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.

Results Of the planned 1400 MSM, 99 (53 HIV+) have been recruited. Two equivocal results were excluded from analysis. Some of the questionnaire data were missing. 80%(73/91) were symptomatic and 60% (57/96) reported unprotected anal sex in the last month. The prevalence of CT and/or NG infection was 35% (95% CI 26% to 45%), CT alone 14% (95% CI 8% to 23%) and NG alone 21% (95% CI 13% to 30%). The sensitivity and specificity of PS vs SOC to detect CT/NG is 88% (95% CI 72% to 96%) and 100% (95% CI 93% to 100%), respectively (abstract P98 table 1). PS failed to detect four NG cases (3 pharynx, 1 rectum). MSM reported confidence (n=74, 86%) and willingness (n=75, 88%) to take their own samples (see abstract P98 table 1).

Abstract P98 Table 1 Sensitivity and specificity of pooled samples according to test

	Number positive (%) SOC testing [95% CI]	Number positive (%) PS testing	Sensitivity % [95% CI]	Specificity % [95% CI]
CT &/ or NG* (*CT&NG, n=4)	34 (35) [26 to 45]	30 (88)	88 [72 to 96]	100 [93 to 100]
CT	14 (14) [8 to 23]	14 (100)	100 [73 to 100]	100 [95 to 100]
NG	20 (21) [13 to 30]	16 (80)	80 [56 to 93]	100 [94 to 100]

Discussion Pooling specimens in MSM offers the potential for significant savings and improved access to testing. Missed infections may be due to sampling error or low organism load. The evaluation of this strategy continues.

P99 SOCIO-DEMOGRAPHIC AND BEHAVIOURAL CHARACTERISTICS OF MEN WHO HAVE SEX WITH MEN (MSM) AND HETEROSEXUALS INFECTED WITH GONORRHOEA

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Background As well as monitoring antimicrobial resistance, the enhanced Gonococcal Resistance to Antimicrobial Surveillance Programme dataset can be used to understand the epidemiology of gonococcal infection.
Objective To explore socio demographic and behavioural characteristics of MSM (HIV positive and negative) and heterosexuals (male and female) infected with gonorrhoea.
Methods Demographic and behavioural data from Gonococcal Resistance to Antimicrobial Surveillance Programme, collected annually between July and September 2005–2010 from 26 sentinel GUM clinics were analysed.
Results Of 9239 gonorrhoea cases, 3089 (36%) were in MSM, of whom 861 (28%) were HIV positive; 5588 in heterosexuals, of whom 3012 (54%) were men. Predominantly of white ethnic background, HIV positive MSM (mean age 36 y) were older than HIV negative MSM (mean age 30 y). A higher proportion of HIV positive than negative MSM were co-infected with another STI (OR=1.6, 95% CI 1.3 to 1.9), mainly chlamydia (18% vs 15%) or syphilis (5% vs 2%). HIV positive MSM were also more likely (OR=1.5, CI 1.3 to 1.8) to report rectal gonococcal infection. Over a quarter of HIV positive MSM reported ≥6 sexual partners in the past 3 months compared to 18% of HIV negative MSM. Within the heterosexual population, higher proportion of women than men were of white ethnic background (74% vs 43%) and <25 y (72% vs 47%). Compared to heterosexual men, women were more likely to be co-infected with another STI (OR=1.5, CI 1.4 to 1.7) primarily chlamydia (41% vs 35%). Nearly two-third of heterosexual men reported ≥2 sexual partners in past 3 months while most women (64%) reported one or no sexual partners.
Conclusion Gonorrhoea is concentrated amongst specific population sub-groups. Our analysis indicates that these groups are at high risk of contracting and transmitting other STIs as well as HIV, and underlines the need for targeted interventions.

P100 ASSESSMENT OF BACTERIAL SEXUALLY TRANSMITTED INFECTION (STI) SCREENING FOLLOWING SEXUAL ASSAULT

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Background *Chlamydia trachomatis* and *Neiserria gonorrhoea* screening following sexual assault is undertaken primarily for sexual health purposes but can potentially facilitate criminal investigation in cases of penetration at sexually naive sites. Antibiotic prophylaxis at first attendance (within 7 days of the assault) is not routine but may be given when the return for screening is unlikely.
Aim To improve bacterial STI screening and management in complainers attending our sexual assault referral centre (SARC).
Objectives To determine if complainers were adequately screened for bacterial STIs and if communication with health professionals regarding repeat screening was adequate.
To review prophylactic antibiotic use.
To review the forensic significance of STI screening.
To identify factors which may improve the uptake of screening.
Methods 100 case records were reviewed and information relevant to our objectives extracted. Six cases were excluded.
Results 81% had a STI screen taken at presentation. Only 13% returned for repeat screen after incubation, confirming Chlamydia in two cases. All but one repeat screen correlated to the site of exposure. GPs were informed of the need for a repeat screen in 74% of cases. 59% had an alert sited on their sexual health record highlighting the need for a repeat screen. Antibiotic prophylaxis was given in 25 cases with reasons documented in only 4.
Discussion and/or Conclusion STI screening post sexual assault may be improved through better communication with complainers and other healthcare providers. Improvements to communication methods and training are required to facilitate this. The concern of emerging gonococccal resistance should be considered prior to administering prophylactic antibiotics. One individual, in whom there was no previous sexual contact and baseline screen was negative, had Chlamydia on repeat sample. This may be supportive of the assailant as the source of infection, indicative of the potential forensic role of STI screening.

P101 OLYMPIC OUTREACH: STI TESTING FOR CONSTRUCTION WORKERS

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Background It was feared that construction of venues for the 2012 Olympic and Paralympics Games would increase the burden of sexual ill-health in East London, due to a surge in migrant construction workers and commercial sex work.
Aims/Objectives We analysed data from outreach to construction sites at the Olympic Park and Village in Stratford, East London. We reported demographics, sexual risk factors and STI rates.
Methods An outreach team visited the Olympic site between February 2009 and October 2011. Clients completed a triage form about symptoms and sexual risk factors. Clients were offered nucleic acid amplification tests for Gonorrhoea and Chlamydia, using urine samples from men, and self-taken vulvovaginal swabs