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 message 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% (9/2328) 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 VERTICAL TRANSMISSION OF HIV LESS THAN HALF AMONG MOTHERS BELONGING TO MOTHER-SUPPORT GROUPS (MSG) COMPARED TO NON-MEMBER MOTHERS AT HEALTH CENTRES IN TIGRAY, ETHIOPIA

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Background Mother-support groups (MSGs) are used at hospitals and health centres in Ethiopia to increase uptake of and adherence to PMTCT and reduce vertical transmission of HIV. A study at Dessie Referral Hospital showed that mothers belonging to MSGs had lower vertical transmission rates. The impact on mothers seen at health centres is not known.

Methods Data on the outcome of MSGs and vertical transmission were collected from 15 health centres in Tigray between 2008 and 2011. Data sources included MSG registration log books, regional laboratory DNA/PCR results, and the ART enrollment register. We compared HIV status among babies born to mothers belonging to MSG and those whose mothers did not participate in MSG.

Results A total of 848 HIV-exposed infants (HEIs) were registered between 2008 and 2011. Among 240 HEIs born to mothers enrolled in MSG, 87.5% were tested for HIV and 5.2% were HIV-positive. Among the 608 HEIs whose mothers were not enrolled in MSGs, 44.7% were tested and 11.4% tested HIV-positive (OR = 0.43).

Conclusions The odds of testing positive were 57% lower among HEIs whose mother was enrolled in an MSG compared to those whose mother was not enrolled. The better outcome appears to be due to the support their mothers received from MSGs resulting in better PMTCT and adherence practices as well as high rates of institutional delivery. We are currently collecting more data on PMTCT regimen, HEI testing by age and place of delivery to verify this hypothesis.

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


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 practise followed by telephone assessment of sex partner by clinic-based nurse qualified health adviser;
3. Routine primary care PN: nurse initiated PN of partners was offered to patients and returned completed forms to the clinic.
4. Community messages: the clinic published messages in the local community.
5. Climate PN: a clinic based PN approach with health worker retraining and clinic strategies introduced.

RESULTS

Costs ranged from £23.40 to £154.80.

Conclusions The total cost and the preferred approach has not been resolved and all five approaches should be explored in the light of local and patient preference.

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