Abstract O5-S2.04 Table 1 Sexually transmitted infections provider knowledge, beliefs and attitudes in Gauteng, South Africa, 2008–2009

	Agree		Disagree		Do Not Know	
N=611	%	n	%	n	%	n
Knowledge						
Some STIs cannot be cured with medication	48.1	294	45.7	279	6.2	38
Genital herpes often recurs	93.1	569	3.8	23	3.1	19
Genital Herpes often causes urethral discharge in men	25.7	157	87.4	377	12.6	77
Genital herpes is curable	42.2	258	4.8	324	53.0	29
Genital Herpes sores can be treated with medication(s)	84.9	519	10.0	61	5.1	31
Untreated STIs can develop into AIDS	33.9	207	60.6	370	5.6	34
Many patients with STIs already have HIV or AIDS	42.4	259	52.2	319	5.4	33
Beliefs						
I think one of my most important responsibilities is to strongly recommend HIV testing to each of my STI patients	93.6	572	5.1	31	1.3	8
I think traditional herbal medicine is able to cure some STIs	16.2	99	81.0	495	2.8	17
I think traditional herbal medicine is able to cure HIV/AIDS	1.5	9	79.7	487	18.8	115
In the long run, some HIV medication(s) can be more dangerous than having AIDS	31.1	190	65.1	398	3.8	23
Attitudes						
Under certain circumstances, it is OK to test patients for HIV without telling them	26.0	159	71.8	439	2.1	13

O5-S2.05 ROLE OF REGIONAL REFERENCE LABORATORIES FOR SEXUALLY TRANSMITTED INFECTIONS IN IMPROVEMENT OF SECOND GENERATION HIV SURVEILLANCE EXPERIENCE FROM THE CENTRAL AMERICA REGION

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Background WHO/UNAIDS recommends National HIV/AIDS and Sexually Transmitted Infection STI) Control Programs to implement integrated HIV, STI and behavioural surveillance to assess the disease burden, and to monitor the temporal trends of HIV/STI prevalence and high-risk sexual behaviours. Despite this recommendation, there is limited STI prevalence data available in many resource poor countries owing to lack of STI laboratory capacity to detect multiple STIs. The CDC STD lab explored the feasibility of a decentralised laboratory strengthening approach by applying more advanced molecular STI diagnostic methods to support the second generation surveillance (SGS) activities in the Central American Region during 2007–2011.

Methods CDC STD lab developed a real-time multiplex PCR (MPCR) to detect *Neisseria gonorrhoeae, Chlamydia trachomatis, Trichomonas vaginalis,* and *Mycoplasma genitalium*. In collaboration with regional partners, CDC identified and transferred the diagnostic technology to a regional STI reference laboratory in 2008. The regional reference laboratory provides MPCR testing on specimens collected for surveillance purpose. This standardised SGS study design was implemented at regular intervals in multiple countries in the region to estimate the disease burden and to monitor temporal STI trends.

Results During 2007–2010, four national integrated sexual behavioural and biomarker surveys were implemented using CDC's affiliated regional STI reference center. The quality STI prevalence data was made available to the national HIV/STI programs in Honduras, El Salvador, Nicaragua and Colombia. Similar CDC supported surveillance studies are in-preparation in Guatemala, Belize, Panama, Honduras (second round) and the Dominican Republic.

Conclusions Based on the experience from the Central American Region, it is feasible to implement integrated HIV, STI and behavioural surveillance surveys using robust molecular techniques in resource poor settings. In collaboration with regional partners, CDC's approach to STI laboratory capacity strengthening through establishing a regional reference laboratory should be expanded to other regions.

O5-S2.06 ABSTRACT WITHDRAWN

Health services and policy oral session 3—partner notification

O5-S3.01 USE AND EFFECTIVENESS OF EXPEDITED PARTNER THERAPY IN AN INNER-CITY STD CLINIC

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Background In November 2006, the Denver Metro Health (STD) Clinic (DMHC) began offering Expedited Partner Therapy EPT) to heterosexual patients infected with Chlamydia trachomatis (Ct) or *Neisseria gonorrhoeae* (GC). Among those who accept EPT, the patient delivers treatment to his or her partner(s), removing the need for a clinic visit. We investigate demographic differences among patients who accepted EPT and examine re-infection rates among those who return to the clinic.

Methods Data were extracted from the electronic medical record (EMR) for 2644 eligible patients offered EPT between November 2006 and October 2010. Acceptance rates are compared across demographics and infection status. Rates of re-infection are examined among the 339 patients who returned for re-testing within 21 to 90 days of treatment. Dual infections are excluded.

Results Overall, 763 (28.3%) eligible patients accepted EPT. Women were more likely than men to accept EPT (35.9% vs 23.8%, $p<0.01$). Patients younger than 40 accepted EPT at a higher rate than those 40 or older (29.6% vs 20.0%, $p<0.01$). African Americans were least likely to accept EPT (23.0%), whereas approximately 30% of Hispanics and Whites accepted and those reporting multiple races accepted at the highest rate (43.6%) ($p<0.01$). Ct infected patients were significantly more likely to accept EPT than those infected with GC (32.7% vs 24.6%, $p<0.01$). Within 21 to 90 days of treatment initiation, 339 patients returned for re-testing (221 for Ct and 118 for GC). Overall, re-infection rates differed significantly by EPT acceptance at the initial visit with 11.1% re-testing positive among those who accepted EPT compared to 20.4% among those who refused ($p=0.04$) (Abstract O5-S3.01 table 1). When stratified by type of infection, the differences were no longer significant but the direction of the relationship remained. Among those originally Ct-infected, 9.1% of those who accepted EPT re-tested positive vs 15.3% among those who refused ($p=0.19$). Among those originally GC-infected, 16.1% of EPT acceptors re-tested positive compared to 28.7% of those who refused ($p=0.17$).

Abstract O5-S3.01 Table 1 Use and effectiveness of expedited partner therapy in an inner-city STD clinic Mickiewicz T, Al-Tayyib AA, Mettenbrink C, Rietmeijer CA

Re-infection rates among those returning to clinic for re-testing			
	Ct	GC	Ct or GC*
Accepted EPT	7/77 (9.1%)	5/31 (16.1%)	12/108 (11.1%)
Refused EPT	22/144 (15.3%)	25/87 (28.7%)	47/231 (20.4%)

*$p<0.05$.