 234 males) were included in the study. Family level anticipated stigma items that were significantly associated with HIV test refusal were family perception, life partner perception, family break-up and neglect by family. Social indicators for prevalent stigmatisation were losing job and livelihood, bad treatment by the healthcare worker and difficulty in finding marital partner of choice (Abstract P5-S1.03 table 1).
Conclusions The study concludes that prevailing stigma is the major hindrance for running effective AIDS surveillance program. Clinical programs to prevent HIV infection must be integrated with psychiatric care service as a policy to improve awareness and peoples' willingness for HIV testing.

Abstract P5-S1.03 Table 1 Association of HIV stigma with test refusal at personal level as predictors of family and social stigmatisation

Dependent variable	Adjusted OR for HIV test refusal	95% CI	p Value
Family level stigma indicators			
Life partner perception	2.15	0.92 to 3.64	<0.001
Family perception	1.42	1.12 to 2.85	<0.01
Family break-up	1.16	1.02 to 2.88	<0.05
Neglect by family	1.83	1.32 to 2.41	<0.01
Social stigma indicators			
Losing job	1.72	1.22 to 3.74	<0.01
Livelihood loss	1.05	0.29 to 0.65	<0.001
Health worker treatment	1.22	1.23 to 4.67	<0.05
Marital life entry fallout	2.41	0.39 to 2.16	<0.05

P5-S1.04 THE IMPACT OF PELVIC INFLAMMATORY DISEASE ON SEXUAL, REPRODUCTIVE AND PSYCHOLOGICAL HEALTH

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Background and Aim Pelvic inflammatory disease (PID) is a condition commonly attributable to chlamydia infection. This qualitative study sought to explore the sexual, reproductive and psychological impact of this condition.
Methods In depth, semi-structured interviews were conducted with 23 women diagnosed with PID. Both symptomatic and asymptomatic women were recruited from primary and tertiary healthcare services. Interviews were conducted with women from 2 to 12 months post-diagnosis in order to explore short and longer term psychological responses and experiences. A brief, self-report questionnaire containing demographic items was also completed by all women. Interview analysis was conducted using an inductive, thematic approach.
Results Nearly all women experienced some form of distress when they received their diagnosis, and the emotional impact of their diagnosis was generally prolonged. Women typically experienced emotions such as shock, sadness or anger. At the time of diagnosis, women frequently had little or no knowledge of PID and continued to experience confusion about their condition post-diagnosis. Some women reported that PID had created conflict in their intimate relationships or had impacted on the level of intimacy they shared with their partner. Almost all women reported that their sexual behaviour had changed dramatically post- diagnosis. The possibility of being infertile stood out for women as their greatest health concern and nearly all women reported changes to their health behaviours since their diagnosis.
Conclusion The findings of this study indicate that a diagnosis of PID can have significant psychosocial implications for the diagnosed individual. Recommendations for healthcare professionals are proposed.

Health services and policy poster session 2: Circumcision

P5-S2.01 SURVEY ON KNOWLEDGE, ATTITUDE AND PRACTICES ON MALE CIRCUMCISION IN RWANDA

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Background WHO/Joint United Nations Program on AIDS (UNAIDS) has recommended adult male circumcision (AMC) for the prevention of heterosexually acquired HIV infection in men from communities where HIV is hyper endemic and AMC prevalence is low. The aim of this study was to provide evidences on knowledge and attitudes of non-circumcised men with regard to MC, and to determine the willingness to be circumcised among Rwandan men aged 15–59 years.
Methods This cross sectional study was part of a large survey conducted in Rwanda in January 2010 by the Ministry of Health, to assess knowledge, attitudes and practices regarding MC in the general population (KAP). The data were collected independent of religions and participants were recruited from all of the five provinces of Rwanda and 29 out of 30 districts were covered The data were

collected using quantitative technique and a structured questionnaire written in Kinyarwanda was administered and completed by 1098 men.

Findings The study findings showed that the prevalence of circumcision is 16.5% (95% CI 14.3 to 18.7%) in the study population. This proportion is the highest in the City of Kigali (52.5%) and in the Western Province (25.9%). The district of Rusizi in the western Province has the highest rate of circumcised men in our study, compared to other districts (71%). Among 63.3% of circumcised men, the procedure was performed by a healthcare provider. An estimated 50.2% of uncircumcised men would consider being circumcised and 78.5% would support circumcision for their sons and uptake will steadily increase if services are provided. The main reason would be to prevent them to be infected with STIs (including HIV) and Hygiene. The major reasons preventing uncircumcised men to circumcise is being too old for that procedure, the fear of pain and not becoming sexually promiscuous.

Conclusion This study demonstrates that male circumcision prevalence in Rwanda remains low although MC is a known and acceptable practice among the study participants. The major barriers to MC acceptability can be removed by effective interventions like education and social mobilisation. Interventions should also target women as they can play a key role in the decision making process about circumcision within their couples and families.

P5-S2.02 ABSTRACT WITHDRAWN

P5-S2.03 PHASE 1 IMPLEMENTATION OF MALE CIRCUMCISION AS A COMPREHENSIVE PACKAGE OF HIV PREVENTION IN RWANDA

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Background Rwanda adopted Male Circumcision (MC) as part of a comprehensive package of HIV prevention strategies since 2007. In order to facilitate national roll out of MC, a Phase 1 campaign involving training of healthcare providers in Nyanza and Ruhengeri District Hospitals and their affiliated health centers targeting adolescents and adults was held from 30 August to 24 September 2010. The Center for Treatment and Research on AIDS, Malaria, Tuberculosis and Other Epidemics (TRAC Plus) provided MC kits and financial support (training, cost of MC procedure) to two selected districts hospitals (Nyanza and Ruhengeri) to implement phase 1. The aim of this training was to accelerate the implementation of safe, affordable and accessible male circumcision as an HIV prevention strategy while contributing in strengthening the existing programs. The quality of the MC services provided through routine data collection and formative supervision was ensured.

Methods The training provided covered both theoretical and practical aspects of MC as an HIV prevention strategy considering the WHO training modules. The training was conducted by a team of five National trainers (three doctors, two counsellors) and the selection criteria of participants (doctors and nurses) considered those with minimum surgical skills.

Results The training was for 10 days and 25 trainees (Medical doctors and nurses) from each District Hospital and health centers were trained in both theory and practical courses on Male Circumcision as an HIV prevention strategy and also provision of counselling on MC to the client before surgery. A 1-day training of community health workers on community sensitisation was done. Following the 2-week practical session in the two DH, 120 male circumcisions were performed and acceptability for HIV testing was 100%. Communication messages on male circumcision as an HIV prevention strategy and the other benefits of MC were provided to the communities. The follow-up visit of all people circumcised was done, and no adverse events were reported.

Conclusion The MC phase 1 was successfully implemented in two district hospitals of Nyanza and Ruhengeri and the evaluation will be done. Among the lessons learnt were mainly on the coordination of MC activities as it requires a focal point to facilitate the activity on a continuous basis.

P5-S2.04 ASSESSING COMPREHENSION OF KEY INFORMED CONSENT CONCEPTS AMONG CLIENTS UNDERGOING MALE CIRCUMCISION DURING SCALE UP OF SERVICES IN ZAMBIA AND SWAZILAND

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Background We evaluated the informed consent (IC) process for male circumcision (MC) as services were being scaled up in Swaziland and Zambia. A primary objective was to assess male clients' comprehension of key concepts in the informed consent process to improve, standardise and streamline consent procedures as service delivery was expanded.

Methods In a post-test study design, we asked adult (18 years and older) and adolescent (13–17 years) clients who had completed counselling, but had not yet undergone MC, to respond to a 10-question, interviewer-administered, true-false comprehension test. We also collected data on demographics, recruitment for MC, and type of counselling received (group, one-on-one, VCT), and administered literacy and numeracy tests. Participants represented a convenience sample recruited from selected sites in urban Lusaka, and urban and rural sites in Swaziland. We used T-tests to test the null hypothesis that 90% of clients could pass the test (could score $\geq$80%), χ^2 tests to compare scores between subgroups (eg, adults vs adolescents), and multivariate logistic regression models to explore factors associated with passing the comprehension test.

Results Between November 2009 and August 2010, 228 MC clients in Lusaka (n=159 adults, 69 adolescents) and 953 MC clients in Swaziland (n=756 adults, 197 adolescents) participated in the comprehension assessment. Most clients (90%, Swaziland; 89%, Zambia) passed the comprehension test; however, the pass rate in Swaziland was significantly higher among adults than adolescents (96% and 85%, respectively; $p<0.001$). The question that posed the greatest difficulty to clients was about surgical risks; 67% of Zambian clients (71% adults; 56% adolescents) and 87% of Swazi clients (adults and adolescents) incorrectly responded that MC surgery has no risks. Factors significantly ($p<0.05$) associated with passing the test included: literacy (both countries); advanced education (Zambia); counselling language (Zambia); and age (Swaziland). In addition, not passing the test was significantly associated with hearing about MC from a friend (vs any other source) in Swaziland.

Conclusions Service providers must place greater emphasis on potential risks of MC surgery to ensure that clients are fully informed before they consent to the procedure. Counselling messages should be tailored for adolescent clients, who may have lower levels of education and less sexual experience than adults undergoing male circumcision.