Methods A casenote review was done on all new and rebook (attending again after 3 months or more for a new episode of care) patients who attended during the first week of September 2011. The history proforma included questions on DV, alcohol consumption, recreational drug use and if they felt this affected their risk taking. Asymptomatic patients for screening were excluded as no detailed history was taken.
Results The history proforma was filled out for 55 women and 22 men. All were heterosexuals. The median age was 25. 26 attended for contraception, 44 for sexual health screen and 7 for both. 21 were rebook patients. 38/55 (69%) women were asked about DV. Five gave a history of DV, four were historic, one unspecified. 63 (82%) and 62 (81%) were asked their alcohol and drug use respectively. One man disclosed drinking >21 units/week and that it affected his risk taking. 10 used drugs: six cannabis, one cocaine and three unspecified. None were referred to other agencies. Of those not asked about DV, alcohol or drug use, no reason was documented.
Discussion The relatively low rate of enquiry for DV may increase with training and awareness raising. Only one patient considered his risk taking affected by alcohol. This may be due to the lack of sensitivity of direct questioning. Closer working with supporting agencies for DV, alcohol and drug use may increase referrals.

P93 THE ACCEPTABILITY OF ROUTINE ENQUIRY OF GENDER-BASED VIOLENCE AT SEXUAL HEALTH CLINICS

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Background In 2008/09, 53 861 incidents of GBV were reported to the police in Scotland; 84% were male perpetrator against female victim and 14% female vs male. National guidance recommends routine enquiry of abuse (REA) amongst female attendees at sexual health clinics. Section SH 4.3 of the Sexual Health and Blood Borne Virus Framework says that levels of GBV should be recorded. Research in an antenatal setting found that 99% of respondents thought REA was acceptable. However, a literature review found no assessment of the acceptability of REA in sexual health clinics. It is also unclear what value there may be of REA in male attendees.
Aim In order to elucidate these areas, attendees at the sexual health service in the city were asked for their opinion of REA and their experience of GBV.
Method As part of our 2010 patient satisfaction survey, attendees were asked: We are considering asking people whether they have been a victim of domestic violence (eg, being hit by a girlfriend, boyfriend, husband or wife). Q1. Do you think we should routinely ask patients this? Q2. Have you ever been the victim of domestic violence? (Support is available here).
Results Of the 110 respondents, 100 answered Q1 and 104 Q2. Of the 100, 81% (95% CI 72% to 88%) said REA would be acceptable. No significant difference between men and women or abused and non-abused (9/10 of abused, 90% (CI 56% to 100%)). One man (1/42 2% (CI 0.1% to 12.6%) and 10 women (10/42, 16% (CI 8% to 28%) reported GBV (p=0.025 for gender difference). One man and three women declined to answer. Comments from women who reported GBV included "Other departments should deal with this " – 38 yr old seen at CSRH and "Gives them someone who will listen" – 64 yr old seen at GUM.
Discussion REA was acceptable to the majority. GBV history was not insignificant in men. This survey used a narrow definition of GBV and reports may have been higher had a more inclusive definition been used. Implications are that REA should be done in clinics and should be considered in men, perhaps using a self-completed questionnaire.

P94 PREVALENCE AND CORRELATES OF SEXUAL VIOLENCE IN FEMALE ATTENDEES AT GENITOURINARY MEDICINE CLINICS

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Background Sexual violence (SV) is common but under-reported in the UK. Victims of SV may be more likely to attend genitourinary medicine (GUM) clinics but there are no recent urban data.
Aims To determine the prevalence and correlates of SV in female GUM attendees. To assess whether routine enquiry on SV is warranted and to gauge if specific SV resources are needed in GUM.
Methods Questionnaire-based survey offered to all women attending our two urban walk-in GUM clinics. Participants self-completed anonymised proformas about any experiences of SV using a broad definition of SV. Demographic, clinical and behavioural data were also collected.
Results Analysis of the initial 164 surveys showed a median age of 27 (IQR 23–31). Ethnicity was typical of the clinics' populations: 62% UK born; 40% White British, 21% White other, 16% Black British, 8% Black African and 7% Black Caribbean. When asked about a history of SV ever, 17% responded yes; in 36% of these women SV had happened more than once. Median age at the time of SV was 19 years (range 6–40); 22/164 (13%) described the SV as rape/sexual assault and in two women this was in the last year. Only two women described their assailant as a stranger; one confirmed her SV was gang-related. Additional women responded to queries on forced oral sex 5%, forced touching 7%, forced sex without a condom 11%. Of 32 women who told someone it included a health professional in only 28% and the police in 25%. 78% of all participants agreed it was helpful to ask routinely about SV and 87% felt that a SV worker was needed in the clinic; four women indicated that their reason for attending GUM today was SV-related. Qualitative comments were mostly positive and accepting of SV enquiry, though several women expressed negative comments about the difficult emotions it had evoked.
Conclusions Women attending GUM have a high prevalence of SV. Further study is warranted within GUM settings to establish if routine enquiry and SV service provision should be core business.

P95 ATTITUDES TO SEXUAL HISTORY TAKING AND STI SCREENING IN A NON-SEXUAL HEALTH DELIVERED HIV SERVICE

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Background An audit within our HIV service failed to meet national sexual health targets. Barriers to sexual history (SHx) taking and STI screening include fear of causing offence. This may be more so in HIV services delivered by non-sexual health clinicians.
Aim To determine patients' attitudes to SHx taking and STI screening in an infectious diseases-led HIV service.
Methods An anonymous, semi-structured questionnaire was offered to all clinic attendees from September-December 2011. Data collected included demographics, HIV history, sexual history and attitudes to SHx taking and STI screening.
Results Of the 101 questionnaires returned; 68% were male and almost two thirds were aged 26–40. 30% were MSM. 35% were in sero-discordant regular relationships. 37% had one partner in the

last year and 15% had >1. 35% had a previous STI. 94% agreed with regular syphilis and hepatitis B (HBV) testing. 40% would have declined STI screening if offered; 26% of these were MSM, 16% had >1 partner in the last year and 34% had ≥1 past STI. Only 62% recalled being asked about sex. Preferred sites for sexual health consultations are detailed in abstract P95 table 1.

Abstract P95 Table 1 Preferred site for delivery of sexual health care (respondents may have given multiple preferences)

Service offered (no of respondents)	HIV clinic n (%)	Sexual health clinic n (%)	Primary care n (%)	None/other n (%)
SHx taking (n=90)	70 (78)	21 (23)	25 (28)	7 (8)
STI screening (n=90)	72 (80)	17 (19)	11 (12)	4 (4)
Contraception (n=27)	15 (56)	5 (19)	11 (41)	4 (15)
Cervical cytology (n=27)	7 (25)	5 (19)	17 (63)	3 (11)

Conclusions Most patients found regular HBV and syphilis testing acceptable, however 40% would decline STI screening indicating that they may be uninformed about STIs, be uncertain of their risk and misperceive the invasiveness of STI screening. Most patients found the HIV clinic a preferable site for both SHx taking and STI screening. Specific sexual health training should be delivered to clinicians in non-sexual health led HIV services in order to improve the sexual health of HIV patients.

STIs in special groups

P96 CHARACTERISTICS AND SEXUAL HEALTH OUTCOMES OF SEX WORKERS SEEKING SEXUAL HEALTH CARE IN ENGLAND

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Background Until recently the only data on sexual health of sex workers (SWs) were from special studies. We used new STI surveillance data to investigate the characteristics and health outcomes of SWs visiting GUM clinics in England.
Aim To assess the sexual health needs of SWs.
Methods Provisional data from the GUM Clinic Activity Dataset (GUMCAD) on consultations by SWs (SHHAPT code SW) were analysed.
Results Reporting began on a rolling basis in 207 GUM clinics during 2011; 2305 SWs were reported from 83 clinics to date. Of these, 1908 were female and 397 male (including 29 MSM). Among female SWs, median age was 29 years, 69% were white and 65% born abroad (migrants). Of the migrants, 35% were from Eastern Europe (60% Romania) and 31% from South America (93% Brazil). The 1908 women made 3131 visits with 63% having a repeat visit within 6 months; 5.4% having chlamydia, 1.2% gonorrhoea, 1.8% genital warts, 1.6% genital herpes, 0.1% syphilis and 0.1% HIV. Migrant SWs were more likely than UK-born women to be seen in London clinics, and less likely to have a sexual health screen (67% vs 83%) or HIV test (67% vs 82%). Migrants were less likely to be diagnosed with chlamydia (4.4% vs 7.3%) or gonorrhoea (1.0% vs 1.5%) but more likely to have genital warts (2.4% vs 1.0%) or genital herpes (1.8% vs 1.3%).
Conclusions Overall STI rates among female SWs are low, particularly among migrants. Lower rates of HIV testing among migrants should be analysed further.

P97 WOMEN REQUIRING EMERGENCY CONTRACEPTION ARE A HIGH RISK GROUP FOR SEXUALLY TRANSMITTED INFECTIONS IN FUTURE

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Background Women in UK are able to get emergency hormonal contraception from various sources including general practice, community contraception clinic, A&E, pharmacies and GUM services. Other than the GUM services most other providers are not offering integrated sexual health services so the screening and prevention of sexually transmitted disease (STI) may be inadequate.
Aim The aim of this study was to find the incidence of STI in this group of clients requesting emergency contraception at the time of their visit for emergency contraception and in subsequent visits within 6 months of the index visit.
Methods We did a retrospective review of all electronic consultations in which Levonelle was issued during 6 months from January 2011 to June 2011. 102 consultations were identified by electronic search using search term Levonelle. Data were collected on Excel spreadsheet and analysed.
Results 102 consultations were identified for 91 patients. Median age was 20 (range 15–42), 55% (50/91) were Black Caribbean. On the day of the index visit for emergency contraception, out of the 102 consultations 79 had STI screen (77%). We detected STI in six women (7.5%). Five women had *Chlamydia trachomatis* and one had gonorrhoea. In the subsequent 6 months, 59 out of the original 91 women (64%) returned to our services. Out of these 59 women, 52 (88%) underwent STI screen. 15 women out of the 52 tested (28.8%) had a positive diagnosis of STI. 9/52 (17.3%) had *Chlamydia trachomatis* infection, 3/52(5.7%) had gonorrhoea; two patients had both *Chlamydia trachomatis* and gonorrhoea. The other STI diagnosed were trichomonas vaginalis 2/52(3.8%), first episode genital herpes infection 2/52(3.8%) and 1/52 (1.95%) had first episode genital warts.
Conclusion Women who attend for emergency contraception are at high risk of contacting future sexually transmitted infections and should be advised to have screening for sexually transmitted infection at 3 and/or 6 months. More research is needed in this sub group of women to improve the sexual health of the community.

P98 IS POOLING OF SELF-TAKEN SPECIMENS AN EFFECTIVE AND ACCEPTABLE METHOD OF TESTING FOR SEXUALLY TRANSMITTED INFECTIONS IN MSMS?

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Background APTIMA Combo 2 (AC2) performs well for the detection of *Chlamydia trachomatis* (CT) and *Neisseria gonorrhoeae* (NG) from extra-genital sites in high prevalence groups such as men who have sex with men (MSM), but testing three samples (pharynx, urethra and rectum) is a significant cost pressure for services.
Aims To determine the; (1) Performance of AC2 to detect CT and NG from a pooled specimen: self-taken pharyngeal and rectal samples added to first-void urine (PS) compared with standard of care testing from individual sites (SOC). (2) Acceptability of pooling among MSM.
Methods MSM (symptomatic or contacts of CT/NG) attending two London sexual health services were recruited. Information about demographics, sexual behaviour, symptoms, signs and acceptability of pooling was collected. PS and SOC sampling order was randomised and results compared.