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Background We implemented a facility-based intervention aimed at reducing the proportion of patients lost to follow-up at an out-patient HIV clinic in Jinja district, Eastern Uganda, over a period of 6 months (February-July 2012).

Methods The intervention was implemented with the aim of decreasing the proportion of patients lost to follow-up from 1% (23/2328) at baseline to 0.25% by July 2012. Simple and innovative strategies were introduced into the HIV clinic. These included retraining of clinic staffs on the importance of patients keeping their appointments; development of new messages on keeping appointments; retrieving patient files a day before the day of appointment; sending two text message reminders a day to the clinic; and actively following up patients who had not kept their appointments through home-visiting. At each follow-up visit, reasons for the patients' failure to keep appointment were noted and information on age, gender, CD4 count (captured from patient records) and duration in HIV care was obtained. Data were fed into an IQ Care programme and analysed using Microsoft Excel.

Results The proportion of patients lost to follow-up decreased from 1% (23/2328) at baseline to 0.4% (9/2528) in 6 months. Men, those with a CD4 > 350, those aged < 30 years and those in care for < 1 year had the biggest decline in proportion of patients lost to follow-up compared to other patients.

Conclusion The proportion of patients lost to follow-up declined by 60% through use of simple and innovative strategies introduced in the HIV clinic.

P6.058 UNIVERSAL HIV SCREENING OF INMATES IN ISRAELI PRISONS: SHOULD THE POLICY BE UPDATED?

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Background HIV rates among inmates are mostly higher than the general population. Israel is a relative low-HIV prevalence country (107:100,000 population, 2011 data). All criminal inmates incarcerated in prisons/gaols at the Israeli Prison Services (IPS) are routinely screened for HIV. This retrospective study evaluates the necessity of the current policy of universal HIV-testing policy.

Methods We reviewed all inmates diagnosed with HIV/AIDS upon incarceration in Israel between 2003 and 2010, and assessed their risk-behaviours and the date of diagnosis.

Results During the 8 years follow-up, 108,866 new criminal inmates were incarcerated in 31 correctional facilities, and it is estimated that 95% of those were tested for HIV. Of those, 201 (0.2%) were tested positively with HIV, in a direct testing cost of 622,000 (US\$).

Of all 201 HIV-infected inmates, 118 (58.7%) were intra-venous drug-users (IVDU), 55 (27.4%) originated in high-prevalence countries, 13 (6.5%) were men who have sex with men (MSM), 12 (6.0%) were heterosexuals not originating in endemic country, 2 (0.1%) the risk-group was undetermined and one (0.5%) was infected vertically.

Of all 201 HIV-infected inmates, 157 (78.2%) were diagnosed in the community, prior to their imprisonment, and were re-tested in prison; while 44 (21.8%) were firstly diagnosed in prison. Of those 44 inmates, 25 (56.8%) were IVDU, 13 (29.5%) originated in endemic country, three (9.1%) were MSM and in two (4.5%) the risk-group was not determined.

Conclusion HIV-infection rate in prison is twice higher than the general population. The majority (98.5%) of all inmates was diagnosed prior to their incarceration or had a key risk-behaviour expos-

ing them to HIV. Therefore, questioning each new inmate upon incarceration about previous HIV-diagnosis, and targeted testing for other inmates who are IVDU, MSM or originating in endemic countries for HIV can detect almost all HIV-infected prisoners, presuming they respond reliably.

P6.059 VERTICAL TRANSMISSION OF HIV LESS THAN HALF AMONG MOTHERS BELONGING TO MOTHER-SUPPORT GROUPS (MSG) COMPARED TO NON-MEMBER MOTHERS AT HEALTH CENTRES IN TIGRAY, ETHIOPIA

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Background Mother-support groups (MSGs) are used at hospitals and health centres in Ethiopia to increase uptake of and adherence to PMTCT and reduce vertical transmission of HIV. A study at Dessie Referral Hospital showed that mothers belonging to MSGs had lower vertical transmission rates. The impact on mothers seen at health centres is not known.

Methods Data on the outcome of MSGs on vertical transmission were collected from 15 health centres in Tigray between 2008 and 2011. Data sources included MSG registration log books, regional laboratory DNA/PCR results, and the ART enrollment register. We compared HIV status among babies born to mothers belonging to MSG and those whose mothers did not participate in MSG.

Results A total of 848 HIV-exposed infants (HEIs) were registered between 2008 and 2011. Among 240 HEIs born to mothers enrolled in MSG, 87.5% were tested for HIV and 5.2% were HIV-positive. Among the 608 HEIs whose mothers were not enrolled in MSGs, 44.7% were tested and 11.4% tested HIV-positive (OR = 0.43).

Conclusions The odds of testing positive were 57% lower among HEIs whose mother was enrolled in an MSG compared to those whose mother was not enrolled. The better outcome appears to be due to the support their mothers received from MSGs resulting in better PMTCT and adherence practises as well as high rates of institutional delivery. We are currently collecting more data on PMTCT regimen, HEI testing by age and place of delivery to verify this hypothesis.

P6.060 PATIENT OR PROVIDER REFERRAL FOR CHLAMYDIA - WHAT IS THE COST AND IS IT WORTH IT? A COST COMPARISON OF ALTERNATIVE STRATEGIES

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Background Partner notification (PN) is an essential element of STI control. Typically partner notification has been supported by specialist health advisors based in GUM clinics, but recently the role has been extended to community based Chlamydia screening officers (including primary care). We aimed to explore and compare costs of various approaches to PN for Chlamydia in different settings.

Methods We compared costs of being offered one of five approaches to partner notification from the health service perspective:

1. Routine specialist clinic PN (patient referral including infection specific information, and advice that the sex partner should attend clinic for testing and treatment)
2. Accelerated Partner Therapy (APT Hotline): nurse initiated PN at the general practise followed by telephone assessment of sex partner by clinic-based nurse qualified health adviser;

3. Accelerated Partner Therapy (APT Pharmacy): nurse initiated PN at the general practise followed by assessment of sex partner by trained community pharmacist;
4. Patient referral, where patients are advised by phone by qualified health adviser on the need for partner to be tested and treated.
5. Provider referral, where patients accept the offer of a specialist health adviser contacting one or more partner(s) by phone.

For all pathways primary costs were collected prospectively in a specific exploratory study.

Results The least costly strategy is nurse led PN (strategy 2) costing approximately £53 per index case (2011 costs). The most costly strategy is provider referral (strategy 6) which cost £96 per index case.

Conclusion Where health service providers assume responsibility for contacting partners there will be substantial additional cost. Before any such policy is implemented, a demonstrable improvement in PN outcomes should be established.

P6.061 DEVELOPMENT OF A VALIDATED QUESTIONNAIRE FOR HIV ATTENDEES

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Background Patients are becoming more actively involved in decisions about their care and have greater influence to change and improve the quality of services by reporting their experiences. Within HIV services, positive experiences increase engagement with services and have been linked to higher levels of treatment adherence. A previous systematic review assessing satisfaction with care failed to locate a gold standard method of measuring satisfaction in this setting.

Aim to design a specific HIV patient satisfaction questionnaire

Methods Four work streams were employed to develop and test a new questionnaire. Firstly, key themes identified in the systematic review were used as a topic guide for focus group discussion to assess their relevance and importance. Four focus groups comprising 32 participants were conducted and revealed the importance of physician knowledge and expertise; dignity, autonomy and respect; and good communication. The second stream involved interviews with ten patients, exploring their motivation to complete a questionnaire. Thirdly, data from the focus groups and interviews were used to develop an initial questionnaire which was cognitively tested on a further ten patients, this provided face validity for the questionnaire design, layout and wording. The final stream employed a pilot study of the questionnaire with 80 clinic attendees.

Results The pilot survey demonstrated that there was a high completion rate. Two questions were modified and additional routing instructions were added. Pairwise correlations reflected the thematic structure of the questionnaire and supported good criterion validity.

Conclusions The combination of a systematic analysis of previous patient survey tools, focus group discussions and cognitive testing of the questionnaire was used to ensure high content validity. The questionnaire was found to be acceptable to patients and a high completion rate was attained without the use of a financial incentive.

P6.062 QUALIAIDS: QUALITY OF AMBULATORY HEALTH SERVICES WHO ATTEND PEOPLE LIVING WITH HIV/AIDS IN BRAZIL

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Background Between 2007 and 2012, there was an increase of 14% of Specialized Care Services for people living with HIV/AIDS (PLHIV), totaling 724. A decade ago the Qualiaids evaluates the quality of outpatient care in public services in Brazil. The aim of this study is to describe the dimensions of this evaluation method, the highlights of care services and its importance in monitoring the quality of care for PLHIV.

Methods Were made three national applications: one manual and two online through a questionnaire completed by the services. Each question has a score, and there were grouped under three components: availability of services inputs, organisation of care delivery and managerial aspects. To rank the services Were used the average obtained in the questions and then were grouped by technique of K-mean. The analysis resulted in the layering of five groups in decreasing levels of quality. The online tool also released a set of recommendations for good practises in order to elucidate the quality criteria that support the score of each question.

Results Qualiaids covered 80% of the services in 2007 and 90% in 2010. Increased the overall average and the three dimensions of quality, with statistical significance for most of them. The size of management remains the dimension with the lowest quality rating. The great majority of responses to the questionnaire QUALIAIDS was maintained in similar frequencies (variations less than 10%) among the respondents of the two sets of ratings.

Conclusion From the self assessment were planned the feedback workshops to improving the quality to knowing the difficulties and systematise the priorities for the development of an action plan customised for each service. This process favoured the implementation of agreements and pacts that allowed monitoring of quality indicators and subsidised practises to improve the quality of care services.

P6.063 VERTICAL TRANSMISSION OF HIV BY AGE OF INFANT TESTING AND TYPE OF MOTHER/INFANT PROPHYLAXIS IN TIGRAY, ETHIOPIA

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Background Following a number of other African countries, Ethiopia has recently adopted option B+ as the national PMTCT standard. Option B+ puts all HIV-positive pregnant women on HAART for life, regardless of the CD4 count. This study examines whether HAART for maternal prophylaxis resulted in lower vertical HIV transmission in Tigray.

Methods We used data from Tigray's regional DBS data base to calculate HIV infection rates by PMTCT regimen in all HIV-exposed infants (HEIs) tested by December 2012. We calculated the relative risk (RR) of having a HIV+ baby by age of testing and the mother's PMTCT regimen.

Results There was a significant difference in HIV rates between babies tested at 0–2 months (4%) and 2–8 months (9%) (RR = 0.43, CI = 0.28.0.65; p = 0.0001). HIV infection was significantly higher in babies tested past 8 months (16%) (respectively, RR = 0.23, CI = 0.14.0.38; p < 0.0001 and RR = 0.55, CI = 0.36.0.86; p = 0.005). Maternal prophylaxis was a significant factor with a further significant difference between HAART (2%) and dual prophylaxis (14%) (RR = 0.37; CI = 0.19.0.74; p = 0.006).

Conclusions This study underscores the importance of putting HIV-positive pregnant mothers on PMTCT, especially HAART, and promoting institutional delivery and early infant testing. HAART was the most effective PMTCT regimen, regardless of the infant's regimen. This finding is particularly important in Ethiopia where most women give birth at home and may not be able to give the right medication to their baby at the right time. This data strongly