Introduction In the UK people of black ethnicity experience a disproportionate burden of HIV and STI. We aimed to assess the association of ethnicity with sexual risk behaviours (SRB) and sexual health among heterosexual men and women.

Methods AURAH is a cross-sectional questionnaire study of people without HIV, recruited in 20 GUM clinics in England 2013–14. We assessed the association of ethnicity with (i) condomless sex with non-regular partner(s) (CLS-NR); (ii) ≥2 new partners in the last year (2NPLY); and (iii) STI diagnosis in the past year (STI) using modified poisson regression adjusted for age, study region, education and relationship status.

Results 1075 heterosexual men (n=451) and women (n=624) completed questionnaires. Ethnicity was as follows: 513 (48.4%) black/mixed African (BA), 159 (15.0%) black/mixed Caribbean (BC), 288 (27.1%) white ethnicity (WE), 101 (9.5%) other ethnicity (OE).

Abstract O32 Table 1 AURAH

Adjusted PR (95%CI)	CLS–NR	2NPLY	STI within last year
Women: White	1	1	1
BA	**0.65(0.49–0.85)**	**0.36(0.27–0.48)**	0.92(0.61–1.38)
BC	0.78(0.55–1.10)	**0.39(0.25–0.61)**	1.47(0.95–2.28)
OE	0.66(0.39–1.13)	**0.60(0.37–0.99)**	1.23(0.68–2.23)
Men: White	1	1	1
BA	1.05(0.83–1.32)	**0.77(0.62–0.96)**	1.14(0.75–1.73)
BC	1.02(0.73–1.44)	0.85(0.62–1.16)	**1.76(1.10–2.82)**
OE	0.69(0.43–1.09)	1.29(1.03–1.61)	0.59(0.24–1.43)

Compared with WE women BA women were less likely to report CLS-NR, BA and BC women were less likely to report 2NPLY, and BC women were more likely to report STI. In men CLS-NR did not vary significantly by ethnicity. BA men were less likely to report 2NPLY and BC men were more likely to report STI compared with WE men.

Discussion The prevalence of SRBs was lower in black ethnicity women, but history of STI was more prevalent among BC women. Similarly, higher STI history in BC men was not consistent with ethnic variation in SRB. Additional factors, e.g. sexual networks, may be important determinants of sexual health.

O33 SIGNIFICANTLY HIGHER RATES OF CHLAMYDIA FOUND IN ARMY PERSONNEL COMPARED WITH NON-MILITARY CLINIC ATTENDEES

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Introduction Our Sexual Health service covers a county-wide population, including large numbers of Army personnel. Despite military personnel being recognised as high risk for sexually-transmitted infections (STIs), accurate data on STI and HIV epidemiology within the military is lacking (1).The latter is compounded by difficulties differentiating military from civilian patients attending Sexual Health clinics. We introduced a local code ('ARMY') from April 2016. This has enabled us to monitor numbers of Army attendees and compare STI rates and risk factors with non-military patients.

Methods Local 'ARMY' code added by clinicians at time of consultation, based on information including: patient self-reported occupation, garrison address, military uniform.

Electronic patient records for all male new or rebook attendees between 15/4/16 and 31/10/16 with an 'ARMY' code were reviewed (n = 234). These were compared with a non-military group of patients (n=234) attending during same time period and were matched for age group, gender, sexuality and presence/absence of symptoms.

Results Army personnel were found to have significantly higher levels of chlamydia positivity (19.2%) compared with non-military attendees (11.1%) (p= 0.020, Fisher's exact 2-tail). This higher rate of chlamydia was found despite comparable numbers of: sexual partners in prior three months, presentations as chlamydia contacts and high-risk alcohol users. Rates of gonorrhoea, warts, HSV, HIV and syphilis did not differ significantly. Army personnel were significantly more likely to be of non- white British ethnicity (11.1%) than non-military attendees (2.1%), reflecting local population (p =0.0001, Fisher's exact 2-tail).

Discussion Our findings support promotion of sexual health screening for military personnel and targeting of chlamydia testing. Military personnel often go home to other areas of UK and overseas during leave and could disseminate infections.

O34 BINGE DRINKING, SMOKING AND EXPERIENCE OF INTIMATE PARTNER VIOLENCE AMONG WOMEN AGED 16–44 YEARS ATTENDING SEXUAL HEALTH CLINICS

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Introduction BASHH guidance includes assessment of smoking history, intimate partner violence and alcohol risk in Sexual Health (SH) clinics. As part of a study assessing psychosocial predictors of sexual risk among women of reproductive age, we investigated the prevalence of these issues and their associations with sexual risk.

Methods A convenience sample of women aged 16–44 years attending a busy urban integrated Contraception and Sexual Health clinic was invited to complete a questionnaire about socio-demographic, sexual behaviour and psychosocial factors.

Results Of n=532 eligible women 44.5% were aged 16–24 years. 42.1% of participants reported binge-drinking (6+ units on one occasion) on a weekly basis. 36.7% reported currently smoking cigarettes or roll-ups. Using an adapted HITS domestic violence (DV) measure, 16.1% were classified as currently or previously experiencing DV. None of these factors was associated with reported risk of unintended pregnancy in the last 6 months. Multiple partnerships in the last year was not associated with DV experience (p=0.187) but remained positively associated, after adjustment for age, with current weekly binge-drinking (adjusted odds ratio = 2.13) and with current smoking (AOR =1.87).

Discussion Findings suggest that interventions for binge-drinking, cigarette smoking and DV may be warranted for a