

P2.147 COMMUNITY ENGAGEMENT, THE BEST ANTIRETROVIRAL

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Background As antiretroviral treatment continues to expand, ensuring patient retention over time is an increasingly important concern. This, together with capacity and human resource constraints, has led to the consideration of community drug distribution point (CDDP) model for the delivery of antiretroviral therapy (ART). In 2008, TASO Rukungiri launched a community model of ART distribution and adherence monitoring by community groups in Rukungiri district.

Description Patients who are stable on ART for 3 months are informed about the community ART group model and invited to join the groups. Group members have 4 key functions: facilitate monthly ART distribution to other group members in the community, provide adherence and social support, monitor outcomes, and ensure each group member undergoes a clinical consultation at least once every 6 months. Group members visit the centre on a rotational basis, such that each group member has contact with the service centre every 6 months. Drugs are given on two monthly bases. At every six month visit at the service centre every client is done the following tests: CD₄ count, h b levels, viral load, Lfts and Rfts.

Results Between February 2009 and May 2011, 3000 members were enrolled into 69 groups. Median follow-up time within a group was 12.9 months (IQR 8.5–14.1). During this time, 180 (6%) were transferred out, 2820 patients still in community groups, 2749 (97.5%) were remaining in care, 56 (2%) had died, and 6 (0.2%) were lost to follow-up.

Lessons learnt: Decongestion at the service centre, easy access, monitoring, adherence and quality service, finally proper documentation.

Conclusion The Community ART Group model was initiated by TASO to improve access, patient retention, and decongest centre services. Early outcomes are highly satisfactory in terms of mortality and retention in care, lending support to such out-of-clinic approaches.

P2.148 UPTAKE AND EVALUATION OF AN ELECTRONIC LEARNING TOOL FOR SEXUALLY TRANSMITTED INFECTIONS AND HIV

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Background An elearning tool: eHIV-STI was developed by the British Association for Sexual Health and HIV (BASHH), the Royal Colleges of Physicians (RCP) and e-Learning for Healthcare. The first sessions went live in February 2010 and the project was completed in December 2011 with 141 sessions. eHIV-STI covers the knowledge component of the UK Genitourinary Medicine (GUM) training curriculum, from introductory to advanced STI and HIV knowledge required for practise as a specialist. It also acts a refresher for established consultants and has been approved by the RCP for external CPD, supporting revalidation. It is available free to all clinical staff in the NHS.

Introductory sessions have been embedded in STI training for non specialists, and for GUM trainees, since 2012, sessions are used to complement national specialist courses, delivering some knowledge in advance by allowing the face to face sessions to deal with more complex issues.

Methods Using reports generated within the learning management system we undertook detailed analysis of usage of the tool since its introduction, by clinician type, sessions accessed, and evaluation of sessions, as well as collating more specific feedback from trainees using it as an adjunct to training courses.

Results The number of registered users has risen steadily since 2010 to 10217 individual users accessing sessions 104857 times by the end of 2012. The majority of GUM trainees and consultants are registered users, but additionally it is used extensively across the health service including 2341 nurses, 1122 newly qualified doctors and 1259 general practitioners.

Evaluation of the material ranges from 4.3 to 4.6 out of 5 for content, presentation, interactivity, and self assessment.

Conclusion eHIV-STI has rapidly become a very well used and evaluated learning tool for clinicians working in the fields of sexual health and HIV and in allied areas.

P2.149 ELECTRONIC MEDICAL RECORDS ARE PREFERRED BY CLINICIANS AND ASSOCIATED WITH IMPROVED PATIENT FLOW AT A LARGE URBAN SEXUAL HEALTH CENTRE

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Background Electronic Medical Record (EMR) functions include electronic ordering of investigations and receiving results, electronic prescribing, recording of clinical information and decision support software. Despite substantial investment in EMR systems, there has been little research to evaluate them. Our aim was to evaluate changes in efficiency and quality of services after the introduction of a purpose built EMR system, and to assess its acceptability by the doctors, nurses and patients using it.

Methods We compared the number of patients seen per hour within nine month periods before and after the introduction of an EMR system in a large sexual health service, in Melbourne Australia. A sample of records from both EMR and Paper Medical Record (PMR) periods were audited by two physicians to evaluate quality and completeness of records. Staff and patients completed anonymous surveys about their satisfaction and experience with the EMR system.

Results There were 9,752 doctor consultations (in 5,512 consulting hours) in the PMR period and 9,145 doctor consultations (in 5,176 consulting hours) in the EMR period eligible for inclusion in the analysis. There were 5% more consultations per hour seen by doctors in the EMR period compared to the PMR period (rate ratio = 1.05; 95% confidence interval (CI); 1.02–1.08) after adjusting for type of consultation. The qualitative evaluation of 300 records for each period showed no difference in quality or completeness ($P > 0.17$). The survey of clinicians demonstrated that doctors and nurses preferred the EMR system ($P < 0.01$) and the patient survey in each period showed no difference in satisfaction of their care (97% for PMR, 95% for EMR, $P = 0.61$).

Conclusion The introduction of an integrated EMR improved efficiency while maintaining the quality of the patient record. The EMR was popular with staff and was not associated with a decline in patient satisfaction in clinical care provided.

P2.150 PATTERNS OF STI CLINIC UTILIZATION AMONG NON-MIGRANT AND MIGRANT FEMALE SEX WORKERS IN KARNATAKA, INDIA

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Background Efforts to provide screening or treatment of sexually transmitted infections (STIs) among female sex workers (FSWs) require adequate access and uptake of STI-specific health services; this is especially relevant for female sex workers who migrate for work. We examined the patterns of STI clinic use among non-migrant and migrant FSWs in Karnataka, India.

Methods We used baseline data on 728 non-migrant and 833 migrant FSWs enrolled in a cohort study of FSWs in Karnataka in 2008. The pattern of local (defined as the FSW's place of origin) and destination STI clinic utilisation by migration status of FSWs was examined using univariate and multivariate logistic regression.

Results Overall, 77.9% and 64.5% of non-migrant and migrant FSWs had ever attended a local STI clinic ($p < 0.001$). Irrespective of migration status, local sex work was associated with local STI clinic attendance (AOR, 2.9; 95% CI: 2.3–3.7), and did not vary by other characteristics of sex work. Local clinic attendance was also higher among FSWs who demonstrated awareness of local HIV/STI prevention programmes (AOR 4.7; 95% CI: 3.3–6.5). Only 33.0% of migrant FSWs who engaged in local sex work had attended an STI clinic in their destination city, compared to 63.8% of migrant FSWs who did not participate in local sex work ($p < 0.001$). However multivariate analysis indicated that the association between local sex work and a destination clinic visit was mediated by a lack of awareness of prevention programmes at destination and shorter (< 1 month) destination visits. Local clinic attendance remained independently associated with destination clinic visits (AOR 2.8; 95% CI: 1.8–4.2).

Conclusion Although local STI clinic attendance by FSWs is high, destination clinic visits among migrant FSWs remains low in the presence of local sex work. The findings call for linkages between local and destination HIV/STI prevention programmes to optimise STI-service delivery to migrant FSWs.

P2.151 IMPROVING HAART ENROLLMENT IN ELIGIBLE HIV PATIENTS IN RURAL HAITI

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Background In La Colline Health Care Centre, a resource-poor setting in rural Haiti, the HIV/TB department was faced with low performance in HAART enrollment for eligible HIV patients. HIVQUAL (HIV-Quality) reports generated by our EMR (electronic Medical Record) showed 51.2% ART enrollment for the Oct 2011-March 2012 semester, which further dropped to 33% by May 2012; meaning that 67% of patients who needed treatment during that period, did not receive it. A 5-months Quality Improvement project was initiated, from May to September 2012 to find solutions to that problem.

Methods Quality Improvement methods and tools were used to hasten HAART initiation in eligible HIV patients. The project team used the Ishikawa diagram to evaluate the problem and was able to divide the possible causes into 4 groups: those related to people, to environment, to equipment and to procedures. Using Plan-Do-Study-Act cycles, we considered and tested five interventions. Two of them resulted in most of the improvement: Patient tracking by the community team and obtaining CD4 exam results the same day. Our goal was to reach 80% HAART enrollment within 6 months.

Results Periodic monitoring of the HAART enrollment indicator via EMR's HIVQUAL report, revealed a progressive improvement in the proportion of eligible HIV patients initiated on HAART; going from 33% to 43.9%, 63.85% and 84.6%, after respectively the second, third and fourth interventions. The project ended in September 2012, with 90.2% of eligible HIV patients, receiving HAART.

Conclusion The staff responded positively to the initiative and the changes. The best impact is for the patients who now can benefit from early access to antiretroviral treatment, thus, avoiding

some complications of the disease, which can be fatal. This activity contributed to achieving better health care for our HIV patients and a stronger HIV management system.

P2.152 GIVING PATIENTS WHAT THEY WANT: DISCLOSURE ADVICE FOR SEXUALLY TRANSMITTED INFECTIONS AND INFORMATION ON LEGAL REDRESS FOLLOWING INFECTION

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Background A recent UK prison sentence for transmission of genital herpes simplex virus (HSV) type 2 has caused STI clinics to reassess patient advice on disclosure. Crown Prosecution Service (CPS) guidance, applicable to England and Wales, determines how STI transmission allegations should be handled, including the defensive value of disclosure. Aim: Does advice reflecting CPS guidance alter intended disclosure of STIs and do patients wish to receive this?

Methods Questionnaire study of patients attending a level 3 English STI clinic assessing intended disclosure of STIs and actual disclosure (those with a chronic STI other than HIV) before and after reading CPS guidance on the protective value of disclosure. Likelihood of patients considering legal redress if infected, and whether they wished to receive information on this in STI clinic was reviewed.

Results Of 307 patients the majority intended to disclose an STI diagnosis to regular and casual partners, with generally no significant increase in intended disclosure after disclosure advice. Patients with warts were significantly less likely to disclose to casual than regular partners prior to disclosure advice ($p = 0.0138$), but this difference disappeared after advice. Excluding patients with HSV disclosing to regular partners, intended disclosure was greater than actual disclosure, which was significant in patients with warts ($p = 0.0007$). 49% patients would consider legal redress if infected with a chronic STI and 66% patients would like to receive information on this in GUM clinic.

Conclusion The study demonstrates that most patients intended to disclose an STI to partners, but that in those with a chronic STI, actual disclosure was lower than this. Advice on the protective value of disclosure did alter disclosure intentions for those with some chronic viral diseases. UK STI clinics should consider raising the issue of the law in relation to the transmission of STIs to reflect patient demand.

P2.153 DELAY OF ENTRY INTO CARE IN HIV POSITIVE INDIVIDUALS

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Background Delay between HIV diagnosis and entry into care may have a negative impact on the individual prognosis and may enable further transmission. Insight into duration and determinants of care-delay is important for public health aimed at reducing ongoing HIV transmission.

Methods Prospective data were collected regionally from consenting patients testing HIV positive at the STI clinics in Amsterdam and Rotterdam, from February 2009-December 2011. Logistic regression analyses were performed to assess risk factors for care delay. Delay of entry into care is defined as a time period of 4 weeks or more between confirmed HIV diagnosis and first consultation at the HIV treatment centre.