'Privacy and Confidentiality'. The learning objectives were met for the majority of participants. Different aspects of the modules – format, references, learning activities were rated from 1 (worst) to 5 (best) with all ratings ranging from 3 to 5. Areas for improvement were video time length as some rural areas had difficulty with internet speed but the majority were perceived to be relevant to rural practice and the mode of learning acceptable for practitioners.

Conclusion The modules promote inquiry-based learning for adult learners and provide opportunity for rural doctors to critique and reflect on their own practice.

Disclosure No significant relationships.

P329 STRESS, POST-TRAUMATIC STRESS DISORDER, AND SEXUAL AND REPRODUCTIVE HEALTH IN A NATIONALLY-REPRESENTATIVE SAMPLE OF US WOMEN

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Background Examination of stress and post-traumatic stress disorder (PTSD) in relation to sexual and reproductive health (SRH) is limited. Stress, potentially by impairing immune response and increasing risk-taking behavior, may influence risk of poor SRH. 'Weathering' effects from chronic stress exposure that accumulate over time may further heighten risk.

Methods Using Wave IV data on 7870 women (ages 24–34) in the National Longitudinal Study of Adolescent to Adult Health, we defined high stress as scores ≥ 6 (75th percentile) on the 4-item Perceived Stress Scale and PTSD as self-reported diagnosis by a healthcare provider; we categorized years since diagnosis as never, ≤ 2 , 3–5, ≥ 6 . Women reported lifetime and past year sexually transmitted infection (STI) and pelvic inflammatory disease (PID) diagnoses, adverse pregnancy outcomes (miscarriage, ectopic/tubal pregnancy, stillbirth), and impaired fecundity (difficultly becoming/staying pregnant). We used modified Poisson regression to estimate sociodemographic-adjusted prevalence ratios (APR) and 95% confidence intervals (CI).

Results Approximately 43% reported high stress and 4% PTSD (1% ≤ 2 years since diagnosis, 1% 3–5 years, 2% ≥ 6 years). High stress was associated with past year bacterial STIs (APR=1.53, 95%CI: 1.13, 2.09), unassociated with viral STIs, and weakly associated with adverse pregnancy outcomes (APR=1.24, 95%CI: 1.02, 1.50) and impaired fecundity (APR=1.13, 95%CI: 0.98, 1.30). PTSD was also associated with lifetime viral STIs (APR=1.40, 95% CI: 1.06, 1.83) and PID (APR=3.12, 95%CI: 1.59, 6.12). Compared to women never diagnosed with PTSD, APRs for past year bacterial STIs were 2.66 (95%CI: 1.28, 5.55) and 3.12 (95%CI: 1.49, 6.55) for women diagnosed ≤ 2 years and ≥ 6 years ago respectively, but not associated for women diagnosed 3–5 years ago.

Conclusion High 'global' perceived stress is associated with increased prevalence of poor SRH among women. Stronger associations were demonstrated in women with PTSD, particularly those with shorter and longer time since diagnosis, potentially suggesting both adverse acute and chronic stress responses.

Disclosure No significant relationships.

P330 THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF HARD TO REACH GROUPS IN UGANDA

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Background In order to achieve universal health coverage for all, the government of Uganda committed to advancing family planning for all during the FP2020 London Summit in July 2017. Despite efforts by Ministry of health (MOH) and Implementing partners (IPs) to implement programs that are complementary to static services, some communities remain hard to reach. Emerging New groups of nomads, balaro (Agago, Gulu, Apach). These don't return but settle in new scarcely populated areas, father children, acquire STI The Ike suffer from attacks from Kenya and Uganda, are isolated, not reached by SRHR services, have SRH needs. The Batwa, lived in forests but now displaced. Lost livelihood, Not integrating well with communities. Sexually exploited by communities due to myths. These groups remain hard to reach by due to factors like; stigma, geographical isolation, cultural beliefs, life style patterns and biological factors. There's been minimal change in SRH indicators, despite growing focus by IP (Kanungu, Kisoro, Rubanda)

Methods A qualitative design utilizing case study approach to qualitative inquiry was used Data collection was by; Document review Key informant interviews (KIIs) Focus group discussions (FGDs) Sampling for FGDs and KIIs was purposive with maximum variation Data collected was transcribed, analysed thematically and report generated

Results The key SRHR needs include; sexually transmitted infections, sexual and gender-based violence, family planning, female genital mutilation, limited delivery at health facilities, low ANC attendance and a high held role of TBAs in these communities. The most significant barriers to SRHR services include; extreme poverty, poor cultural beliefs, low literacy levels, alcohol abuse, language barriers, distance between the clients and available health services.

Conclusion The SRHR needs are documented in the existing literature and not unique to hard to reach groups though of greter impacts among these groups. The most unique barrier to SRH services include; language barrier, poverty and distance to existing health services

Disclosure No significant relationships.

P331 QUANTITATIVE EVALUATION OF AN INNOVATION CONTEST TO ENHANCE A SEXUAL HEALTH CAMPAIGN IN CHINA

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Background Crowdsourcing method is an excellent tool for developing tailored interventions to improve sexual health. We