include programme management and outreach activity costs. Incremental cost-effectiveness analysis allows us to identify the most cost-effective NGO/CBO model for STI service delivery.

Results Most of the NGO/CBOs served more than 2,000 HRIs. However, when standardised to reflect a population of 1,000 HRIs, the programme operated clinic with outreach model was able to deliver STI control services at a lower cost per STI consultation, than alternative models. Incremental cost-effectiveness analysis of alternative STI service models with regards to coverage of STI screening & syphilis testing, show this model to be the most cost-effective model.

Conclusions For larger NGO/CBOs, use of outreach is critical to obtain operational efficiencies. Program operated clinics with outreach were found to be the most cost-effective model, probably due to increased access to scattered high-risk populations through effective outreach activities and continuity of care.

Results As results were compared to the original WHO indicators for EWI 1 (percentage of ART prescribing practices with appropriate first-line regimen) at the studied site were 91% and 95%, for 2009 and 2010 respectively, WHO recommends 100% for this indicator. EWI 2 (patients lost of follow-up 12 months after ART initiation): 30% (2009) and 36% (2010) (WHO = less than 20%). EWI 3 (patients on appropriate first-line regimen 12 months after ART initiation): 40% (2009) and 49% (2010); (WHO = up to 70%). About 75% picked up ART drugs on time (EWI 4), instead WHO recommends up to 90%. EWI 5 (patients with viral load suppression after 12 months of ART): 31% for 2009, and 30% (2010); WHO recommends up to 70%.

Conclusions EWI were implemented in other Latin America countries to determine a valid tool compared to viral load. Brazil does not have yet a national monitoring system to monitor sites. This one, located at an HIV late diagnosis area showed deficit in maintenance in care. The managers need to improve monitoring adherence and prevent HIV resistance by therapeutic failure, since there was not any local indicator which achieved WHO recommendations.
Background We implemented a facility-based intervention aimed at reducing the proportion of patients lost to follow-up at an outpatient HIV clinic in Jinja district, Eastern Uganda, over a period of 6 months (February-July 2012).

Methods The intervention was implemented with the aim of decreasing the proportion of patients lost to follow-up from 1% (23/2328) at baseline to 0.25% by July 2012. Simple and innovative strategies were introduced into the HIV clinic. These included retraining of clinic staffs on the importance of patients keeping their appointments; development of new messages on keeping appointments; retrieving patient files a day before the day of appointment; sending two text messages reminders a day to the clinic; and actively following up patients who had not kept their appointments through home-visiting. At each follow-up visit, reasons for the patients’ failure to keep appointment were noted and information on age, gender, CD4 count (captured from patient records) and duration in HIV care was obtained. Data were fed into an IQ Care programme and analysed using Microsoft Excel.

Results The proportion of patients lost to follow-up decreased from 1% (23/2328) at baseline to 0.4% (9/2528) in 6 months. Men, those with a CD4 > 350, those aged < 30 years and those in care for < 1 year had the biggest decline in proportion of patients lost to follow-up compared to other patients.

Conclusion The proportion of patients lost to follow-up declined by 60% through use of simple and innovative strategies introduced in the HIV clinic.

**P6.059** UNIVERSAL HIV SCREENING OF INMATES IN ISRAELI PRISONS: SHOULD THE POLICY BE UPDATED?


Z Mor, H Vider, G Grotto, D Tischler Auerkin. Ministry of Health, Ramla, Israel; 2Israel prison Services, Ramla, Israel; 3Ministry of Health, Jerusalem, Israel; 4Ben Gurion University, Beer Sheva, Israel; 5Israel Prison Services, Ramla, Israel

Background HIV rates among inmates are mostly higher than the general population. Israel is a relative low-HIV prevalence country (107:100,000 population, 2011 data). All criminal inmates incarcerated in prisons/gaols at the Israeli Prison Services (IPS) are routinely screened on arrival to IP and at the time of release. Cellmates of HIV-infected inmates are not screened. The current policy of universal HIV-testing policy.

Methods We reviewed all inmates diagnosed with HIV/AIDS upon incarceration in Israel between 2003 and 2010, and assessed their risk-behaviours and the date of diagnosis.

Results During the 8 years follow-up, 108,866 new criminal inmates were incarcerated in 31 correctional facilities, and it is estimated that 95% of those were tested for HIV. Of those, 201 (0.2%) were tested positively with HIV, in a direct testing cost of 622,000 (US$).

Of all 201 HIV-infected inmates, 118 (58.7%) were intra-venous drug-users (IVDU), 55 (27.4%) originated in high-prevalence countries, 15 (6.5%) were men who have sex with men (MSM), 12 (6.0%) were heterosexuals not originating in endemic country, 2 (0.1%) the risk-group was undetermined and one (0.5%) was infected vertically.

Of all 201 HIV-infected inmates, 157 (78.2%) were diagnosed in the community, prior to their imprisonment, and were re-tested in prison; while 44 (21.8%) were firstly diagnosed in prison. Of those 44 inmates, 25 (56.8%) were IVDU, 13 (29.5%) originated in endemic country, three (9.1%) were MSM and in two (4.5%) the risk-group was not determined.

Conclusion HIV-infection rate is twice higher than the general population. The majority (98.5%) of all inmates was diagnosed prior to their incarceration or had a key risk-behaviour exposureing them to HIV. Therefore, questioning each new inmate upon incarceration about previous HIV-diagnosis, and targeted testing for other inmates who are IVDU, MSM or originating in endemic countries for HIV can detect almost all HIV-infected prisoners, presuming they respond reliably.

**P6.060** PATIENT OR PROVIDER REFERRAL FOR CHLAMYDIA - WHAT IS THE COST AND IS IT WORTH IT? A COST COMPARISON OF ALTERNATIVE STRATEGIES


T Roberts, H Mistry, M Rossello-Roig, G Rait, J Dadds, S Lanza, C S Escourt, M Symonds, E A Cassell. University of Birmingham, Birmingham, UK; 2University of Warwick, Coventry, UK; 3University College London, London, UK; 4Queen Mary, University of London, London, UK; 5Brighton and Sussex Medical School, Brighton, UK; 6Barts Health NHS Trust, London, UK

Background Partner notification (PN) is an essential element of STI control. Typically partner notification has been supported by specialist health advisors based in GUM clinics, but recently the role has been extended to community based Chlamydia screening officers (including primary care). We aimed to explore and compare costs of various approaches to EN for Chlamydia in different settings.

Methods We compared costs of being offered one of five approaches to partner notification from the health service perspective:

1. Routine specialist clinic PN (patient referral including infection specific information, and advice that the sex partner should attend clinic for testing and treatment)

2. Accelerated Partner Therapy (APT Hotline): nurse initiated PN at the general practice followed by telephone assessment of sex partner by clinic-based nurse qualified health adviser;