P6.09 IDENTIFYING THE BARRIERS SEX WORKERS EXPERIENCE TO PARTICIPATE IN POLICY MAKING DECISIONS IN JOHANNESBURG, SOUTH AFRICA

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Introduction The basis of a democratic government is consultation and participation by its citizenry in public policy making. Marginalised populations don't have the power and authority due to a lack of agency and a variety of factors. These factors in combination with socio-economic challenges cripple their rights to healthcare policies that is realistic with their needs.

Are sex workers able to participate in policy making in South Africa? And what hinders their participation in the policy making decisions. By having a better understanding of the barriers to participation in the policy making process, we are more readily able to address these barriers for an inclusive consultation of sex workers in future policy work.

Methods This is a qualitative study conducted in South Africa using grounded theory.Data from informants who currently are or have been involved in policy making are collected as well as focus group discussions with sex workers. Informants were asked a series of questions relating to legislation that governs participation in policy making, participation and consultation platforms available to sex workers, social exclusion and stigma experienced by sex workers, the impact of knowledge and education on the ability to participate, agency (political, human and social), the impact of organisation/mobilisation on participation, identifying their perceived barriers to participation and how to strengthen participation of sex workers in public policy making institutions.

Results and conclusion The barriers identified by both sex workers and key informants to participation of sex workers in policy making includes:

Stigma of sex workers;
Time away from income earning activities
Criminalization of sex work
The political interests of development aid providers
The internal locus of control of sex workers
Lack of political support

P6.10 INTERVENIENT FACTORS IN THE NOURISHMENT OF CHILDREN VERTICALLY EXPOSED TO HIV

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The vertical transmission control after birth is passed to the child's caregiver, having them ties of consanguinity or not, once the child does not promote self-care itself. When supported and guided by health professionals, it is the caregiver who has the power to ensure the prevention and improvement of the child's quality of life. However, when these guidelines are insufficient or inadequate, the children receive nourishment that do not supply their nutritional needs, the deficiency of adequate information about the nourishment of children vertically exposed to HIV, its common. The guidelines effectiveness is directly related to the psychosocial, cultural and biological specificities of each family, and to comprehend them, it is necessary that health professionals have an approach of the reality experienced by them, through the settlement of a relationship of bond and respect. It is known that there is a variability of factors that influence in a positive or negative way on the food choices offered to children exposed to HIV. This study has as a purpose to evaluate the available evidences in scientific articles about the intervenient factors in the nourishment of children vertically exposed to HIV. It's an integrative revision of the literature, performed on the LILACS, PubMed and Scopus data bases, in January 2016. 29 primary studies evidenced the factors that interfere in the nourishment of these children: on the individual surface, the maternal feelings and desires, beliefs and practical difficulties. On the social surface, the socioeconomic conditions, social support and prejudice. On the political surface, the services' structure and organisation, input supplies, guidance and the professionals' empathy and ethics. The factors that interfere in the nourishment of vertically exposed children may be independent or associated to each other. For the risks of inadequate nutrition and associated diseases to be reduced, action is needed to identify and minimise these factors, guaranteeing the promotion of health and reduction of infant morbimortality.

P6.11 STEMMING THE TIDE OF RISING SYPHILIS IN THE UNITED STATES (U.S.)

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Introduction In the U.S., rates of primary and secondary (P and S) syphilis increased by 19% from 2014–2015. While rates have increased among both men and women, men account for more than 90% of all P and S cases; the majority (83%) among men who have sex with men (MSM). Likewise, increases in congenital syphilis (CS) have paralleled the national increase in P and S syphilis among women.

Methods On January 23–26, 2016, CDC held a consultation with 140 experts in the field of syphilis to discuss current issues, trends, and priority actions in response to increasing syphilis rates. Consultants included experts from academia, local and state health departments, and other federal agencies. The summit included five focus areas; 2 sessions concentrated on congenital and MSM syphilis. Strategies for a syphilis action plan were discussed. Meeting notes were taken during the summit, then independently reviewed, reconciled, and summarised.

Results Several cross-cutting themes emerged: clearer recommendations for better clinical management of syphilis; better diagnostics for detection of active *Treponema pallidum* infection with need for new testing technologies and strain surveillance; and the need to address CS and MSM (and transgender) data gaps through better coordination between epidemiology, surveillance, lab, and program. Specific to CS, strategies need to address penicillin G manufacturing and supply line shortages; healthcare providers need to test all pregnant women for syphilis at the prenatal visit, the beginning of the third trimester and at delivery, promptly treat and quickly report cases to health departments where all CS cases should be reviewed for missed opportunities in the CS prevention cascade to inform interventions. Strategies relevant to MSM