

system for verified diagnoses of STI/HIV, that uses an index-chosen method per partner (email, text messaging, postal letter or a gay dating site; anonymous or non-anonymous). SAT was piloted at the Public Health STI clinics in Amsterdam and Rotterdam, the Netherlands. It was offered additional to counselling by the nurse.

**Method** We evaluated SAT use and effectiveness from March-July 2012. Numbers/method of sent SAT notifications were extracted from the SAT database, and epidemiological data from electronic patient records. Determinants for SAT use (age, sex, ethnicity, partners, STI) were assessed using logistic regression analysis.

**Results** Of 1184 index-clients receiving a SAT code, 160 (14%) notified through SAT. They sent 588 notifications (median 2), 82% by text messaging and 16% by email; 86% was non-anonymous. Univariate analysis of SAT use in heterosexuals showed that people with only 1 partner used SAT less often than others; this was the only significant predictor. In MSM, the STI diagnosed was the only significant univariate factor, with MSM with syphilis using SAT more often than MSM having other STI. Among all 67 SAT users in Rotterdam, 56% (225/402) of their eligible partners were notifiable, and 95% (213/225) of those were notified using SAT. In 17 MSM, 36% (87/239) of eligible partners were notifiable, and 97 (111% of 87) were notified in SAT. Of all notified partners, 56% entered SAT to see the STI they were notified for, and 20% visited the STI clinic in Amsterdam/Rotterdam. STI positivity in partners was lower in those notified by SAT (28%, n = 116) than in those with contact cards (45%, n = 152; p < 0.001).

**Conclusion** SAT is a valuable addition for supporting partner notification and management, although challenges as non-notifiable partners are not solved by SAT.

**008.3 BARRIERS TO BACTERIAL STI SCREENING OF HIV+ MEN WHO HAVE SEX WITH MEN (MSM) IN HIV PRIMARY CARE SETTINGS**

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**Background** In the U.S., bacterial STI disproportionately affect HIV+ MSM. Screening for STI in HIV care settings remains suboptimal, but barriers have not been fully elucidated.

**Methods** As part of a CDC initiative to increase STI screening among HIV+ MSM in care, we sought to (1) define current screening coverage, and (2) identify patient and provider related barriers to screening at the largest HIV clinic in the Pacific Northwest. We extracted aggregated testing data from electronic medical records, and created separate anonymous surveys for patients (written) and providers (electronic). All male clinic attendees seen during a 3-week period in 2012 were invited to participate; 110 MSM contributed. Of 33 clinic providers invited, 28 (85%) responded; 82% (23/28) were attending physicians.

**Results** From March 2011-September 2012, among 1,379 HIV+ MSM engaged in care, 38% had extragenital testing, 40% urine testing, and 80% syphilis serology at least once. Of patients surveyed, 71% reported having sex in the last 2 months. 31% described seeking STI screening outside of the HIV clinic; of those, reported reasons included: being "easier" (42%), preferring "anonymity" (21%), wanting "more frequent screening" (16%). Providers reported being unfamiliar with current CDC screening guidelines (32%) and uncomfortable with discussing sexual practises and performing a genital exam (21%). Many (68%) stated time was a major barrier. Eleven (40%) providers cited patients' reluctance as a barrier, reporting common patient excuses including: being unprepared (55%), testing elsewhere (82%) and preferring same-gender provider (27%). Asked about potential solutions, providers chose easier access to electronic-tracking of testing results (82%), access to results from other clinics (71%) and self-collection of specimens (57%).

**Conclusion** At a large academic HIV primary care clinic, STI screening was substandard, with providers reporting numerous barriers. Interventions to address these obstacles include implementation of an STI self-testing programme, and enhanced education for providers.

**008.4 ONLINE ACCESS TO HOME STI SPECIMEN COLLECTION AND E-PRESCRIPTIONS LINKED TO PUBLIC HEALTH - IS A COMPARATIVE EFFECTIVENESS TRIAL FEASIBLE?**

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**Background** Online STI testing and treatment may improve access at lower cost and with higher acceptability than clinic-based services.

**Methods** We conducted a demonstration (non-significant-risk medical device) study of an online system for STI education, vaginal specimen collection for chlamydia, gonorrhoea, and trichomonas testing, treatment, and partner notification, in collaboration with 4 San Francisco Bay area health departments. English and Spanish speaking women (18-30 yr) were recruited over 3 months through various methods.

**Results** The website had 6,855 hits with a click through rate of 6.6%(450). Of 256 deemed eligible, 85%(217) enrolled. Among these, 54% (117) had not seen a clinician in the past year and 87%(142) had not had an STI test since last unprotected sex. Among those mailed a kit (213), 67% (143) returned the kit. Of these, 80% (115) of participants accessed test results online the same day results were posted, within 2 days (86%, 122) or by study end (92%, 131). STI prevalence was 5.6% (chlamydia and trichomonas). All STI infected participants received treatment either the same day (75%,6/8) at a pharmacy or within 7 days at a clinic (25%, 2/8). Internet recruitment reached the highest number of participants (100/217, 46%), while advertising on subways reached the highest number of positives (5/8, 63%). Of 106 participants completing follow-up surveys, 98% (104) indicated the site was easy to use and 98% (104) would recommend the project to a friend. No negative outcomes were reported. If participating in a future trial, 94% (100) would prefer an online system over clinic-based care.

**Conclusions** An online system for STI testing and treatment appears feasible, and highly acceptable to participants. We recommend a future comparative effectiveness trial to determine whether an online system can increase testing and treatment of STI infections at lower cost and with higher acceptability than clinic-based care.

**008.5 SHOULD ALL PREGNANT WOMEN BE SCREENED FOR CHLAMYDIAL INFECTION AS RECOMMENDED BY CDC, OR ONLY THOSE YOUNGER THAN 25 YEARS AS RECOMMENDED BY USPSTF?**

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**Background** In the United States, chlamydia screening has been recommended for pregnant women of all ages by CDC, and for pregnant women younger than 25 years by USPSTF. The benefits of chlamydia screening are highly dependent on chlamydia prevalence. Very limited evidence, such as age-specific positivity in pregnant women, has been available to support these recommendations. We analysed data from a large commercial laboratory corporation with a substantial share of the U.S. market, with testing in all 50 states, to estimate the positivity of chlamydia among pregnant women.

**Methods** Among all chlamydia tests performed at a woman's first pregnancy-related visit between June 2008 and July 2010, we estimated chlamydia positivity by age, then further stratified by insurance coverage and geographic region.

**Results** Of 600,990 pregnant women aged 15–44 years, 61.9% had private insurance and 34.1% had Medicaid coverage; 60.8% resided in the South region; 43.4% were aged 15–24 years, 26.7% 25–29 years, and 19.1% 30–34 years. Chlamydia positivity significantly decreased by age (15–19 years: 10.3%; 20–24 years: 5.6%; 25–29 years: 1.9%; 30–34 years: 0.9%; and 35–44 years: 0.6%). The pattern of decreased age-specific positivity was similar among insurance and region subgroups.

**Conclusions** Our findings of age-specific positivity, derived from a very large number of tests among pregnant women in the United States, suggest that it is more effective to screen younger pregnant women than older ones. Harmonizing CDC and USPSTF recommendations for pregnant women could be explored by review of age-specific positivity data and estimates of prenatal adverse health outcomes caused by chlamydia (miscarriage, preterm birth, and infant mortality) in order to develop consensus regarding quantitative thresholds of these health outcomes.

#### 008.6 DO YOU HAVE AN STI? FINDINGS FROM A DEDICATED MEN'S SEXUAL HEALTH CLINIC IN ALEXANDRA TOWNSHIP, SOUTH AFRICA

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**Background** A walk-in weekly men's sexual health clinical service, provided by a male clinical team, was established in 2006.

**Methods** We analysed new patient episodes at a dedicated men's sexual health clinic in Alexandra Township, South Africa over 6 years (2007–2012). STI syndromes were treated immediately and all men were offered urine-based molecular screening for *Neisseria gonorrhoeae* (NG), *Chlamydia trachomatis* (CT), *Trichomonas vaginalis* (TV) and *Mycoplasma genitalium* (MG) infections and serological screening for syphilis. Clinical and laboratory data were analysed using STATA™ version 10.

**Results** Among the 876 new clinical episodes, the most common presentations were genital warts (432, 49.5%), male urethritis syndrome (188, 21.6%) and genital ulceration (82, 9.4%). The proportion of patients attending for genital wart treatment increased over time. Few men (51, 5.9%) presented as sexual contacts. The patients' peak age range was 25–29 years; only 40 (4.6%) men were < 20 years old. HIV testing history was provided by 871 men: 156/430 (36.3%) men who knew their serostatus were HIV positive but 441 (50.6%) had never tested. Laboratory testing of 822 urine specimens detected 108 (13.1%) NG, 100 (12.2%) CT, 51 (6.2%) TV and 68 (8.3%) MG infections. The syndromic approach alone would not have treated 16 (14.8%) NG, 57 (57.0%) CT, 46 (90.2%) TV and 49 (72.1%) MG infections. NG/CT infections were most prevalent among those aged 18–19 years old (34.5% and 17.2%, respectively); in contrast, TV/MG infections were most prevalent in the 35–39 year old age group (1.7% and 11.8%, respectively). The prevalence of rapid plasma reagin seroreactivity was 2.2%. Overall condom use was 16.9% with regular partners and 52.5% with non-regular partners.

**Conclusion** Asymptomatic STIs, poor clinic attendance by youth, poor uptake of HIV testing by men and low rates of condom use with partners remain challenges for STI management in South Africa.

## 0.09 - Programme implementation and scaling up

### 009.1 VOICES OF HIV INFECTED CHILDREN AND THEIR FAMILIES

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Chandipur Mother & Child Welfare Society, in partnership with Bengal Network of People Living with HIV/AIDS tied up with district networks, to achieve the following objectives:

- Building capacity of the Network of People Living with HIV/AIDS to track children.
- Assessing the profile of these children, their families and the extent to which these children are able to access basic services related to health, nutrition and education.

Sixty trained HIV positive network members collected the information in 2010–11. Information collected from the families have HIV/AIDS infected or exposed children. The study team traced 1,639 children in 995 families, out of whom 857 children were reported as HIV infected and 130 were exposed children. To gather more qualitative information, number of FGDs & consultations were held.

1. 72% families fall in BPL category and mostly engaged in unorganised sector
2. 29% of fathers and 33% of mothers illiterate
3. 65% mothers not received any PPTCT services during their last pregnancy
4. 11% transmission through contaminated blood and blood products
5. 60% children receive care from a single institution
6. 43% families have spent an out of pocket expense
7. Very few children who were tracked are below 2 years of age, indicating late detection & initiation of treatment
8. 65% of eligible children attend school & 62% children, < six years are enrolled in ICDS
9. Parents exhibit an inherent fear of stigma and discrimination

The study reveals that most of these children belong to poor socio-economic condition. It emphasises the need to improve existing services in terms of timely access to appropriate medicine, treatment and nutrition.

It also strongly recommends the need to scale up the coverage of services towards virtual elimination of mother to child transmission of HIV. There is need to change in attitude of service providers and society at large to remove stigma and discrimination.

### 009.2 FINANCING FREE AND UNIVERSAL ACCESS TO ANTIRETROVIRAL DRUGS IN THE LONG-RUN: ART COST EVOLUTION IN BRAZIL

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**Background** Following the international aid crisis, developing country governments have assumed greater financial responsibility in the fight against HIV/AIDS. First-line antiretroviral drugs (ARVs) have become more affordable, yet, assuring lifetime treatment requires the provision of expensive second and third-line therapy. Considering the longterm perspective, this analysis examines ARV mean cost evolution in Brazil and highlights main factors influencing its behaviour.

**Methods** Transactional data for ARV procurement made by the Brazilian Ministry of Health (BMoH) between 1998 and 2011 were used to calculate mean annual ARV cost, adjusted to 2011 US\$.