

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.