

**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**

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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**

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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**

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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.

**Methods** In order to reduce stigmatisation and increase uptake of HIV screening and treatment services at three clinics in Northern Nigeria, the MSH PrO-ACT project implemented the following interventions

- Amalgamation of clinic space to ensure that HIV positive clients are attended to at the same clinic as other patients.
- Training of health care providers on patient confidentiality protection.
- Ensured that the same doctor attends to all patients irrespective of their HIV status.
- Blood samples for all patients visiting the laboratory are collected at the same phlebotomy point irrespective of their HIV status.
- Initiated focus group discussions on stigmatisation within the community and health facilities to promote a change in attitude towards PLWHA.
- Initiated support group meetings for PLWHA in order to encourage open discussions on stigma and partner disclosure.

**Results** At the end of twelve months, 12,436 (Male- 3,616, Female- 8,820) clients were counselled and tested for HIV and the number who accessed laboratory services for CD4 count monitoring increased from 53.8% to 93.3%. The number of partner testing also increased from 35% to 68%. In addition, health worker attitude towards PLWHA improved significantly as workers now report a stronger belief in patient confidentiality protection.

**Conclusion** Integration of HIV related services into existing health systems has helped reduce stigmatisation of PLWHA. However, a lot more still needs to be done in enlightening and equipping health care providers in the fight against stigma in rural communities.

**P4.126 AVAILABILITY OF SERVICES FOR DISCORDANT COUPLES TO PREVENT HIV AND STIS**

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**Introduction** A survey was conducted in the three regions of Russia, Orel, Bryansk and Voronezh from 2008 to 2012. 64 HIV-negative partners living more than a year in a HIV discordant-couple relationship were enrolled in the survey. The main purpose of the survey was to assess the disparities of medical services for discordant couples over a four year period.

**Method** survey/questionnaire. Participants were collected from a social networking structure and support groups.

**Results** The majority of the discordant couples did not receive complete health services. 72% of the discordant couples had consultation for prevention of HIV transmission with their gynecologists, but only 38% had consultation about family planning. The medical providers can generally advice on common HIV prevention, but are not equipped with specialty advice and communication tools. For example, 86% of discordant couples tell their gynecologists that they use condoms. When speaking openly with peer-consultants, the expression of condom use decreased to 23%.

Today, 74% of them have ceased to be discordant because the HIV negative partner seroconverted. Out of the 74%, 13% of the relationships ended.

In general the Russian health care system has difficulties training professionals about HIV prevention and treatment. Not only are doctors not trained with comprehensive information, but communication is limited. The average conversation with a doctor is only 12 minutes. Only 47% of discordant couples have the opportunity to go to the doctor for important recommendations once a week. Only 26% of the couples had the possibility to access emergency medical advice. Services are critical at the moment of an immediate engagement with a risk behaviour.

**P4.127 RED RIBBON CLUBS (RRCs): A LOW COST COMMUNITY LED STRUCTURAL INTERVENTION TO REACH OUT THE YOUTH TO INITIATE DIALOGUE ON SEX & SEXUALITY & TO CONTROL THE SPREAD STI/HIV AND OTHER COMMUNICABLE DISEASES IN RURAL SETTING**

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The focus on rural areas was on account of many reasons including principally the higher HIV prevalence in rural areas, migration, strong presence of rural sex work and widespread social stigma. Over 57% of the HIV infected persons in India live in the rural areas.

A need was clearly felt to targeting youth and the adolescent. There is robust evidence that nearly one third of new infections are among young people in the ages 15–29. Young people, particularly those in rural areas, stand at persistent risk of contracting HIV due to lack of proper information and social taboos prohibiting discussion on matters of sex and sexual health.

As part of the Link Worker Scheme, young people in the villages have been motivated to form RRC and take lead in creating awareness on HIV/AIDS in the community. Over 400 RRCs are functional and acts as an Information Hub to impart knowledge and skills among the village youth on STI/HIV/AIDS prevention, risk reduction and access to other social security schemes. RRCs are functioning in existing Youth Clubs, local govt. office, Health Centers, Rural Library, Road side hotel in order to sustain awareness and raise demand for services. Series of mid media activities like local folk song, dance, theatre etc. engaging the local youth based on their talents. Over 3600 community volunteers have been identified, mobilised and trained to work as volunteers and become a member of respective RRC and further provide training. RRC members has reached over 240,000 (38% female) vulnerable youth and adolescents including HRGs.

This is a most sustainable model for setting up RRC engaging the youth from villages, who can take lead, exchange information and share ideas to initiate dialogue on sex & sexuality to prevent RTI/STI and other communicable diseases and continue the activities beyond the project period.

**P4.128 AMERICAN INDIAN EMERGING ADULTS: PARTNERSHIP FORMATION AND HIV RISK AND PROTECTIVE FACTORS**

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Multiple challenges such as high rates of discrimination, poverty and traumatic events, expose American Indian (AI) women to high-risk sexual partnerships placing them at an increased risk for HIV/STI. Characterizing sexual partner networks, or who is partnering with whom, and how partnerships change over time, is essential for translating the concept of sexual health beyond the individual to the partnership and the population of connected emerging adults.

We interviewed 129 AI women age 15–35 years residing on a rural reservation with 189 unique partnerships to understand patterns of relationship formation and dissolution and how these partnerships differ in terms of socio-demographic characteristics, sexual risk behaviour within partnerships, and characteristics of place (e.g., where partners met, where they most often have sex, where the partner lives) to inform prevention interventions.

Of the 129 sexually active AI women, 37% reported > 1 partner in the past 6 months. Women reporting one partner (compared to > 1 partner) report lower 12-months binge drinking: 25.9% vs. 58.3%,