## P227 FACTORS ASSOCIATED WITH SEXUALLY TRANSMITTED INFECTIONS IN <16'S ATTENDING A GUM CLINIC

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**Introduction** We established whether number of sexual partners and vulnerability factors were associated with sexually transmitted infections (STIs) in <16 year olds.

**Methods** Data was captured on <16's attending a GUM clinic 01/01/15–31/12/15, using a standardised electronic proforma. Data collected: Demographics, appointment type, postcode, STIs, pregnancy, contraception, number of sexual partners and vulnerability factors (mental health, drug use, history of abuse, known to outside agencies, gang involvement).

**Results** 236 attendances by 124 patients; 89/124 (72%) new, 35/124 (28%) rebook. 50/124 (40%) <16s resident in GUM clinic borough, 59/124 (48%) from neighbouring boroughs. 107/124 (86%) female. Ethnicity: 54/124 (43%) White British, 32/124 (30%) Caribbean, 15/124 (12%) African. Median age at first attendance 14.6 years (range 12–15). 447/88 (53%) patients using contraception and 23/107 (21%) females had pregnancy test; 2/23 (8.7%) positive. 31/124 (25%) were diagnosed with or were contact of an STI (Chlamydia n=22, Gonorrhoea n=5, PID n=2, HSV n=2, HIV n-1), of whom 9/31 (29%) reported ≥ one vulnerability factor. Average number of sexual partners in this group was 3.45 (Range 0–15). 93/124 (75%) were not diagnosed with an STI, of whom 27/93 (29%) reported ≥ one vulnerability factor. Average number of sexual partners was 1.75 (Range 0–20).

**Discussion** 29% of patients (36/124) attending the clinic had ≥ one vulnerability factor. <16s diagnosed with an STI were not significantly more likely to have a vulnerability factor than those who were not. However, those diagnosed with an STI had a greater number of sexual partners than those without a diagnosis.

## P228 SEXUAL & REPRODUCTIVE HEALTHCARE OUTCOMES AMONG THOSE AT RISK OF CHILD SEXUAL EXPLOITATION: A RETROSPECTIVE REVIEW

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**Introduction** The purpose of Multi-Agency Sexual Exploitation (MASE) panels is to consider cases of high risk victims and offenders in relation to Child Sexual Exploitation (CSE) and the criminal justice response to offenders. A multiagency approach should ensure young people (YP) are supported by appropriate services including SRH.

**Methods** A retrospective review of a selection of MASE cohorts from 2016 from three services across England was undertaken. The names of YP were cross-referenced with the SRH clinic system in the locality to determine if they had accessed the service. Information was collected on reason for attendance, sexual health screening, contraception and gravidity. Data was analysed using Excel.

**Results** Of 92 young people discussed at MASE panel, 64 (69.6%) were known to SRH services. The age range was 12–19 years (median 16). Sixty (93.7%) were female. The most common reasons for attendance were request for contraception (35.9%), pregnancy testing (25%) and disclosure of sexual assault (10.9%).

19 (29.7%) individuals had tested positive for chlamydia on at least one occasion (25 episodes in total). Fourteen pregnancies were reported with 8 resulting in termination.

**Discussion** Rates of chlamydial infection and pregnancy were high among the MASE cohorts reviewed. The multi-agency response should provide an opportunity to address health needs of this vulnerable group. Interventions should be targeted accordingly including prioritising referral into SRH services into the care plans of those identified to be at risk of CSE.

## P229 HSV MANAGEMENT IN PREGNANCY AT A JOINT ANTENATAL-GENITOURINARY CLINIC IN A LARGE MATERNITY HOSPITAL IN DUBLIN, IRELAND – A MODEL OF CARE

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**Introduction** The ultimate goal of HSV management in pregnancy is to prevent perinatal transmission and, where possible, to facilitate vaginal delivery.

**Methods** Data was collected from antenatal charts of 107 women who reported a history of HSV or who had a documented outbreak during that pregnancy. Descriptive column statistics were used in excel for data analysis.

**Results** From May 2013 to Feb 2017, 107 Women were seen in the clinic for management of HSV in 108 pregnancies. Median gestation at referral (82/108) was 23/40 (range 2–39/40). Mean age 33yr (range 18–45). 91 (85%) European. 9 (8%) HIV+. 82 (76%) reported prior history. 96 (89%) had type-specific serology sent of which 89 (92%) HSV IgG +ve. 28 (31%) HSV 1 & 2 positive, 47 (52%) Type I positive only, 12 (13%) Type 2 positive only, 2 were weak + and not typed. 69 (63%) had STI testing, 100% negative. 4 of the 107 (80%) had primary HSV in that pregnancy. 67 received HSV prophylaxis; 66 valaciclovir; 1 aciclovir. Mean gestation starting prophylaxis was 36/40 (range 20 – 39). Data on mode of delivery on 82 of 107 (76%) pregnancies; 59 (71%) vaginal, 24 (29%) lower segment caesarean sections, none for HSV. Median gestation at delivery of 84 pregnancies 39/40 (range 29 – 41). To date no cases of perinatal HSV transmission have been reported.

**Discussion** There is good compliance with Irish guidelines on HSV management in pregnancy. HSV2 remains an issue. This combined clinic facilitates good compliance with standard guidelines for HSV management in pregnancy. This model of care should be available across all antenatal settings.

## P230 SEXUAL HEALTH WORKERS ARE AT HIGHER RISK OF POOR SEXUAL HEALTH: A PILOT STUDY

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**Introduction** The effects of occupation on personal heath have been described, but there is a paucity of literature on how working in sexual health affects an individual's sexual behaviour.
**Methods** We gained informed consent from a focus group of 6 female and 2 male sexual health workers in 2010. The focus group was tape recorded, anonymised and transcribed. We used thematic analysis to generate themes.
**Results** Sexual health workers feel confident in making an assessment of their own sexual behaviour; yet acknowledge that this self-assessment is not consistently reliable. Access to medication (including antibiotics and emergency contraception) leads to an increase in sexual risk taking in this group. Self-medication occurs for unplanned risks rather than pre-planned. There is reluctance on the part of sexual health workers to consult colleagues due to concerns about lack of anonymity, confidentiality and how positive results will be managed. Sexual health workers feel that these behaviours are a barrier to good sexual health. They also feel that both patients and sexual partners expect them to be more sexually experienced; this can lead to discord in personal relationships. Sexual health workers feel that due to the nature of their work, they have a greater and more realistic insight into sexual relationships; in particular monogamy. They also have greater confidence in their ability to discuss sex with their children and families.
**Discussion** This pilot study suggests that sexual health workers may be at risk of poor sexual health and have specific sexual health needs not currently addressed.

## P231 UNDERSTANDING SEXUAL PRACTICES, ATTITUDES AND SEXUAL HEALTH SERVICE PROVISION IN THE OVER 50S

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**Introduction** Since 2011 STI incidence has increased in the over-50 population in the UK.

Higher divorce rates, lack of awareness, poor service provision and low pregnancy risk have all been suggested as contributing to these changes.

We examined sexual practices and attitudes of >50s in our city centre clinic, and assessed service accessibility.
**Methods** Anonymous questionnaires distributed opportunistically to 50 attendees (23 male 27 female), examining sexual practices, STI awareness and attitudes towards service provision.
**Results** Almost half had divorced previously. 50% men never used condoms, 67% women; reasons given included 'married', 'no pregnancy risk', 'too old', 'don't like it'. 60% used at least one regular medication and 10% were using >6 drugs. 37% of women and 20% of men were 'too embarrassed' to discuss sex with GP. 44% women, 26% men were first-time attenders. All the women in our sample were white heterosexual. There was more ethnic diversity in men, and 30% MSM. There was good awareness of STIs and safer sex, and 70% felt that current services met their needs.
**Discussion** Reassuringly, many were attending for the first time suggesting ease of access. However, a lack of diversity in female attendees may indicate unmet needs in some groups. Despite being aware of good sexual health, there was low condom use and a lingering embarrassment to discuss problems with family doctor. This survey suggests unmet needs still exist, even in those who already access services. A similar project in primary care is planned to further assess this.

## P232 SOMEWHERE OVER THE RAINBOW: ESTABLISHING ACCEPTABLE LOCATIONS FOR STI SCREENING AND SUPPORT FOR MSM

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**Introduction** Over the Rainbow is a community based LGBT support service and level 3 GUM clinic in Bournemouth, currently under threat due to funding cuts. In May 2016, a patient consultation was undertaken to explore alternative options for service provision.
**Methods** A survey was distributed online and in clinic to capture views on the provision of local sexual health services for MSM.
**Results** 96 people responded to the survey after visiting the service for STI screening (60%) or one to one support (40%). 40% of these would not be happy attending a mainstream GUM or CASH clinic, or GP for STI screening. 34% would not be happy to access STI screening on-line. One third would be unwilling to attend alternative agencies for counselling or support.

80% of the 86 online respondents had attended Over the Rainbow in the past. Responses indicated that even fewer (44-56%) would be happy to attend a mainstream GUM or CASH clinic or GP for STI screening, with a similar proportion reluctant to attend other community settings.

Comments highlighted that service users valued a dedicated LGBT service, in the heart of the gay community. It was described as a safe haven.
**Discussion** Future service design and provision must consider community need. Patients expressed a preference for LGBT specific community based services, able to accommodate their sexual health needs within a holistic framework. Many value a face-to-face consultation rather than accessing STI screening on-line.

## P233 SEXUAL DYSFUNCTION: PRIMARY, SECONDARY OR A BY-PRODUCT OF SECRET ISSUES?

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**Introduction** To explore the referral diagnosis of sexual dysfunction from a psychosexual basis.
**Methods** A retrospective analysis of 50 women who were referred to a clinical sexologist for varying aspects of sexual dysfunction during January 2016 – December 2016.
**Results** Although 100% of women exhibited a variety of sexual dysfunction, 44% displayed variables of sexual abstinence due to real and perceived problems that directly impacted on their ability to participate in sexual intimacy. Factors not explored or discussed by the referring Health Care Professional (HCP) included urinary incontinence, religious/spiritual beliefs, perception of guilt relating to previous sexual behaviours and ill health of the partner.