

**Background** Globally 50,000 women are diagnosed with cervical cancer, many lose their lives per year, majority of these live in resource limited countries like Uganda, the incidence rate is very high. 80% of cervical cancer cases are diagnosed in late stages. Few women screen in developing countries compared to developed countries. Cervical cancer is considered an AIDS defining illness. HIV positive women with CD4 less than 200 are at high risk of getting cervical cancer.

#### Program description

It's under this background that Mild May funded by CDC trained health workers to screen for cervical cancer using the affordability method of visual inspection with acetic acid, treat and manage positive lesions using CRYOTHERAPY. Logistics were delivered and work started on 22nd August 2012 after community mobilisation and referrals. By December 2012 a total of 214 clients were screened of which 47.7% were HIV positive and 52% were HIV negative. 19.2% of clients screened for Cancer of the cervix had positive lesions of which 53.7% were HIV positive and 46.3% were HIV negative; 79.9% had negative results of which 48.5% were HIV positive and 52.6% were HIV negative; 0.9% had suspicious lesions.

#### Lessons learnt

It is important to integrate cervical cancer screening within HIV/AIDS Care setting alongside family planning. It is an entry point for diagnosis and treatment of STI. More gynaecological conditions have been identified, managed and some referred to gynaecologist for specialised management.

It strengthens partnership with stake holders through support and supervision, collaboration and networking.

Stigma to women who are HIV negative or whose serological status is unknown shun away from screening in an HIV/AIDS Care setting.

**Conclusion** The best way to prevent cervical cancer is by early screening and treatment of precancerous lesions; early diagnosis and treatment of cervical cancer thus reducing mortality rate among women.

#### P6.044 SCALING UP STI RESOURCE AND EDUCATIONAL CAPACITY FOR GENERAL PRACTISE IN NEW SOUTH WALES, AUSTRALIA

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**Background** Increasing access to STI resources and education for general practise (GP) and improving referral pathways to specialised STI care were key objectives of the 2006 STI Strategy, New South Wales (NSW). Prior GP STI education and support was ad hoc without strategic direction. No identifiable STI support or training was provided to GP nurses. In 2008 chlamydia was the most commonly reported STI, 200 per 10<sup>5</sup> and annual GP chlamydia testing rate for <30yo, 7%.

**Methods** A multidisciplinary GP working group was created within the newly established NSW STI Programs Unit in 2007. The group coordinated needs identification and development of resources and online and participatory learning packages for NSW GP. Recognised private and non-government GP training providers were identified to host and assist with training coordination for doctors and nurses.

**Results** STI management 'tools' and training modules focussed on chlamydia, the most common STI in NSW. Simple chlamydia testing and treatment provided an easy introduction to STI care. Resources developed include brief and comprehensive online training modules; locally facilitated, in person learning modules; tools for practise audit, STI testing in priority populations, partner notification and

referral pathways; NSW Sexual Health Information telephone Line; competency standards for GP nurses. Resource and training promotion occurred through professional discipline newsletters and journal editorials, interviews and papers; 'master classes' and booths at conferences; and directly to individual doctors, including the NSW Chief Health Officer communiqué reminding GP of their responsibilities with STI partner notification. An external academic process and impact evaluation of the project revealed important GP learning preferences. Chlamydia testing rates have yet to be reassessed. Project scale awaits the results of a cluster randomised control trial, ACCEPt <http://www.accept.org.au/>

**Conclusion** A strategic approach to GP resource and training capacity development has been strengthened by concurrent planning, implementation and programme management.

#### P6.045 WITHDRAWN BY AUTHOR

#### P6.046 INTEGRATION OF STI DIAGNOSTICS AND TREATMENT PROGRAMMES AND HIV PREVENTION PROGRAMMES FOR VULNERABLE GROUPS

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Problem: Ukraine has the fastest HIV/STI spread rate in Europe (221 806 PLWH as of November 2012).

Sexual HIV transmission mode has been dominant in Ukraine since 2008 (51% - sexual mode, 28% - parenteral).

HIV/STI epidemics in Ukraine are concentrated within vulnerable groups and threaten to generalise.

Activities description:

STI diagnostics and treatment programmes for vulnerable groups started in Ukraine since 2008, when the situation was unfavourable due to lack of understanding between medical services, adverse attitude towards case management and integrated services principles. Several models of dermatovenerological assistance to the vulnerable groups and their stage-by-stage implementation were developed.

**Results** In 2008 62 HCFs and 82 NGOs joined the programme.

In 2012 STI diagnostics and treatment became available in 108 healthcare facilities of Ukraine (50 dermatovenerological dispensaries, 25 AIDS centres, 33 general clinics).

As of 31.07.2012 there were 595 812 screening tests and counselling for vulnerable groups on STI and viral hepatitis and 33 637 STI treatment courses were provided.

193 247 vulnerable groups' representatives (as of 31.07.2012) were referred to 15 mobile clinics providing HIV/STI testing and counselling for vulnerable groups.

16 trainings were held for NGOs and healthcare facilities' representatives.

In 2012 22 multidisciplinary teams were created providing STI diagnostics and treatment for vulnerable groups in healthcare facilities.

#### Conclusions

1. STI diagnostics and treatment services should be an integral part of the integrated HIV prevention services package for vulnerable groups.
2. STI programmes can be implemented only in cooperation with the dermatovenerological service and the AIDS service.
3. Programs should be implemented simultaneously under several models considering country and regional peculiarities.
4. MDTs are the most successful model.

#### P6.047 ISSUES AND BARRIERS TO HEALTHCARE SERVICE ACCESS AMONG MEN WHO HAVE SEX WITH MEN IN INDIA: A QUALITATIVE PROSPECTIVE

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**Background** A significant high proportion of men engage in sexual relationships with other men has been observed in the country, which has direct linkage with the physical and the mental health status of this population. The population is more at risk when it is associated with migrant MSMs, having the characteristics of bridge population, due to associated migrant as well as MSM health related issues. Due to their unique health care needs, the population repeatedly remains devoid of basic health care services. The purpose of the study is to highlight their overlooked health issues, barriers to care and stigma associated with migrant MSMs.

**Methods** A cross-sectional qualitative in-depth interviews were conducted with 62 migrated MSMs in New Delhi in the Month of November-December 2012. The snow - bowling method is used to track the hidden population. Interviews were based on pre decided themes of health Issues, service availability, barriers to care and stigma associated. Data was analysed by using thematic framework approach. New emerging issues verbatim were highlighted and the case narrative has been done.

**Results** The majority of the participants of the study reported that they were not aware about the health care service availability even if they are willing to get screened. Most of the participants perceived that they are suffering with the mental disorders but because of stigma associated, along with the other healthcare need, they couldn't able to avail the mental health services. Occupational hazard was also reported in the majority of the cases.

**Conclusion** Special attention to mental health care is required along with a comprehensive package also dealing with the physical as well as the social well being of MSMs. Special attention is required for their screening since the population being migrant is much more at risk when compared to migrant and MSM individually.

**P6.048 REORIENTING PUBLIC SEXUAL HEALTH SERVICE TO PRIORITY POPULATIONS, STIS AND ISSUES IN NEW SOUTH WALES, AUSTRALIA, 2006–2012**

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**Background** Reorientation of publically funded sexual health services (PFSHS) to improve access to priority populations was a key objective of the 2006 New South Wales (NSW). STI Strategy. A network of 13 PFSHS was established across NSW in mid 1990s to support STI/HIV care and prevention without a strategic framework. Priority populations identified in the Strategy now include Aboriginal people, men who have sex with men, young people, sex workers, people with HIV/AIDS, and people who inject drugs.

**Methods** A multidisciplinary PFSHS working group was established within the new NSW STI Programs Unit in 2007. The group coordinated the identification of need, development and promotion of resources, support tools, online and in-persons learning packages for PFSHS staff. Recognised training providers were identified to host and assist with training coordination and evaluation.

**Results** Many PFSHS were unfamiliar with population health principles and their role in supporting local priority populations. Defining local roles in providing sexual health services to large numbers of young people not in other priority populations was particularly challenging. A 'road show' describing STIPU's role and population health principles training was undertaken in 2007–08.

Resources developed included priority population estimation and target calculators; a roles and responsibilities statement; a priority youth discussion paper; online priority population triage training; a state-wide standard operating procedures manual. Annual reports describing priority populations accessing PFSHS, outreach clinical service and educational activities assisted with implementation evaluation. From 2006–2011, NSW PFSHS increased proportions of clinical services to Aboriginal people, men who have sex with men, people with HIV; increased triaging; increased educational activities to local communities; and increased clinical outreach activities to priority populations.

**Conclusion** Fears of annual reports jeopardising funding arrangements were unfounded and proved supportive of local reorientation efforts by revealing service gaps. Appropriate reorientation to priority populations is occurring in NSW PFSHS.

**P6.049 PHC COORDINATORS' STI AND HIV - AIDS TECHNICAL ASSISTANCE**

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**Background** Technical teams (TA) from Indonesia FHI 360 visits to 25 health centres in four provinces in the Indonesian capital. In order to assure and improve the quality and quantity of STI and HIV-AIDS services to be Able to provide comprehensive and sustainable service. As the follow-up of previous series of events in STI and HIV-AIDS; such as HSS, QA/QI, clinical trainings on STI and HIV-AIDS. To get the baseline data for management condom.

**Methods** TA team consists of HIV-AIDS coordinator at Provincial Health Officer and District Health Officer, SUM 1, and some other partners such as WHO. TAs were done by direct observation, role play, staff interview, management interview, and document checking.

**Results** 22 out of 25 PHCs give STI & HCT service. 9% of the PHCs with STI&HCT service, had met the minimum criteria for Management Component. 64% of PHCs have written assignment with job description for the STI Team. 36% of PHCs have written STI and HIV service flow and SOP. 86% PHCs have the latest STI&HCT guidelines from MoH. Most of the PHCs already do Universal Precaution, but only 36% of PHCs have PEP treatment flow.

**Conclusion** Encourage STI, PITC and VCT implementation at the PHCs with trained staffs. Prepare new staff to replace staff who will retire or move. Use all the latest form for recording and reporting HCT activities, and fill the form completely. Distribute guidelines to the PHCs. Re-set the counselling room and prepare counselling kit. Help the PHCs in developing internal referral flow between services. Increase the capacity of counsellor for other skill. Encourage counsellor to do condom use demonstration during counselling session.

**P6.050 EVALUATION OF COMPLIANCE WITH PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV NATIONAL PROTOCOL IN PMTCT SITES IN KINSHASA, DEMOCRATIC REPUBLIC OF CONGO**

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**Background** Nearly 91% of all pregnant women living with HIV worldwide live in 25 countries, including the Democratic Republic of Congo (DRC). Even although the DRC implemented the PMTCT programme in 2001, the prevalence of HIV in pregnant women was