England, we are concerned about compromised access to contraception and a consequent rise in unplanned pregnancy/abortion rates.
Aim To explore our service users' preferences and experiences of accessing contraception.
Methods Between January and February 2016, an anonymised questionnaire was offered to all patients requesting contraception from four integrated GUM clinics.
Results 329 patients (median age 20–30 years) returned their questionnaire. 52%, 19% and 28% of users attended short-acting contraception, sub-dermal implant or intrauterine device (IUD) appointments respectively. 83% respondents found our service easy/very easy to access. Median LARC waiting time was 1–2 weeks. 33/86 (38%) of non-LARC and 29/109 (27%) of LARC (34% IUD, 21% implant) users experienced problems obtaining contraception elsewhere with 88% citing their GP had no suitable appointment or didn't offer their chosen method. 77% (126/164) of respondents prefer to have their sexual health and contraceptive needs met together, whilst 6% prefer separate settings. Patients prefer obtaining contraception from: GUM (46%); GP(19%); community clinics(16%); private establishments/online(6%); no clear preference(13%). 34% of users would consider accessing LARC privately.
Conclusion Two fifths of patients had difficulty accessing any form of contraception outside of GUM, most appreciate a one-stop shop approach and half prefer GUM to be their contraceptive provider. This survey demonstrates the need to preserve GUM as a contraceptive provider.

P119 THEORY OF CHANGE MODEL FOR CLINIC-BASED PREP PROGRAMME EVALUATION

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Background A national programme to provide Truvada HIV pre-exposure prophylaxis (PrEP) is currently being considered in England. Some men already access PrEP and some sexual health clinics already offer PrEP monitoring.
Aim(s)/objectives We created a Theory of Change (ToC) to define the key components of a clinic-based PrEP programme to reduce HIV incidence. We identified indicators, outputs and outcomes to aid programme evaluation for a large London sexual health clinic.
Methods We used a ToC approach to define necessary pre-conditions, indicators, outputs and outcomes for our PrEP delivery programme.
Results The aim of our PrEP programme is to prevent HIV seroconversion in those at greatest risk. There are three broad areas: 1) identifying those eligible; 2) engaging eligibles to initiate PrEP and other HIV prevention activities; 3) maintaining effective adherence in those at continuing risk while advising therapy cessation for those no longer at risk. We estimate that approximately 1,200 men attending our service annually could be eligible for PrEP. Assuming a high level of uptake, these men would require 1,000 follow-up appointments annually in order to fulfil quality measures of three monthly HIV and STI testing in those on PrEP.
Discussion Using a ToC approach we have defined what a clinic-based PrEP programme might look like against our current service specification to enable us to collect meaningful evaluation data. This ToC might be used by other clinics to evaluate PrEP programmes, and allow comparison across programmes to build understanding of PrEP delivery and enhance new national PrEP surveillance systems.

P120 SELF TAKEN EXTRAGENITAL SAMPLING – WHAT DO WOMEN AND MSM THINK? FEEDBACK FROM A SELF-SWAB AND CLINICIAN SWAB TRIAL

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Background/introduction Extragenital sampling for chlamydia and gonorrhoea is standard practice in MSM and is increasingly important in women. Some UK clinics offer self-swabbing from these sites, but little has been published about its acceptability, particularly in women. We explored this as part of a clinician versus self-swab study.
Methods Women and MSM attending a sexual health clinic were invited to take part in a 'swab yourself' study. Clinician and self-swab samples for chlamydia and gonorrhoea NAATs were taken from the rectum and pharynx. Participants then completed a questionnaire.
Results See table. Response rates were >99% in both women (958/968) and MSM (197/210). MSM were not significantly more likely to feel confident taking their own swabs (83% vs 77%, p = 0.53). Of those who agreed/strongly agreed they 'felt uncomfortable taking their own swabs', sexual naivety of the site was not a common factor (53% of women agreeing stated they had never had anal sex; 70% of men agreeing reported receptive anal sex in the preceding 3 months). Free comments included 'more confidence if had clinician samples taken before', 'concerns if self-swabbing would give accurate results' and concerns about being not able to speak to a healthcare professional with home sampling. 10 women commented specifically on discomfort but only 1/10 disagreed with the statement 'I would feel happy to take my own swabs in a non-clinic environment'.

Abstract P120 Table 1 Extra genital sampling in MSM and women

Survey responses	Women (n = 958)	MSM (n = 197)
Strongly agree/agree "I felt confident taking my own swabs"	77%	83%
Strongly agree/agree "I felt uncomfortable taking my own swabs"	25%	23%
Strongly agree/agree "I would prefer to take my own samples	40%	48%
Strongly agree/agree 'I would prefer a clinician to take my samples"	33%	35%
Strongly agree/agree "I would be happy to take my own swabs in a non-clinic environment"	64%	61%

Discussion/conclusion Extragenital self-swabbing was highly acceptable in both groups, with high levels of confidence and low reports of discomfort. This has positive implications for expanding future use.