3. Accelerated Partner Therapy (APT Pharmacy): nurse initiated PN at the general practise followed by assessment of sex partner by trained community pharmacist;
4. Patient referral, where patients are advised by phone by qualified health adviser on the need for partner to be tested and treated.
5. Provider referral, where patients accept the offer of a specialist health adviser contacting one or more partner(s) by phone.

For all pathways primary costs were collected prospectively in a specific exploratory study.

Results The least costly strategy is nurse led PN (strategy 2) costing approximately £53 per index case (2011 costs). The most costly strategy is provider referral (strategy 6) which cost £96 per index case.

Conclusion Where health service providers assume responsibility for contacting partners there will be substantial additional cost. Before any such policy is implemented, a demonstrable improvement in PN outcomes should be established.

P6.061 DEVELOPMENT OF A VALIDATED QUESTIONNAIRE FOR HIV ATTENDEES

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Background Patients are becoming more actively involved in decisions about their care and have greater influence to change and improve the quality of services by reporting their experiences. Within HIV services, positive experiences increase engagement with services and have been linked to higher levels of treatment adherence. A previous systematic review assessing satisfaction with care failed to locate a gold standard method of measuring satisfaction in this setting.

Aim to design a specific HIV patient satisfaction questionnaire

Methods Four work streams were employed to develop and test a new questionnaire. Firstly, key themes identified in the systematic review were used as a topic guide for focus group discussion to assess their relevance and importance. Four focus groups comprising 32 participants were conducted and revealed the importance of physician knowledge and expertise; dignity, autonomy and respect; and good communication. The second stream involved interviews with ten patients, exploring their motivation to complete a questionnaire. Thirdly, data from the focus groups and interviews were used to develop an initial questionnaire which was cognitively tested on a further ten patients, this provided face validity for the questionnaire design, layout and wording. The final stream employed a pilot study of the questionnaire with 80 clinic attendees.

Results The pilot survey demonstrated that there was a high completion rate. Two questions were modified and additional routing instructions were added. Pairwise correlations reflected the thematic structure of the questionnaire and supported good criterion validity.

Conclusions The combination of a systematic analysis of previous patient survey tools, focus group discussions and cognitive testing of the questionnaire was used to ensure high content validity. The questionnaire was found to be acceptable to patients and a high completion rate was attained without the use of a financial incentive.

P6.062 QUALIAIDS: QUALITY OF AMBULATORY HEALTH SERVICES WHO ATTEND PEOPLE LIVING WITH HIV/AIDS IN BRAZIL

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Background Between 2007 and 2012, there was an increase of 14% of Specialized Care Services for people living with HIV/AIDS (PLHIV), totaling 724. A decade ago the Qualiaids evaluates the quality of outpatient care in public services in Brazil. The aim of this study is to describe the dimensions of this evaluation method, the highlights of care services and its importance in monitoring the quality of care for PLHIV.

Methods Were made three national applications: one manual and two online through a questionnaire completed by the services. Each question has a score, and there were grouped under three components: availability of services inputs, organisation of care delivery and managerial aspects. To rank the services Were used the average obtained in the questions and then were grouped by technique of K-mean. The analysis resulted in the layering of five groups in decreasing levels of quality. The online tool also released a set of recommendations for good practises in order to elucidate the quality criteria that support the score of each question.

Results Qualiaids covered 80% of the services in 2007 and 90% in 2010. Increased the overall average and the three dimensions of quality, with statistical significance for most of them. The size of management remains the dimension with the lowest quality rating. The great majority of responses to the questionnaire QUALIAIDS was maintained in similar frequencies (variations less than 10%) among the respondents of the two sets of ratings.

Conclusion From the self assessment were planned the feedback workshops to improving the quality to knowing the difficulties and systematise the priorities for the development of an action plan customised for each service. This process favoured the implementation of agreements and pacts that allowed monitoring of quality indicators and subsidised practises to improve the quality of care services.

P6.063 VERTICAL TRANSMISSION OF HIV BY AGE OF INFANT TESTING AND TYPE OF MOTHER/INFANT PROPHYLAXIS IN TIGRAY, ETHIOPIA

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Background Following a number of other African countries, Ethiopia has recently adopted option B+ as the national PMTCT standard. Option B+ puts all HIV-positive pregnant women on HAART for life, regardless of the CD4 count. This study examines whether HAART for maternal prophylaxis resulted in lower vertical HIV transmission in Tigray.

Methods We used data from Tigray's regional DBS data base to calculate HIV infection rates by PMTCT regimen in all HIV-exposed infants (HEIs) tested by December 2012. We calculated the relative risk (RR) of having a HIV+ baby by age of testing and the mother's PMTCT regimen.

Results There was a significant difference in HIV rates between babies tested at 0–2 months (4%) and 2–8 months (9%) (RR = 0.43, CI = 0.28.0.65; p = 0.0001). HIV infection was significantly higher in babies tested past 8 months (16%) (respectively, RR = 0.23, CI = 0.14.0.38; p < 0.0001 and RR = 0.55, CI = 0.36.0.86; p = 0.005). Maternal prophylaxis was a significant factor with a further significant difference between HAART (2%) and dual prophylaxis (14%) (RR = 0.37; CI = 0.19.0.74; p = 0.006).

Conclusions This study underscores the importance of putting HIV-positive pregnant mothers on PMTCT, especially HAART, and promoting institutional delivery and early infant testing. HAART was the most effective PMTCT regimen, regardless of the infant's regimen. This finding is particularly important in Ethiopia where most women give birth at home and may not be able to give the right medication to their baby at the right time. This data strongly

supports the validity of option B+ as the national PMTCT standard in Ethiopia.

P6.064 INTEGRATING SIMULTANEOUS TRIPLE POINT-OF-CARE SCREENING FOR SYPHILIS, HEPATITIS B AND HIV IN ANTENATAL SERVICES THROUGH RURAL OUTREACH TEAMS IN GUATEMALA

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Background In May 2012, a simultaneous triple point-of-care screening programme for syphilis, hepatitis B (HBV) and HIV was integrated in antenatal services in rural Guatemala. The programme included screening for pregnant women with mobile outreach teams, promotion through community networks, partner notification, and linkage to care. Our aim was to evaluate its feasibility and effectiveness in increasing testing uptake, case detection and referrals for positive cases.
Methods A network of over 200 midwives and community volunteers promoted testing and recruited pregnant women through community IEC campaigns. Nurses from three mobile outreach teams, two health posts, and the district health centre offered counselling and triple screening by fingerprick. Syphilis cases were treated on-site. HIV and HBV were referred with accompaniment to the tertiary hospital for care and prevention of mother to child transmission. Testing uptake was compared with the 8-month period prior to implementation of the programme.
Results In 8 months, 978 women sought prenatal services; 65% were screened for HIV and syphilis and 62% for HBV. Testing uptake increased 209%/30% from baseline for HIV/syphilis ($p < 0.001$). 29% were screened during the first trimester. Six cases of syphilis were detected and treated (0.95%); two cases of HIV (0.32%) were detected and initiated prophylaxis/treatment; and 0 cases of HBV. All of these cases were identified by the rural outreach teams or health posts. Seven women notified their partners (5 for syphilis, 2 for HIV) yet only 1 partner was tested, resulting positive. Three children were born with suspected congenital syphilis and all three died.
Conclusions This outreach programme shows the feasibility of simultaneous screening for three infections in rural Guatemala and its effectiveness in increasing screening coverage, case detection, and access to treatment services. Further efforts should work to improve earlier detection, results of partner notification, and adverse outcomes due to congenital syphilis.

P6.065 SEXUAL HEALTH IN GERMANY - USING INDICATORS AS AN INSTRUMENT TO DESCRIBE, PLAN AND EVALUATE. A CATALOGUE OF INDICATORS OF THE GERMAN STI SOCIETY

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Background Sexual health is an integral part of the personal well-being of human beings, as defined by the WHO. Thus, instruments to measure the respective needs, to design appropriate and effective interventions, and to evaluate their impact and success are of high importance. These tools should be adopted on a local, regional and national level. There have been no such instruments available to specify the situation of sexual health in Germany to date. The "Sexual Health" section of the German STI Society has now adopted a set of indicators in order to depict the sexual health status of people in Germany, as well as to plan and evaluate activities for the improvement of sexual health as a whole.
Methods Basis for defining indicators consisted of draught submittals of WHO and EU. All indicators described were considered as to their explanatory power and applicability for the specific German situation in terms of political structures, medical care, and epidemiology, and were partly adopted, revised or complemented by new indicators. Every indicator was operationalised in terms of appropriate variables, type of documentation, administration level, data source, availability, and assessed by its specific importance.
Results 39 indicators on policy and social determinants, 28 on access (availability, information, demand, and quality), 24 on the use of services, and 33 outcome/impact indicators were defined. To allow for flexibility, these categories were grouped by the following subdivisions: general, family planning, maternal and prenatal health, STI/RTI/reproductive morbidities, promotion of sexual health, adolescent sexual education and health, and sexual violence.
Conclusion A logical, convincingly conclusive and yet manageable list of indicators for Germany has been compiled. The selected indicators display the German situation and are at the same time highly comparable internationally. Potential users of the document are health experts, policy developers, researchers and other health care professionals.

P6.066 WHERE ARE WE NOW AND WHERE ARE WE GOING?: A META-ANALYSIS OF 10 YEARS OF SEXUAL HEALTH SERVICE INTEGRATION IN GLASGOW, SCOTLAND, UK

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Background In 2000, family planning and reproductive health, genitourinary medicine, and women's health converged to form integrated sexual health services in Glasgow and Clyde, Scotland - the first large-scale UK example. The service now supports 100, 000 people annually via 250 multi-skilled staff in 20 sites across a large post-industrial area with major deprivation, and 1+ million population. Its services include contraception, termination, HIV and STI testing, young people's and gay men's services, counselling and a public library. After ten years, the service commissioned three external evaluations to assess success and potential developments. This paper describes a meta-analysis of these.
Methods The evaluations used qualitative and quantitative methods including reviewing activity; undertaking staff surveys, user engagement, stakeholder interviews, population research and feedback from doctors and health professionals. The meta-analysis systematically reviewed the evaluations to triangulate main themes, patterns and disconnects.
Results The meta-analysis revealed significant themes. For example, only 5% of local young people knew the service at its start and 61% a decade later, whereas people in their 40s did not think it relevant. Strategically, the service was felt to have developed an innovative resource for professionals and policy-makers and to be leading sexual health developments and training nationally, but not engaging with local health care enough.
Conclusion The meta-analysis reveals a service that has demystified sexual health care and influenced nationally and more widely. The paper concludes with recommendations that the service should remain integrated, with inequalities-sensitive practise central, and continue inclusive approaches to staff involvement. The service should better utilise social media; engage more with other health staff; better understand older people's motivations to use services; focus more on men, especially young men, and young people from