to 4%. Success stories document the increased quality of life and ability to cope with stigma and discrimination.
Conclusions People living with HIV can be engaged in effective outreach when they function as spokes from the hub of a community care centre. Community outreach complements facility based clinical care and a comprehensive approach that includes both a bio-medical and social focus can improve quality of life and minimise death.

P5-S6.25 INTEGRATING HIV/AIDS, FAMILY PLANNING, AND REPRODUCTIVE HEALTH SERVICE INTO NIGERIAN COMMUNITIES

doi:10.1136/sextrans-2011-050108.581

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Background In response to the rapid and complex HIV/AIDS epidemic, EPIC/DOD- Nigeria expanded its focus on family planning and reproductive health (FP/RH) to integrate HIV/AIDS prevention and care activities in 2008. Approaches include the establishment of work place programmes. Whereby peer promoters are selected from among the personnel. The peer promoters undergo a 2-week training that enables them to provide FP/RH and HIV/AIDS- related information and services to their co-workers.
Methods The objective of the assessment was to identify the benefits of the workplace Programme as perceived by workplace organisations, peer promoters, and workers. The assessment was designed to obtain qualitative information through focus group discussions and reviews of client registration books.
Results Peer promoters educate workers during tea and lunch breaks. They also provide pills and condoms and refer to nearby clinics for injectables and other services. From 2008 to 2009, they served 2215 new family planning users in two sites mainly in the medical centers of Mogadishu cantonment- Asokoro - Abuja. Uptake of condoms is high-for dual protection against unintended pregnancy and STI/HIV/AIDS. Condoms are also available in workplace restrooms for soldiers and their families, especially at the Defence Health Club (DHC). Peer promoters are more than satisfied to provide this service, and say that since their involvement in the project, they know more about HIV/AIDS and other health issues. The management also acknowledges benefits of the Programme, both financially and in terms of workers health.
Conclusion Many people working in military units and establishments in Nigeria have reproductive health and HIV/AIDS needs. Due to the characteristics and timing of their work, they have limited access to needed FP/RH and HIV/AIDS information and services. Workplace and Programme benefit managers, peer promoters and workers and others they should be expanded in other barracks and defence locations across the nation.

P5-S6.26 PREVENTION WITH POSITIVES IN NIGERIA: WHAT HAVE WE LEARNT?

doi:10.1136/sextrans-2011-050108.582

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Background The introduction of care and treatment at the service delivery points at the community and the clinical settings- hospital facilities for prevention with the positives have giving the HIV/AIDS, STIs, TB management high quality significant improvement in the first 8 months of implementation in Nigeria.
Methods Association of positive youth in Nigeria is a national non-governmental organisation in Nigeria, involved in HIV prevention, care and support. APYIN started implementing HIV prevention strategies in 2009 with a focus on involving HIV—positive people in prevention. The strategies included; counselling on prevention of HIV to positive persons this involved discussion of behavioural intervention in medical and counselling visits. Promoting the use and provision of condoms to sexually active HIV—positive individuals, promoting adherence to antiretroviral drugs, by counselling, use of pills boxes, and medicine companions. Encouraging HIV-positive persons to disclose HIV status to sex partners either by self or counsellor mediated during home visits or at the nearest opportunity. Home base management, HIV counselling and testing targeting partners and children born to all people living with HIV/AIDS.
Results Most of the persons living with HIV realise that they have a role to play in prevention of HIV. There is 8.5% increase in the uptake of condoms by HIV -positive person between the year 2008 and 2009. Antiretroviral therapy adherence levels of 92% of the clients on ART with adherence >95%. In the same period there is an increase of 50% of HIV -positive individuals disclosing HIV status to partners. Community awareness of HIV has increased in the area serviced by the organisation.
Conclusion Increase collaboration between the clinical and community base interventions. Regular monitoring of the community response for improvement. The capacity building of for community staff. HIV-positive persons are very important partners in HIV prevention. Therefore their involvement should be prioritised.

P5-S6.27 NEW AVENUES TO INCREASE QUALITY OF STI-CARE IN GENERAL PRACTICE

doi:10.1136/sextrans-2011-050108.583

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Background The role of primary care in STI-control has long been neglected. Although national STI surveillance often thrives on data of STI-Clinics, recent research in the Netherlands shows that approximately 70% of all STI-related consultations are in General Practice (GP). More attention for sexual health in primary care is warranted.
Methods In 2004 the Dutch College for Family Physicians (NHG) added a guideline about the "STI consultation" to their list of GP certified "standards of care". The guideline describes care for patients with complaints of STI, for patients with questions about STI (test request), and also describes pro-active testing policies for persons visiting the health centre for a not-STI related reason. The guideline is currently being updated. Implementation of the guideline is facilitated by regional "expert" GP, united in the GP-advisory group on STD, HIV and Sexuality (the Expert group Sexual Health (SeksHAG). Such Expert Groups within the GP institutional body are relatively new and also exist, for example, diabetes and Asthma/COPD.
Results Annually approximately 1500 GP receive a continuous education session on STI facilitated by the GP expert in their region. Previous research showed moderate impact on testing habits and case detection. Qualitative interviews describe insight in personal barriers as a positive gain in training sessions. Prescribing habits of GP for Gonococcal infections are legging behind, half of GP prescribing ciprofloxacin, for which resistance is well above 40%.
Discussion A substantial but often hidden proportion of STI consultations take place in general practice. More interventions on STI-care in GP are recommended. An expert group within the national GP body can enhance attention for quality of care. The new

emerging paradigm within primary care to focus not only on disease (pathogenesis) but also on health (salutogenesis) might open new avenues for sexual health counselling. New technology also has potential: continuous education sessions have limited impact on prescribing habits for infrequent conditions with fast changing resistance patterns like gonoccocal infections; learning GP to use more and better their electronic prescription expert-system based on patient ICPC code (Prescriptor) is a better option and now available in most GP operating systems in the Netherlands.

P5-S6.28 HIV PREVENTION BASED ON THE STATIC MODES OF TRANSMISSION SYNTHESIS FOR TWO INDIAN DISTRICTS: INSIGHTS FROM DYNAMICAL MODELLING

doi:10.1136/sextrans-2011-050108.584

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Background The Modes of Transmission (MOT) synthesis uses a static HIV transmission model to predict distribution of incident infections along subgroups over 1 year, and directs HIV prevention along this distribution. Because the MOT does not consider where sustained transmission is most likely to occur, and does not use parameter combinations fitted to observed epidemic characteristics, its relevance for planning interventions may be limited.
Methods We fitted a dynamical HIV/STI heterosexual transmission model to districts Mysore and Belgaum, India. The MOT and dynamical models estimated the proportion of new HIV infections over 1 year due to transmission between female sex workers/clients, their non-commercial partnerships, and low-risk partnerships. We compared predictions from the dynamical model to MOT results using prior and posterior (fitted) parameters. Intervention impact was illustrated using the dynamical model.
Results Using prior inputs, the MOT predicted that commercial sex accounted for 66.2—70.6% of incident infections among males, whereas 71.7—74.2% of incident infections among females were due to bridging infections from clients. There was less variability in MOT results when fitted inputs were used. The majority of the remaining new infections in males and females were due to transmission within low-risk partnerships. In contrast, the dynamical model predicted a higher contribution of commercial sex among males (90.7—91.2%), a higher contribution of bridging infections among females (70.5—86.9%), and that <1.5% of infections were due to low-risk partnerships. Dynamical modelling predicted that any intervention that reduces transmission by 20% applied among commercial sex partnerships could decrease overall HIV incidence by 12% in the first year and by 21% in 5 years see Abstract P5-S6.28 table 1. Applying this intervention among non-commercial partnerships of clients reduces overall incidence by 9% in years 1 through 5 because clients continue to become infected from their commercial partnerships.
Conclusion Prior inputs for the MOT will not reflect observed HIV prevalence, and as a result, will produce greater variability in MOT predictions. Allocating resources along a 1-year distribution of incident infections can prioritise prevention to the wrong subgroups because they do not account for the dynamic effects of interventions. Improved methods of epidemic appraisals are urgently needed to guide prevention programming.

P5-S6.29 INTENSIVE USE OF A CLINICAL DOCUMENTATION AUDIT TOOL TO BRING ABOUT SUSTAINED IMPROVEMENT IN THE STANDARD OF RECORD-KEEPING IN A BUSY GENITO-URINARY MEDICINE (GUM) CLINIC

doi:10.1136/sextrans-2011-050108.585

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Introduction Accuracy and consistency in clinical note-keeping is an essential element of clinical governance. In this busy GUM clinic, up to 12 different healthcare practitioners (both nurses and doctors) see patients for their history and examination, as well as taking tests, making microscopic diagnoses, giving treatment and notifying contacts. With this many staff of differing clinical backgrounds seeing patients autonomously, it is important that minimum standards of documentation are maintained. This study reports the use of an audit tool designed to provide clinic workers with regular feedback on their individual record-keeping performance compared to the clinic as a whole, thereby identifying areas where documentation standards can be improved.
Methods The audit was started in January 2009 and carried out monthly for 12 months with three sets of clinical notes audited per clinician each month. Collective scores for the clinic were issued on a monthly basis, with individual clinicians also receiving their own scores confidentially every quarter. The audit was discontinued for a year, then repeated so as to evaluate the extent to which improvements made in the first year had been maintained. Clinicians were unaware that the re-audit was taking place. The audit was based on 31 separate criteria divided into administrative (7 criteria), clinical (20 criteria) and health adviser (4 criteria) sections. This report focuses on the outcome of the clinical section, which included criteria such as adequacy of history and examination records, choice of tests conducted, consistency of diagnoses with findings, and suitablility of treatments prescribed. The internal standard was set at 100% for each criterion.
Results Overall scores for individual clinicians in the first month ranged from 72% to 96%, with median 82% and mean 83%. At month 12, the range was 87—100%, median 98%, mean 97%. The

Abstract P5-S6.28 Table 1 Distribution of 1-year incident infections by type of partnership, as predicted by the MOT and a fitted dynamical model

		Median % of incident infections attributable to partnership types (2.5 and 97.5 percentiles)					
		MOT (prior inputs)		MOT (posterior inputs)		Dynamical model	
	Partnership type	Mysore	Belgaum	Mysore	Belgaum	Mysore	Belgaum
Females	Commercial	6.5 (2.4, 14.9)	5.1 (1.9, 12.2)	7.0 (3.3, 13.0)	4.5 (2.0, 8.8)	28.4 (18.6, 35.5)	11.7 (5.7, 15.0)
	Main partnerships of FSWs/Clients	71.7 (50.4, 88.7)	74.2 (48.6, 90.9)	75.6 (61.0, 87.8)	73.0 (55.4, 84.9)	70.5 (63.6, 80.3)	86.9 (83.5, 92.9)
	Casual partnerships of FSWs/Clients	0.03 (0.01, 0.09)	0.01 (0.003, 0.04)	0.02 (0.01, 0.07)	0.01 (0.004, 0.04)	0.30 (0.25, 0.38)	0.31 (0.23, 0.38)
	Low-risk	20.0 (4.6, 40.7)	19.4 (4.3, 44.3)	15.8 (7.1, 29.3)	21.8 (10.9, 38.7)	0.76 (0.31, 1.1)	1.0 (0.61, 1.4)
Males	Commercial	70.6 (21.4, 92.6)	66.2 (14.3, 92.8)	66.0 (40.6, 81.1)	69.1 (41.7, 84.3)	91.2 (90.8, 95.6)	90.7 (88.4, 96.1)
	Main partnerships of FSWs/Clients	9.8 (3.4, 21.3)	10.8 (3.6, 20.9)	11.3 (6.1, 20.2)	9.6 (4.2, 19.5)	6.3 (3.4, 8.1)	7.3 (2.9, 9.2)
	Casual partnerships of FSWs/Clients	2.0 (0.5, 4.0)	4.5 (1.2, 9.9)	1.7 (0.66, 3.7)	3.8 (1.3, 8.3)	0.5 (0.3, 0.6)	0.87 (0.51, 1.2)
	Low-risk	15.6 (2.8, 58.5)	13.0 (1.6, 65.8)	19.7 (10.0, 36.9)	14.9 (6.0, 35.4)	0.6 (0.3, 0.9)	1.0 (0.37, 1.4)

FSW, female sex worker; MOT, Modes of Transmission.