Women who have sex with women (WSW) were reluctant to attend services due to perceptions of low risk and discrimination, and valued the choice of a women-only service).

In 2012 a women's clinic opened, offering a range of sexual health and contraception services. Staffed by female HCPs and receptionists, the service has been well received by women. Plans for a women-only waiting area proved challenging within the confines of environment and patient activity.

Aim(s)/objectives To assess patient experience of the women's clinic, including that of mixed sex versus female only waiting areas.

Methods An anonymous patient experience questionnaire distributed 3rd–17th April 2014. Women were asked their age, sexual orientation, previous experience of services and their views on accessing integrated contraception and sexual health care. Data was collated and entered into an excel database.

Results Questionnaires were received from 43 women (36 fully completed); Majority (n = 21, 50%) 26–35 years. 33 (77%) WSM, 3 (7%) WSW; 7 (16%) did not answer. 28 (66%) had accessed other sexual health/contraception services within 3 years. 3 (6%) preferred female only waiting areas, with 40 (94%) wanting a choice, or stating that they had no strong feelings.

Discussion Assumptions about acceptability of single-sex waiting areas did not match the majority of patients' views. WSM and WSW accessing the service valued the choice of mixed or single sex waiting areas.

P250 SEXUAL HEALTH INFORMATION AND SERVICES: THE VIEWS AND EXPERIENCES OF 14 TO 22 YEAR OLDS

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10.1136/sextrans-2015-052126.292

Background/introduction Young people are not always consulted about their sexual health information and service needs.

Aim(s)/objectives The authors sought to capture young people's views and experiences of sexual health information and services in a specific geographical area.

Methods An online survey was published on survey monkey between 4 and 16 December 2014. It was promoted via social media, youth groups and Lesbian, Gay, Bisexual and Transgender (LGBT) organisations. 207 responses from young people aged between 14 and 22 were analysed.

Results 50% of respondents were female. Of 190 stating sexuality, 12% may be gay or bisexual. Only 13% had attended sexual health classes that met all their sexual health needs. Young people reported getting sexual health information from TV programmes and websites. Young women were more likely to get information from family members than young men. Most young people knew where they could get condoms, pregnancy tests and emergency contraception. 85% did not know about PEP (Post Exposure Prophylaxis) for HIV. 30 young women had talked to a health professional about contraception, most commonly the pill and implant. Young people want sexual health services to be open in the evenings and weekends, the most common combination was Monday evening, Friday evening, and Saturday afternoon.

Discussion/conclusion The sexual health information needs of young people are not being met in education settings. More

information about PEP is needed, especially for young gay and bisexual men. Sexual health services should have extended opening hours leading up to, during and after weekends.

P251 TREATMENT DILEMMA OF CHLAMYDIA IN PREGNANCY

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10.1136/sextrans-2015-052126.293

Background Drug hypersensitivity reactions are immunological responses to medications. An accurate understanding of the type of antibiotic hypersensitivity reactions is crucial in the decision making process of alternative antibiotic usage versus desensitisation.

Clinical presentation A 25-year old female, twenty-four weeks pregnant, with dysuria was diagnosed with Chlamydia. She had asthma, which was treated with inhalers. She gave a history of reaction to penicillin and an episode of collapse and rash to erythromycin. Effective treatments for Chlamydia are azithromycin, erythromycin, amoxicillin and doxycycline. The latter is contraindicated in pregnancy and erythromycin and amoxicillin were contraindicated because of this patient's history. There is small risk of cross reactivity between azithromycin and erythromycin, so a desensitisation protocol was drawn up by the immunologist. The patient was counselled regarding the possibility of a reaction even to small doses of azithromycin and the possibility of an anaphylactic reaction needing adrenaline, which could precipitate preterm labour. She was admitted on the ward and given azithromycin in titrating doses, which was tolerated well without any problems. The repeat chlamydia test following treatment was negative.

Discussion There are limited therapeutic choices for treatment of various sexually transmitted infections in patients with allergies particularly in pregnancy. These patients will need desensitisation under an immunologist with careful monitoring. If a patient with a reported allergy is deemed not allergic or if the allergy is simply an expected side effect, the medical record should be updated to reflect this change along with educating the patient.

P252 TILL DEATH DO US PART: MARRIAGE, AFRICAN-BORN WOMEN AND HIV PREVENTATION IN THE UNITED KINGDOM

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10.1136/sextrans-2015-052126.294

Background/introduction Recent studies from Sub-Saharan Africa, most especially Southern Africa, reveal a shocking trend in HIV transmission with married couples recording the biggest percentage of new infections per annum. Hence the mode of transmission as far as HIV is concerned has been evolving and the previously so called 'low risk' unions are no longer as safe as previously thought, most especially for women. UK literature shows that the trend of HIV in Black-African population mirrors that in Africa. Making of culturally sensitive and therefore effective policies and interventions for this particular group calls for a good in-depth understanding and insight into experiences and strategies that persists and those that newly emerge for married African-born women when they immigrate into UK.

Aim(s)/objectives The aim of this study was to explore experiences and strategies of married African-born women who are living in the United Kingdom in prevention of HIV.

Methods Eighteen in-depth Interviews were conducted with married African-born women who were aged between 25 to 55 years old in three Scottish cities: Aberdeen; Edinburgh; and, Glasgow.

Results Women's reports suggest a false sense of security amongst married women in regard to HIV prevention. Contrary to the daily exposure to the lived realities of HIV in Africa, HIV is rarely mentioned in media or discussed by health professionals. Condom use and asking husbands to get HIV tested was deemed unnecessary and therefore often neglected.

Discussion/conclusion Policies and interventions for HIV prevention amongst married African-born women should transcend multiple levels: individual-level; couple-level; and, structural-level.

P253 REGIONAL AUDIT OF TESTING CHILDREN OF HIV POSITIVE MOTHERS

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10.1136/sextrans-2015-052126.295

Background In 2009, the "Don't forget the children" report recommended that all new HIV-positive patients attending adult HIV services should have any children identified, tested and the information clearly documented. In our clinic, HIV diagnosis in a child was delayed due to lack of a robust testing protocol despite regularly engaging with the mother for her care. We aimed to survey our clinic's testing practice before and after publication of this report to assess impact.

Method A retrospective case note review on all HIV positive women registered at the Solent adult HIV service. The population will be divided into 2 groups: (a) pre guidelines (n = 81), and post guidelines (n = 61). Details of children, their ages, country of residence, testing status, outcomes and timescales were recorded.

Results

	Pre-guidelines (2000–2009) n = 81	Post-guidelines (2010–2014) n = 61
Number of children <18, UK resident, at risk	36	33
Number of children for whom HIV testing was discussed and documented in maternal notes	22 (61%)	33 (100%)
Testing initiated by HIV service	10	15
Time scale for children to be tested (range)	3 months – 9 years	3 months – 3 years

Conclusion Testing of children at risk of HIV has significantly improved in our service since the publication of "Don't forget

the Children". However this audit identified some children who continue to remain untested or status unconfirmed. We have implemented a robust protocol to chase up outcomes of children tested outside of HIV service and to proactively negotiate testing when parents initially decline consent. Since January 2012, Southampton has been integrated with 3 other clinics to form Solent Sexual Health Service. We plan to extend this retrospective audit to include HIV positive women attending 3 other clinics, which may result in identification and testing of more children at risk.

P254 SAFEGUARDING CHILDREN IN SEXUAL HEALTH SERVICES – A GROWING CONCERN

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10.1136/sextrans-2015-052126.296

Background Additional focus on child sexual exploitation (CSE) and high profile safeguarding cases within the media has impacted on workload within sexual health services. Our trust has established pathways for sharing information about the most vulnerable children in the form of named nurse (for safeguarding children) notifications (NNN). These facilitate the triangulation of information and senior review of cases. Following integration in 2011 we have emphasised the need for all clinical staff working across different sites to recognise children at risk and notify cases.

Aim To quantify the NNN made from our integrated service as a measure of safeguarding children workload.

Methods Numbers of safeguarding referrals in the form of NNN initiated by our service over 3 years were obtained from the NNN database.

Results

Year	January–March	April–June	July–September	October–December	Total
2012	0	0	2	1	3
2013	3	4	6	7	20
2014	11	19	18	23	71

10 database entries were undated: 5 closed in 2012; 5 in 2013.

Discussion The workload in managing children at risk has increased as demonstrated by the large rise in NNN. It is important that the additional workload falling upon teams is recognised and particularly the disproportionate burden falling upon health advisors who may be supporting the young people in addition to advising colleagues. The marked increase may have resulted from community staff gaining more experience in recognising the signs of children in need. Further training, supervision and the use of a standardised proforma across all sites may also have contributed.