

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% ( $\beta = -0.166$ , 95% CI  $-0.31$  to  $-0.02$ ) lower among men compared to women. It is 31.8% ( $\beta = -0.318$ , 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 ( $\beta = -0.20$ , 95% CI  $-0.36$  to  $-0.04$ ) compared to those with steady income. PLHIV who live in Kuccha (house built of temporary material) houses ( $\beta = -0.26$ , 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	$\beta$ -Coefficient*	p Value	95% CI
<b>Age</b>			
Age in years	-0.002	0.549	-0.01 to 0.004
<b>Gender</b>			
Female	Reference		
Male	-0.17	0.022	-0.31 to -0.02
<b>Locality</b>			
Urban	Reference		
Rural	-0.05	0.447	-0.19 to 0.09
<b>Exposure to program</b>			
Low	Reference		
High	0.02	0.677	-0.09 to -0.13
<b>Marital status</b>			
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
<b>Literacy</b>			
Illiterate	Reference		
Literate	0.1	0.092	-0.02 to 0.22
<b>Source of Income</b>			
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
<b>Type of housing</b>			
Pucca	Reference		
Kuccha	-0.26	<0.0001	-0.38 to -0.14
<b>Constant</b>	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.

There are no routine outcome measures to judge the effectiveness of this NICE guidance. The process measures above have demonstrated variable implementation in GUM services in England. With present resources, as one example providing 15–20 min of one-to-one structured discussions based on behavioural change theories is not deliverable. Service commissioners should ensure that services are implementing guidance and using recognised standards for the management of sexually transmitted infections. Prevention of sexually transmitted infections should be targeted, informed by the sexual health profile of local populations with resources identified by commissioners for prevention activities as integral to service delivery.

**P5-S6.39** **INTEGRATING MEDICATION ASSISTED THERAPY WITH BUPRENORPHINE AND OTHER HARM REDUCTION INTERVENTIONS INTO AN URBAN PUBLIC HEALTH DEPARTMENT STD CLINIC IN THE SOUTHWESTERN USA**

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**Background** Public Health Department STD clinics often serve high risk populations that have limited access to treatment of opiate addiction using evidence-based medication assisted therapies (buprenorphine and methadone) and to other clinical preventive services. In Albuquerque, New Mexico, in the southwestern US, an urban STD clinic has developed an integrated buprenorphine induction program for injecting heroin users that prioritises those recently released from a county jail. Patients are also recruited directly from the STD clinic and from a co-located syringe exchange program.

**Methods** Patients enrolled in the buprenorphine induction program who met specific screening criteria were tested for chlamydia, gonorrhoea, HIV, hepatitis C and syphilis. Patients who completed 2 months of buprenorphine were referred to primary care providers for continuation of treatment.

**Results** In the first 2 years, a total of 291 patients received buprenorphine. 85 clients (29.2%) were referred to the program from public health programs including STD clinic, family planning and harm reduction. 67 (23.0%) were recently released from jail. Of the first 191 patients, 55 (28%) completed 2 months of buprenorphine treatment. 1 of 160 clients screened for syphilis were positive. 68 of 131 (51.9%) screened for hepatitis C were positive. 10 of 89 (11.2%) screened for gonorrhoea and chlamydia were positive for one or both infections. 194 were tested for HIV; none were positive.

**Conclusion** An integrated STD clinic and opiate addiction treatment program can provide comprehensive services to a high risk population.

## Health services and policy poster session 7: screening

**P5-S7.01** **EXPLORING THE ACCEPTABILITY OF MEDICAL, EDUCATIONAL AND SPORT SETTINGS FOR STI SCREENING: STRATIFIED RANDOM PROBABILITY SURVEY OF YOUNG MEN IN THE UK**

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**Background** UK prevalence of STIs in young people is rising. Although a similar number of infections are diagnosed in men and

women, men account for only 20% of National Chlamydia Screening Program tests. New strategies are required to increase uptake of STI screening in young men.

**Methods** Stratified random probability survey of men (18–35 years) using computer-assisted personal- and self-interviews, including use of healthcare; sporting activity; acceptability of accessing urine/oral fluid self-taken tests for STIs and HIV in a variety of healthcare and non-healthcare settings.

**Results** Data were collected from 411 (632 weighted) men median age 28 y; 39% aged <25 y. 29% and 20% of men had previously tested for STIs and HIV, respectively. Two-thirds of men <25 y had tested in the last year vs one-fifth of men >25 y ( $p < 0.0001$ ). 75% of men had seen their Family Physician within the last year. 91% of men would be willing to self-test for STI/ HIV. Primary Care settings (80%), sexual health clinics (67%) and pharmacies (65%) were the most acceptable test kit pick-up points. Further education settings were more popular than school settings as pick-up points (42% vs 28%) and the workplace was acceptable to 22% of men. Of the 391 (69%) men who reported playing sport in the last 4 weeks 18% found a sports club/centre acceptable. Among the 37% men who reported playing the most popular sport (soccer), 47% and 43% said they would be willing to pick-up STI and HIV test kits, respectively, from their club. This did not vary by whether they had previously tested for STI/ HIV.

**Conclusions** Almost one-third of men under 25 have already tested for STI/ HIV. Most men have seen their Family Physician in the last year, which challenges the assumption that young men infrequently attend primary care. Primary care is a highly acceptable setting for STI/ HIV screening. Non-traditional settings such as soccer clubs are acceptable to some men but further research is needed to better understand the barriers and opportunities with this approach to testing.

**P5-S7.02** **TRENDS IN SCREENING FEMALES FOR CHLAMYDIA IN JUVENILE DETENTION CENTERS US 2005–2009**

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**Background** CDC began development of Performance Measures in 1999 and 58 Project Areas have continuously reported on the measures twice yearly since 2005. Two Performance Measures from Juvenile Detention Centers (screening in 2004 and positivity in 2009) were developed to capture the burden of chlamydia infection in this underserved population of adolescent females.

**Objectives** To assess changes in performance of screening of females in juvenile detention centers (JDC's) from the US as reported through Performance Measures and to obtain a measure of the positivity detected.

**Methods** 50 US States, six US cities, Washington, DC and Puerto Rico are asked to report the percentage of females screened for chlamydia twice yearly from all juvenile detention centers that admit 500 or more adolescent females annually. Project Areas with no facilities that admit 500 or more are to report on one or more facilities of their choice. A chlamydia positivity measure was added in 2009. We collapsed the 2 half-yearly reports for each Project Area into yearly summaries from 2005 to 2009.

**Results** The percentage of Project Areas that were able to report any chlamydia screening from their JDC's increased from 60% in 2005 to 84% in 2009. The mean percentage of Project Areas reporting any screening over the 5 years was 80%. Many Project Areas reported from multiple JDC's during 2005–2009 with California reporting from 12 facilities and Ohio reporting from 11 facilities. The reported percentage of juvenile females screened by year were 54, 63, 59, 60 and 51% from 2005 to 2009. The percentage screened ranged from