Methods Case-control study where treatment error cases were defined as any patient 15–65 years of age, diagnosed with gonorrhoea in 2010, who did not receive ceftriaxone 125 mg or 250 mg IM or other approved cephalosporin regimen, or azithromycin 2 g PO. Two controls were randomly selected from patients who received correct treatment, matched to cases in regard to age, sex, and month of diagnosis. Data regarding exposures to various provider characteristics were collected from case report cards, provider licensing databases, and direct provider phone calls. Proportions of cases and controls were compared on the basis of provider training, years in practice, specialty, and practice type by χ^2 analysis or Fisher's exact test.

Results 76 cases were matched to 152 controls. In preliminary analysis, no differences were identified with respect to provider degree (MD/DO or NP/PA; p>0.25). More treatment errors occurred in private practice/health maintenance organisations compared to STD or family planning clinics (p<0.0001), emergency departments (p<0.0001), or community health centers/hospital clinics (p=0.0004). Among physicians, no differences were identified with respect to years since residency graduation (p>0.25). More treatment errors occurred with family medicine physicians compared to OB/GYN (p=0.0225) and emergency medicine physicians (p=0.0101), but not compared to paediatricians or internists see Abstract P5-S6.34 table 1.

Conclusions Although gonorrhoea treatment errors were rare, specific practice locations and physician specialties were significantly associated with gonorrhoea treatment errors, suggesting important opportunities for educational intervention. Further studies may determine reasons for errors, relative importance of provider factors, and what systems support accurate treatment.

Abstract P5-S6.34 Table 1 Analysis to date

	Controls (n, %)	Cases (n, %t)	p Value
Provider degree			
NP/PA	49 (45%)	30 (41%)	NS
MD/DO	59 (55%)	43 (59%)	
Practice location			
Private practices/HMOs	22 (18%)	41 (56%)	Reference
STD clinics	15 (13%)	0	<0.0001
Emergency departments	40 (33%)	11 (15%)	<0.0001
Community health centers/hospital clinics	43 (36%)	21 (29%)	0.0004
Residency graduation year			
After 2000	27 (47%)	15 (39%)	NS
1990s	16 (28%)	13 (33%)	
Before 1990	14 (25%)	11 (28%)	
Physician specialty			
Family Medicine	5 (9%)	11 (24%)	Reference
Paediatrics	3 (5%)	5 (11%)	NS
Internal Medicine	10 (18%)	10 (22%)	NS
OB/GYN	18 (32%)	7 (16%)	0.0225
Emergency Medicine	20 (36%)	7 (16%)	0.0101

P5-S6.35 EFFECTIVENESS OF MOBILISING MEDICAL FACILITIES TO PARTICIPATE IN STD/HIV CONTROL ACTIVITIES

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Since 2000, the STD clinics were brought into intervention service aimed at high-risk population by some projects, such as Health Project, Comprehensive Demonstration Area Project and the Global Fund to Fight AIDS Project. The ability of providing standardisation service in STD clinics was improved through the project activities. The outreach service increased awareness of STD clinics and attracted or made referral patients seeking service at standard clinic, and that strengthened the role of medical sites in preventing STD/AIDS.

Method Two jobs improved the intervention service aimed at STD/AIDS at clinics. 1. The intervention service aimed at outpatient. Including the following service: (1) setting heath education bulletin and publicity photographs at STD clinics to spread information about prevention STD/AIDS (2) providing Health education prescription about prevention STD/AIDS freely (3) the medical staff provided health education and consultation after diagnosis and treatment and extended the use of condom (4) to advise patient to inform their partner of examination at clinic (5) the medical staff mobilised outpatients to accept HIV-test forwardly 2. The medical staff provided field service aimed at high-risk population (CSW, MSM).

Result Several projects evaluated prevention service effect at STD clinics. The rate of medical staff accepting training on STD standardisation service increased from 9.21 to 21.56% to 68.99–89.7%. The rate of object population knew information about STD/AIDS prevention increased from 31.02–45.52% to 72.4–87.86%. The rate of outpatients accepting HIV test increased from 3.45% to 44.25%. While STD clinic staff provided field service for high-risk population, they advised people who needed further service to seek help at STD clinic. From 2006 to 2009, the proportion of high-risk in outpatient was increasing yearly. The evaluation result from three STD clinics showed the proportion of MSM in outpatient was increasing from 0.97% to 8.15%, from 2006 to 2009. And the evaluation result from 7 STD clinics showed the proportion of CSW in outpatient was increasing from 1.57% to 9.74%, from 2006 to 2009. The outpatient at STD clinic is high-risk population for STD/AIDS infection and spread, and most male outpatient especially had high-risk act, but the intervention in China touched on that. The prevention service at STD clinic smoothed over routine prevention action and expanded the range that STD medical service covered, so this prevention controlled the spread of STD/AIDS furtherly.

P5-S6.36 FACTORS AFFECTING QUALITY OF LIFE OF PEOPLE LIVING WITH HIV IN KARNATAKA, INDIA

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Background In India, stigma and discrimination in healthcare settings, poor linkages between services and lack of trained personnel affect the quality and accessibility of HIV services. In effort to both scale up and strengthen the quality and coordination of HIV care and support services in the state of Karnataka, the Samastha Project was developed. This enhanced care model uses a district based approach which integrates government services with project-based care and support services. Quality of life (QOL) is a critical outcome of HIV intervention. There is little data on the effect of HIV care and support services on QOL. We used baseline data from a 2-year prospective cohort study (QOL-Cohort study) of people living with HIV (PLHIV) in the Samastha program to identify factors affecting QOL among PLHIV.

Methods We conducted Factorial analysis using a set of key variables assumed to be associated with QOL to develop a factor score from the data collected by a face-to-face interview using a standardised questionnaire from QOL cohort study. Multivariate linear regression analysis was conducted using the factor score as dependent variable. High factor score indicated high QOL. Age, gender, locality and intensity of exposure to Samastha program were considered a priori

independent variables. Factors which were associated with the outcome variable and at least one a priori independent variable were included in the final model for multivariate analysis.

Results Gender, marital status, type of housing and occupation were significantly associated with quality of life of PLHIV. Mean score (QOL) is 16.6% (ß=−0.166, 95% CI −0.31 to −0.02) lower among men compared to women. It is 31.8% (ß=−0.318, 95% CI −0.19 to −0.08) lower among widowed/divorced/separated PLHIV compared to currently married PLHIV. Mean score (QOL) is significantly lower among PLHIV who do not have a perceptible income source (ß=−0.20, 95% CI −0.36 to −0.04) compared to those with steady income. PLHIV who live in Kuccha (house built of temporary material) houses (ß=−0.26, 95% CI −0.38 to −0.14) had a significantly higher mean QOL score compared to those living in Pucca (house built of permanent material) house. Intensity of program exposure was not associated with QOL of PLHIV in this baseline survey see Abstract P5-S6.36 table 1.

Conclusions Illiteracy, male gender, no perceptible source of income, living in a Kuccha house and being widowed, divorced or separated are associated with poor QOL among PLHIV.

Abstract P5-S6.36 Table 1 Factors associated with Quality of life of People living with HIV in Karnataka, India- Quality of life Cohort Study—2010–2011

Factor score as dependant variable	β-Coefficient*	p Value	95% CI
Age			
Age in years	−0.002	0.549	−0.01 to 0.004
Gender			
Female	Reference		
Male	−0.17	0.022	−0.31 to −0.02
Locality			
Urban	Reference		
Rural	−0.05	0.447	−0.19 to 0.09
Exposure to program			
Low	Reference		
High	0.02	0.677	−0.09 to −0.13
Marital status			
Currently married	Reference		
Widowed/Seperated/Divorced	−0.32	<0.0001	−0.45 to −0.19
Never married/Devadasi	−0.26	0.046	−0.51 to −0.01
Literacy			
Illiterate	Reference		
Literate	0.1	0.092	−0.02 to 0.22
Source of Income			
Steady income	Reference		
Irregular income	0.01	0.903	−0.13 to 0.15
No perceptible source of income	−0.2	0.014	−0.36 to −0.04
Type of housing			
Pucca	Reference		
Kuccha	−0.26	<0.0001	−0.38 to −0.14
Constant	0.37	0.01	0.09 to 0.64

*Adjusted for all other factors in the table.

P5-S6.37 A COMMUNITY LED DECENTRALISED AND INTEGRATED APPROACH FOR PERSONALISED PREVENTION AND CARE SERVICES TO PLHIV IN KARNATAKA, SOUTH INDIA

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Background Care and support for People living with HIV (PLHIV) is often limited to institutional settings with considerable time lag between diagnoses and access to care, and poor linkages with other social support services. The USAID supported Samastha project aimed to address the gaps through an innovative approach.

Method Drop-in centres (DIC) were set up within the PLHIV networks as a hub of decentralised care and support. They offered psychosocial, outpatient medical care, positive prevention and nutritional services. To increase accessibility to general medical care, outreach clinics were clubbed with support group meetings and held in local government hospitals. The linkages to treatment, testing, screening for TB and institutional care were strengthened through referral systems, including accompaniment by outreach workers and coordination meetings at district level. All outreach workers were trained on government sponsored social entitlements and schemes for PLHIV and methods of assessing and addressing these needs.

Results By the fourth year of the project, 45 009 PLHIVs (53% female) had availed services of which 52% received clinical care, 99% of clinical visits screened for TB and 4% of PLHIV were treated for TB. 51% received positive prevention services, including treatment adherence counselling while 39% received treatment for minor OI and general ailments. 85% are registered at ART center and 44% are on ART. 91% were provided with psychosocial support, 81% received nutritional support and 51% attended support group meetings. Nutrition and livelihood support were leveraged from other sources.

Lessons Learned The Drop-in centre run by people living with HIV makes a continuum of care possible. In resource poor settings, DICs helps in early enrolment of PLHIVs into care, thereby resulting in timely initiation of treatment for HIV and TB and a qualitative improvement in the life of a PLHIV.

P5-S6.38 NICE GUIDANCE ON PREVENTION OF SEXUALLY TRANSMITTED INFECTIONS AND UNDER 18 CONCEPTIONS; HAS IT INFLUENCED SERVICE PROVIDERS?

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Background National Institute of Health and Clinical Excellence (NICE) Public Health guidance on the prevention of sexually transmitted infections and under 18s conception was produced in 2007 for implementation in sexual health services in England. We undertook to find out what impact these had on Genito-urinary Medicine (GUM) service providers across UK.

Methods In December 2009 lead consultants of UK GUM clinics were identified using the British Association for Sexual Health and HIV website and sent a postal survey as part of a larger study. Responses were analysed using a SPSS database.

Results Of 222 clinics, 152 responses were from UK clinics overall of which 136 were from England. 115 of 148 (78%) from UK clinics answered that they had read the guidelines, 80% (106/132) for England only. For England 39% (54/133) of respondents were aware of a local lead to implement the guidance of which 9 (16.7%) named the Director of Public Health, 17 (31.5%) GUM physician with a variety of other healthcare professionals for the remainder. Only 30% had compared current service activity to NICE recommendations and 20% (26/132) were aware of an action plan being developed by local strategic partners to implement the guidance; 8% (10/128) had developed a business plan. Only three clinics had formally audited their clinic practice against the guidelines. In total, only 18 of 131 (13.7%) had implemented the recommendations but 56 (42.6%) had partially or were doing so. The barriers to implementation were cost pressure, cost of staff skills training, lack of time and capacity to implement, lack of leadership.

Conclusion NICE takes an evidence-based approach to guidance development but has no mechanism to review implementation.