

**Background** To examine the associations between social characteristics of US states and the presence of laws authorising expedited partner therapy (EPT).

**Methods** Data were collected from various sources for 2008–2010 on US state healthcare system characteristics (adult enrollment in Medicaid, number of physicians per 100,000), governmental characteristics (the size of state legislatures, percent of state residents in poverty, percent state financial contribution to state STD programme), and state STD morbidity (chlamydia rates per 100,000 among females age 15–24). Data were analysed in an adjusted logistic regression model in SAS.

**Results** Overall, 23 states have passed legislation authorising EPT as of February 2013. In adjusted analyses, the only healthcare system variable significantly associated with the presence of a state law authorising EPT was higher adult Medicaid enrollment (AOR=7.871 [95% CI: 1.644, 37.685]), which may represent an increased willingness to authorise EPT where publicly-funded healthcare coverage is more widely available. The only other variable significantly associated with the presence of a law authorising EPT was lower chlamydia rates per 100,000 among females age 15–24 (AOR = 0.332 [95% CI: 0.122, 0.903]). The presence of a state law authorising EPT did not differ by the size of the state legislature, percent in poverty, percent state contribution to state STD programme, or number of physicians per 100,000.

**Conclusions** States with higher adult Medicaid enrollment and lower chlamydia rates among females 15–24 were more likely to have a law authorising EPT. Increased adult Medicaid enrollment may represent an increased willingness of a state to provide publicly-funded healthcare services to its residents; the legal acceptability of EPT may thus be associated with general willingness to provide publicly-funded healthcare within a jurisdiction. This may translate to increased social compatibility of laws authorising EPT in non-US jurisdictions characterised by high rates of publicly-funded healthcare.

#### P4.120 EVALUATING THE IMPACT OF SHORT TERM FINANCIAL INCENTIVES ON HIV AND STI INCIDENCE AMONG YOUTH IN LESOTHO: A RANDOMISED TRIAL

doi:10.1136/sextrans-2013-051184.1017

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**Background** This study tests the hypothesis that a system of rapid feedback and positive reinforcement using a lottery scheme as an incentive to reduce risky sexual behaviour can be used to promote safer sexual activity and reduce HIV incidence among youth in Lesotho.

**Methods** An unblinded, individually randomised control trial with 3426 participants, males and females 18–30 years old drawn from 30 villages in Lesotho. The intervention linked the receipt of lottery tickets to negative results for rapid tests for curable STIs: syphilis and *Trichomonas vaginalis*. The study objective was to test the efficacy of the lottery incentive scheme in reducing HIV incidence. Participants were randomly assigned to either a control arm (n = 1347) or one of two intervention arms eligible to receive lottery tickets: high (n = 1116) or low (n = 963) value lottery (1,000 or 500 South African Rands). All arms received STI testing, counselling, and STI treatment every four months during two years. All participants were tested for HIV at baseline and after 16, 20 and 24 months. Village level lotteries were organised every 4 months in which STI negative individuals from the intervention arms were eligible to participate and during which 4 lottery winners (2 males, 2 females) were drawn. The primary study outcome is HIV incidence.

**Results** After 2 years of intervention, HIV incidence was significantly lower among study participants eligible for the lotteries (OR 0.75, 95% CI 0.58 – 0.97), especially among women (OR 0.67, 95% CI 0.52 – 0.86), and in the group eligible for the high prize lotteries (1000 Rands)(OR 0.69, 95% CI 0.50 – 0.98). No harm reported.

**Conclusion** The results indicate that short-term financial incentives to engage in safe sex can lead to a measurable decline in HIV incidence. It would however be advisable to replicate such an intervention in other settings.

#### P4.121 GOVERNMENT ROLE'S IN SUPPORTING KEY POPULATION NETWORK

doi:10.1136/sextrans-2013-051184.1018

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In the AIDS response, the involvement of key populations is important. It means that without their contribution in AIDS response, it is impossible to prevent new infection.

To that end, the Indonesian National AIDS Commission supports key population groups to form a national network. With the support of the National AIDS Commission, some network such as Indonesian Drug Users Network, Positive Women Network, LSL Network and Sex Worker Network are formed.

To strengthen the network, the National AIDS Commission provides financial and technical support through Indonesia Partnership Fund since 2009. The financial support was allocated for operational cost and offices. Apart from Indonesia Partnership Fund support, Those networks are also supported Global Fund through National AIDS Commission.

In coordination meetings that conducted every three months with all members of the National AIDS Commission, these networks are also invited as observers and provide important input related to the AIDS response. The coordination meeting led by Minister of Public Welfare in January 2010 have decided that these networks should be a part of the member of the National AIDS Commission. Since then, the network has been facilitated with grants and state funds. The funding provides each network some grants for coordination meeting, leadership training, community mobilisation training and other activities.

With such support, Indonesian government has shown some recognition of the role of networks of key populations in the AIDS response which has enabled the network to collaborate with various government agencies such as with the Ministry of Health and Social Ministry. The support of the other Ministries are also emerging following the recognition of these two Ministries. With a variety of existing support, the network has also been able to strengthen the system within each network to take more active role in the AIDS response.

#### P4.122 EFFECTIVENESS OF COMUNIDADES POSITIVAS: A RANDOMISED COMMUNITY-LEVEL COMBINATION HIV PREVENTION INTERVENTION FOR MEN WHO HAVE SEX WITH MEN IN PERU

doi:10.1136/sextrans-2013-051184.1019

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**Introduction** Comunidades Positivas was a randomised clinical trial that assessed a community-level structural combination HIV prevention intervention for men who have sex with men (MSM) in Peru from 2008–2011. We used a 2 × 2 factorial design to determine the independent and combined effectiveness of community-level behavioural and biomedical HIV/STI prevention interventions.

**Methods** We cluster-randomised 24 low-income neighbourhoods in Lima, Peru, to one of four conditions: (1) Establishment of Community Centers focused on empowerment and promotion of HIV/STI prevention messages for MSM; (2) Expedited Partner Therapy for bacterial STIs; (3) Both interventions combined or; (4) No intervention. To determine the effectiveness of the interventions, a cohort of participants from each neighbourhood was interviewed concerning sexual risk behaviours and tested for HIV, HSV-2, syphilis, chlamydia and gonorrhoea (pharyngeal and anal) at baseline and 9- and 18-months follow-up visits. We used Poisson regression adjusted for neighbourhood clustering to determine the association of intervention allocation with unprotected anal intercourse (UAI) and overall STI incidence.

**Results** We enrolled 718 MSM and retained 571 (80%) at 18 months. At baseline there were no differences by intervention arm in either UAI or STI prevalence. The overall STI incidence was 19/100 person years with no difference in STI incidence by intervention allocation (all  $p > 0.05$ ) (Table 1). There was an 19% absolute reduction in reported UAI in all communities comparing baseline to 18 months. There was no difference in the probability of reporting UAI by intervention allocation at the second follow-up (all  $p > 0.05$ ) (Table 2).

**Conclusions** There was no significant intervention effect on STI incidence or UAI. Further analyses to interpret the lack of intervention effectiveness are ongoing and should be considered in future efforts to conceptualise and study the relationship between structural and biomedical components of combination prevention.

**Abstract P4.122 Table 1** STI incidence during the 18 month follow-up by intervention component.

	Community Center vs. No community Center	Expedited Partner Therapy vs. No Expedited Partner Therapy
Any STI incidence	18.4 Community Center 19.7 No Community Center	23.1 Expedited Partner Therapy 14.0 No Expedited Partner Therapy
RR	0.93 (95% CI 0.49–1.76)	1.65 (95% CI 0.85–3.21)
p-value	0.42	0.07

**Abstract P4.122 Table 2** Unprotected anal sex in the past 6 months at the 18 month final study visit

	Community Center vs. No Community Center	Expedited Partner Therapy vs. No Expedited Partner Therapy
Any unprotected sex, past 6 months	37.3% Community Center 47.9% No Community Center	44.3% Expedited Partner Therapy 41.8% No Expedited Partner Therapy
RR	0.76 (95% CI 0.56–1.03)	1.07 (95% CI 0.79–1.44)
p-value	0.07	0.66

**P4.123 HIV/STI PREVENTION IN MEDICAL PRACTISES: THREE YEARS OF EXPERIENCE WITH A PILOT PROJECT**

doi:10.1136/sextrans-2013-051184.1020

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**Background** Sexually transmitted infections are often diagnosed too late or not at all. The reason for this may not only be the unspecific or inconspicuous symptoms of many STIs. When it comes to “sexual subjects”, both physicians and patients are hesitant to discuss related concerns. This may result in important health risks not being addressed and vital diagnostic measures not being offered.

**Methods** Strengthening HIV and STI prevention in the healthcare system is the joint objective of an interdisciplinary work group established in 2006, consisting of representatives of the DAGNÄ

[German Association of Practicing Physicians Treating HIV-Infected Patients], the DSTIG [German STI Society], the DAIG [German AIDS Society], the BZgA [Federal Centre for Health Education] and Deutsche AIDS-Hilfe [German AIDS Service Organisation]. Based on a qualitative survey interviewing in 2009, investigating the expectations of physicians and patients for preventive consultations, a further training for physicians was developed.

**Results** The evaluation of 16 workshops held in 2012 confirmed a central result of the former qualitative survey: The majority saw greatest benefit in workshop modules that allocate opportunities to discuss the correlation between sexual identities, lifestyles and prevention behaviour. Role-playing-units received a particularly positive rating. Basic facts about diagnostic of STIs and information about present-days life of PLWH got a positive voting especially by doctors who do not deal regularly with HIV/STIs. Occasionally, the wish for a structured conversation guide was expressed as well.

**Conclusion** Our experiences with the trainings leads to the development of a three-pillar model. Firstly: Extending the ability to communicate about sexuality without prejudice as the basic prerequisite for talking about STIs. Secondly: Communicate simple, target group-specific STI diagnostics geared to sexual practises. Thirdly: Offering optional, setting-oriented conversation guides.

**P4.124 STI AND LOCAL REGULATION**

doi:10.1136/sextrans-2013-051184.1021

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Mimika is one of the districts in the province of Papua, Indonesia. Based on mapping result, the number of sex workers in district of Mimika is 480 people. Unsafe sexual behaviour has led to a high number of HIV cases in Mimika district. To prevent HIV transmission, local governments has open an STI clinic services. However, the number of STI between the sex workers remain high. In 2008, the total number of visits to the STI clinic is 2810. Of this amount, 616 are positive for STI. In 2009, the total number of visits to the STI clinic is 1550 visits with 531 positive STI cases. While in 2010, the number of visits is 2576 and found 731 cases. On the other hand, AIDS prevention regulations have been made and passed in 2007. One of the contents of these regulations is how to cope with STI by giving penalties for pimps whose sex workers are found to be positive for STI. Looking at the condition, the local government formed a team Chaired by District AIDS Commission to implement the aforesaid local regulation and to do monitoring to its result. The team routinely perform STI test to all sex workers in the site. Should the sex worker is found positive for STI, the penalty is given immediately to the pimp. And if the pimp refuse to pay, then the business site will be closed temporarily until the pimp paid the fine as mandated by the new law. Once the regulation is enforced, there are apparent positive results. In January-March 2012, there were 621 visits to the clinis with only 10 cases of STI. This number is highly significant compared to the STI cases in 2008 and 2010. Thus, local regulation is highly effective in suppressing STI to the sex workers.

**P4.125 STRUCTURAL INTERVENTIONS TO REDUCE STIGMATIZATION AND INCREASE UPTAKE OF HIV TREATMENT SERVICES**

doi:10.1136/sextrans-2013-051184.1022

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**Background** Stigmatization of persons living with HIV/AIDS (PLWHA) is a major reason for low uptake of HIV screening and treatment services. This paper describes the impact of integration of health services on stigma reduction in Nigeria.