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–17thApril 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.

### Abstracts

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

1Babs Evans*, 2David Armitage, 1Nudge Associates, London, UK; 2Tameside Metropolitan Borough Council, Ashton-Under-Lyne, UK.  

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. 83% did not know about PEP (Post Exposure Phrophylaxis) 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**

Jemy Thomas*, CM Bates, T Mathew. Royal Liverpool University Hospital, Liverpool, UK  

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 PREVENTION IN THE UNITED KINGDOM**

Tabeth Timba-Emmanuel*, Thib Kroll, Mary Rennfrew. University of Dundee, Dundee, UK  

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.

**Results**

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</tbody>
</table>

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.