

18% were against this strategy. Only 44% reported having sufficient knowledge about the use of HPV vaccine for MSM and 49% reported having skills to identify MSM likely to benefit from HPV vaccination. While 19% agreed that it is too late to offer HPV vaccine to sexually active MSM, 53% thought all MSM, regardless of their age, should be offered the vaccine.

**Conclusion** SHCPs perceived the need to vaccinate MSM against HPV. Despite insufficient knowledge, a gender-neutral HPV vaccination strategy was favoured over targeted HPV vaccination for MSM. Clear advice and guidelines for SHCPs on HPV vaccine use in men at sexual health clinics are required to ensure equitable opportunities for vaccination. If MSM-targeted HPV vaccination is recommended, SHCPs' attitudes need to be taken into account to achieve optimal uptake.

**P106 HOW SHOULD PATIENTS BE CALLED FROM THE WAITING AREA WHEN ATTENDING FOR SEXUAL HEALTH SERVICES? A SERVICE EVALUATION**

<sup>1</sup>Emma Dorothy Mills\*, <sup>2</sup>Steve Baguley. <sup>1</sup>University of Aberdeen, School of Medicine and Dentistry, Aberdeen, UK; <sup>2</sup>Genitourinary Medicine, NHS Grampian, Aberdeen, UK

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**Background/introduction** The initial encounter between health professional and patient is fundamental to establishing rapport. It is important in a sexual health setting that patients feel at ease with however they are identified in the waiting area. Recent research suggested patients with HIV preferred to be identified by first name whereas most others preferred a number, and all patients in these categories should be called in these ways.

**Aim(s)/objectives** To determine the proportion of patients who expressed a preference to how they were called from the waiting room. And, to determine whether there was any association with reason for attendance, age, gender or HIV status.

**Methods** 167 patients who attended a drop-in clinic in October 2014 and 50 patients with HIV who had recently attended for HIV care were identified and included. Pearson's Chi-Squared Test was used to analyse the relationship between calling preference and sex, reason for attendance, and age (based on the median age of 26). When assumptions were not met, Fisher's exact test was used.

**Results** 60.8% (n = 132) of patients expressed no preference as to how they would like to be called from the waiting area. 36.4% requested their real details be used, 2.8% requested false details be used (n = 6). There was no statistical significance found between reason for attendance and preference (p = 0.406), age and sex did not significantly influence preference (p = 0.172, p = 0.288).

**Discussion/conclusion** The results suggest offering every patient the choice of how they wish to be addressed would be the most appropriate method used to call patients from the waiting area.

**P107 SEXUAL HEALTH SERVICES FOR MEN WHO HAVE SEX WITH MEN (MSM): ARE THEY ACCEPTABLE?**

<sup>1</sup>Thomas Kurka\*, <sup>2</sup>Suneeta Soni, <sup>2</sup>Daniel Richardson. <sup>1</sup>Brighton and Sussex Medical School, Brighton, UK; <sup>2</sup>Brighton and Sussex University Hospitals NHS Trust, Brighton, UK

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**Background/introduction** Locally, there is a large population of MSM. MSM have high and increasing rates of STIs and HIV: sexual health services should be accessible and MSM focussed.

**Aim(s)/objectives** The aims of this study were to assess patients' satisfaction with the current services, preferences on staff gender, preferences on self-taken rectal and throat swabs, and the need for a specialist MSM service.

**Methods** Patient satisfaction survey of MSM attending four MSM-services in our city (hospital-based STI clinic and HIV clinic, a local non-government organisation (Terence Higgins Trust) and a walk-in primary care centre). Data were analysed using SPSS.

**Results** 246 MSM completed surveys between January–March 2014. The median age was 35 years (18–79). Most MSM (92.3%) self-identified as gay, 7.3% as bisexual and 0.4% as other. 12.7% self-identified as HIV-positive, 61.1% HIV-negative, 20.0% unsure and 5.7% never tested. 206/246 (83.7%) did not have a staff gender preference, the male: female staff preference was 35:5/246 (14.2%:2.0%). 113/227 (49.8%) would welcome self-taken rectal/throat swabs. 101/232 (43.5%) would prefer to be seen in a specialist MSM service. Overall, there was no significant difference in preference between HIV-positive and HIV-negative/unsure/never tested. The overall satisfaction with reception staff was 95.5% (outstanding/good) and 99.1% with doctor/nurse (outstanding/good).

**Discussion/conclusion** Overall, there is high satisfaction with sexual health services currently provided to MSM locally. Most patients do not have a staff gender preference but almost half of MSM would prefer a specialist service. We concluded that offering self-taken rectal and throat swabs would be acceptable for many MSM patients.

**P108 HOW DO MEN WHO HAVE SEX WITH MEN FARE IN INTEGRATED SEXUAL HEALTH CENTRES? AN AUDIT OF HEPATITIS B VACCINATION RATES BEFORE AND AFTER INTEGRATION**

Sally Wielding\*, Andy Ma, Dan Clutterbuck. Chalmers Centre, NHS Lothian, Edinburgh, UK

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**Introduction** In Scotland, Health Improvement Scotland (HIS) standards require that 70% of men who have sex with men (MSM) attending specialist sexual health services who are not known to already be immune should receive at least one dose of hepatitis B vaccine. The integration of sexual health services could theoretically disadvantage MSM.

**Objectives** Audit was performed before and after integration of genitourinary medicine (GUM) and sexual and reproductive health (SRH) services in April 2011 to assess the impact of service redesign.

**Methods** HBV vaccination eligibility, uptake and course completion by MSM registering as new patients in general sexual health and specialist MSM clinics was audited retrospectively for 6 month periods before and after integration of services.

**Results** Pre-integration 239 MSM registered for a first episode of care: 62.8% were eligible for vaccination. Post-integration 25.3% of 343 new patients were eligible. The proportion of eligible men receiving at least 1 dose of vaccination pre- and post-integration was unchanged (130/150 = 86.7% vs 78/87 = 89.7%, p = 0.6458, Chi<sup>2</sup> 0.2223043) However, there was a significant reduction in the proportion of men receiving 3 doses of vaccination; (76/150 = 50.7% vs 30/87 = 34.5%, p = 0.0157, Chi<sup>2</sup> 5.834).

**Discussion** SRH services continued to provide very high levels of initiation of HBV vaccination, even during the period