

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.