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 be 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.

Poster presentations

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


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PHC Coordinators’ STI and HIV – AIDS Technical Assistance

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 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 PFHS, outreach clinical service and educational activities assisted with implementation evaluation. From 2006–2011, NSW PFHS 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 PFHS.