Sexual Health Information and Services: The Views and Experiences of 14 to 22 Year Olds

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.

Till Death Do Us Part: Marriage, African-Born Women and HIV Prevention in the United Kingdom

Background 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

Victoria McArdell*, Katrina Humphreys, Sangeetha Sundaram, Raj Patel, Selvavelu Samraj, University of Southampton, Southampton, UK; Solent NHS Trust, Southampton, UK

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of children &lt;18, UK resident, at risk</td>
<td>36</td>
<td>33</td>
</tr>
<tr>
<td>Number of children for whom HIV testing was discussed and documented in maternal notes</td>
<td>22 (61%)</td>
<td>33 (100%)</td>
</tr>
<tr>
<td>Testing initiated by HIV service</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Time scale for children to be tested (range)</td>
<td>3 months – 9 years</td>
<td>3 months – 3 years</td>
</tr>
</tbody>
</table>

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.