small proportion (4%) indicated they had never had a Pap test. In multivariate models, having a Pap test in the past year was negatively associated with income >3500 pesos/month, more years in the sex trade and having regular clients. Marginal positive associations remained with older age, reporting condom use less than half the time with non-regular clients and having any children.

Discussion Prevalence of pap tests in the past year was higher than expected and may be attributed to recent efforts by the Tijuana Municipal Health Services to increase outreach to FSWs in these areas. However, since initiating sex work, only half reported the recommended yearly Pap testing which is concerning given the increased risk for HPV infection and cervical cancer among FSW. Sexual health education, including where access services, is needed to encourage regular cancer screening among this high risk population, especially among younger women and women who have been working in the sex trade for longer durations.

P5-S6.32 USING A CONTINGENT VALUATION METHOD TO UNDERSTAND CONSUMER PREFERENCES FOR CARE OF ADOLESCENTS WITH PELVIC INFLAMMATORY DISEASE (PID)

doi:10.1136/sextrans-2011-050108.588

[1]M Trent, [2]Q Qian, [3]K Frick, [3]C Thompson, [4]A Butz, [4]J Ellen, [4]H Lehmann. *[1]Johns Hopkins University School of Medicine, Baltimore, USA; [2]University of Maryland, Towson, USA; [3]Johns Hopkins Bloomberg School of Public Health, Baltimore, USA; [4]Johns Hopkins School of Medicine, Baltimore, USA*

Objective Adolescent girls diagnosed with PID are at higher risk for subsequent sexually transmitted infection (STI), pregnancy, and long-term pelvic pain. Although the 72-h post-PID evaluation provides an opportunity for risk reduction counselling, few adolescents adhere. Use of public health nurses (PHN) for clinical follow-up may meet the needs of this vulnerable population. The objective of this study is to estimate consumers' willingness-to-pay (WTP) for follow-up PID services by physicians and PHNs, differences by consumer type, and the differences in health-provider predicted consumer WTP values and actual consumer WTP values.

Methods A contingent valuation method was used to collect WTP data regarding co-payments to physicians or nurses for clinical service delivery from the consumers of adolescent PID services (parents (n=121) and adolescents (n=134)) and a national sample of health providers (n=102). Consumers were recruited from an academic paediatric practice and school-based health clinics in a large urban community with high STI prevalence. Participants completed a web-based survey with data uploaded to a secure server after obtaining online consent. Data were analysed using linear regression analyses.

Results The mean WTP for physician services was $16 (SD $16.9) for clinicians, $81.9 ($34.0) for parents, and $72 (SD $ 39.1) for adolescents. The mean WTP for PHN services was $13.6 (SD $17.4) for physicians, $62.4 (SD $44.1) for parents, and $49.7 (SD $44) for adolescents. Using physician estimates for WTP as the reference group, adolescents were willing to pay $56 more (95% CI 48.6 to 63.4) for physician care and parents were willing to pay $66 more (95% CI 59.0 to 72.8) than physician's predicted controlling for informant employment status. Adolescents were willing to pay $36 more (95% CI 48.6 to 63.4) for community-based nursing care and parents were willing to pay $48 more (95% CI 59.0 to 72.8) than physician's predicted. Consumers' (adolescents' & parents') WTP for physician services were on average $18.50 higher than PHN services (p=0.01).

Conclusion While adolescents and parents prefer physician follow-up for PID based on WTP, they are amenable to PHN follow-up visits. Our data suggest that health providers underestimate the value the consumers place on clinical service for PID. Given poor adherence to office-based follow-up and consumer interest in PHN visits, additional research evaluating the effectiveness of PHN visits for PID is warranted.

P5-S6.33 HIV/AIDS IMPACT MITIGATION IN RESOURCE-POOR SETTINGS: SCALING-UP A MULTI-SECTORAL RESPONSE

doi:10.1136/sextrans-2011-050108.589

[1]A Mwendwa, [2]N Kyalo, [3]W Kihara, [4]J Mburu, [5]M Mutua. *[1]Moi University Hospital Teaching and Referral Centre, Eldoret, Kenya; [2]University of Nairobi, Nairobi, Kenya; [3]Kenyatta National Hospital, Nairobi, Kenya; [4]Redeemed Gospel Church Development Programme, Nairobi, Kenya; [5]Centre for Integrated Community Development and Outreach, CICDOT, Nairobi, Kenya*

Background/issues The HIV and AIDS epidemic constitutes not only the worst scourge and onslaught with which peoples in resource-limited places must contend; It also occurs in a context in which the effects of the epidemic and key issues which they engender are juxtaposed with a multiplicity of societal problems. Many high HIV/AIDS prevalence countries apparently remain unconvinced of the longer term impact of this epidemic, and have not yet developed strategies to cope with the obvious and incontrovertible impact of HIV and AIDS. Impact mitigation of HIV and AIDS is not high on the agenda of the many organisations which are involved in mounting a response to this epidemic. These organisations have assumed HIV/AIDS to be a public health issue and failed in many cases to recognise it for the socio-economic development challenge it more properly represents. Empirical research findings and Observations/In resource poor settings, greed and avarice of the political leadership overwhelms their responsibilities take urgent action to mitigate HIV/AIDS impact. There are small islands of dazzling abundance which exist side by side with a cheerless ocean of absolute poverty, dehumanising HIV/AIDS high prevalence rate and wide-scale social exclusion. Africa's famed traditional extended family system, exemplary at absorbing members under stress, is confronted with HIV and AIDS impact on every constituent part of its network and may reach breaking point without some assistance. This strain may have the effect of not only accelerating the reversal of development gains of the last decade but of fragmenting the very societal structure that has so far sustained marginal societies.

Conclusions/policy implications There's the pressing moral, social, political and economic imperative to scale up the impact mitigation of HIV/AIDS among residents of poor areas. The immediate focus of managing the crisis of HIV and AIDS in resource-limited settings will impact every aspect of multi-sectoral, systemic functioning, response. The advent of a vastly improved prognosis of new classes of ARV drugs and their use in combination can dramatically improve rates of mortality and morbidity, prolonged lives, improved quality of life, revitalised communities and transformed perceptions of HIV/AIDS from a plague to a manageable, chronic illness in resource poor settings.

P5-S6.34 PROVIDER CHARACTERISTICS ASSOCIATED WITH GONORRHOEA TREATMENT ERRORS, MASSACHUSETTS, 2010

doi:10.1136/sextrans-2011-050108.590

[1]J Swails, [2]L Smock, [2]Y Tang, [2]K Hsu. *[1]Brigham and Women's Hospital, Boston, USA; [2]Massachusetts Department of Public Health USA*

Background Massachusetts experienced a 29% increase in gonorrhoea cases during 2010. In 4% of cases where treatment was known, treatment was inconsistent with public health guidelines. We examined healthcare provider characteristics associated with gonorrhoea treatment errors to help target future educational outreach strategies.

Methods Case-control study where treatment error cases were defined as any patient 15–65 years of age, diagnosed with gonorrhoea in 2010, who did not receive ceftriaxone 125 mg or 250 mg IM or other approved cephalosporin regimen, or azithromycin 2 g PO. Two controls were randomly selected from patients who received correct treatment, matched to cases in regard to age, sex, and month of diagnosis. Data regarding exposures to various provider characteristics were collected from case report cards, provider licensing databases, and direct provider phone calls. Proportions of cases and controls were compared on the basis of provider training, years in practice, specialty, and practice type by χ^2 analysis or Fisher's exact test.

Results 76 cases were matched to 152 controls. In preliminary analysis, no differences were identified with respect to provider degree (MD/DO or NP/PA; p>0.25). More treatment errors occurred in private practice/health maintenance organisations compared to STD or family planning clinics (p<0.0001), emergency departments (p<0.0001), or community health centers/hospital clinics (p=0.0004). Among physicians, no differences were identified with respect to years since residency graduation (p>0.25). More treatment errors occurred with family medicine physicians compared to OB/GYN (p=0.0225) and emergency medicine physicians (p=0.0101), but not compared to paediatricians or internists see Abstract P5-S6.34 table 1.

Conclusions Although gonorrhoea treatment errors were rare, specific practice locations and physician specialties were significantly associated with gonorrhoea treatment errors, suggesting important opportunities for educational intervention. Further studies may determine reasons for errors, relative importance of provider factors, and what systems support accurate treatment.

Abstract P5-S6.34 Table 1 Analysis to date

	Controls (n, %)	Cases (n, %t)	p Value
Provider degree			
NP/PA	49 (45%)	30 (41%)	NS
MD/DO	59 (55%)	43 (59%)	
Practice location			
Private practices/HMOs	22 (18%)	41 (56%)	Reference
STD clinics	15 (13%)	0	<0.0001
Emergency departments	40 (33%)	11 (15%)	<0.0001
Community health centers/hospital clinics	43 (36%)	21 (29%)	0.0004
Residency graduation year			
After 2000	27 (47%)	15 (39%)	NS
1990s	16 (28%)	13 (33%)	
Before 1990	14 (25%)	11 (28%)	
Physician specialty			
Family Medicine	5 (9%)	11 (24%)	Reference
Paediatrics	3 (5%)	5 (11%)	NS
Internal Medicine	10 (18%)	10 (22%)	NS
OB/GYN	18 (32%)	7 (16%)	0.0225
Emergency Medicine	20 (36%)	7 (16%)	0.0101

P5-S6.35 EFFECTIVENESS OF MOBILISING MEDICAL FACILITIES TO PARTICIPATE IN STD/HIV CONTROL ACTIVITIES

doi:10.1136/sextrans-2011-050108.591

G Liang. *National Center for STD Control, China CDC, Nanjing, China*

Since 2000, the STD clinics were brought into intervention service aimed at high-risk population by some projects, such as Health Project, Comprehensive Demonstration Area Project and the Global Fund to Fight AIDS Project. The ability of providing standardisation service in STD clinics was improved through the project activities. The outreach service increased awareness of STD clinics and attracted or made referral patients seeking service at standard clinic, and that strengthened the role of medical sites in preventing STD/AIDS.

Method Two jobs improved the intervention service aimed at STD/AIDS at clinics. 1. The intervention service aimed at outpatient. Including the following service: (1) setting heath education bulletin and publicity photographs at STD clinics to spread information about prevention STD/AIDS (2) providing Health education prescription about prevention STD/AIDS freely (3) the medical staff provided health education and consultation after diagnosis and treatment and extended the use of condom (4) to advise patient to inform their partner of examination at clinic (5) the medical staff mobilised outpatients to accept HIV-test forwardly 2. The medical staff provided field service aimed at high-risk population (CSW, MSM).

Result Several projects evaluated prevention service effect at STD clinics. The rate of medical staff accepting training on STD standardisation service increased from 9.21 to 21.56% to 68.99–89.7%. The rate of object population knew information about STD/AIDS prevention increased from 31.02–45.52% to 72.4–87.86%. The rate of outpatients accepting HIV test increased from 3.45% to 44.25%. While STD clinic staff provided field service for high-risk population, they advised people who needed further service to seek help at STD clinic. From 2006 to 2009, the proportion of high-risk in outpatient was increasing yearly. The evaluation result from three STD clinics showed the proportion of MSM in outpatient was increasing from 0.97% to 8.15%, from 2006 to 2009. And the evaluation result from 7 STD clinics showed the proportion of CSW in outpatient was increasing from 1.57% to 9.74%, from 2006 to 2009. The outpatient at STD clinic is high-risk population for STD/AIDS infection and spread, and most male outpatient especially had high-risk act, but the intervention in China touched on that. The prevention service at STD clinic smoothed over routine prevention action and expanded the range that STD medical service covered, so this prevention controlled the spread of STD/AIDS furtherly.

P5-S6.36 FACTORS AFFECTING QUALITY OF LIFE OF PEOPLE LIVING WITH HIV IN KARNATAKA, INDIA

doi:10.1136/sextrans-2011-050108.592

[1]P Banandur, [2]M L Becker, [3]L Garady, [3]A Yallappa, [3]S Isaac, [3]R S Potty, [3]R G Washington, [2]J F Blanchard, [2]S Moses, [3]R M Banadakoppa. *[1]Rajarajeswari Medical College and Hospital, Bangalore, India; [2]University of Manitoba, Winnipeg, Canada; [3]Karnataka Health Promotion Trust, Bangalore, India*

Background In India, stigma and discrimination in healthcare settings, poor linkages between services and lack of trained personnel affect the quality and accessibility of HIV services. In effort to both scale up and strengthen the quality and coordination of HIV care and support services in the state of Karnataka, the Samastha Project was developed. This enhanced care model uses a district based approach which integrates government services with project-based care and support services. Quality of life (QOL) is a critical outcome of HIV intervention. There is little data on the effect of HIV care and support services on QOL. We used baseline data from a 2-year prospective cohort study (QOL-Cohort study) of people living with HIV (PLHIV) in the Samastha program to identify factors affecting QOL among PLHIV.

Methods We conducted Factorial analysis using a set of key variables assumed to be associated with QOL to develop a factor score from the data collected by a face-to-face interview using a standardised questionnaire from QOL cohort study. Multivariate linear regression analysis was conducted using the factor score as dependent variable. High factor score indicated high QOL. Age, gender, locality and intensity of exposure to Samastha program were considered a priori