

Medicine services. Since 2011 Abertawe Bro Morgannwg Health Board deliver an Integrated Sexual Health service.

Aim(s)/objectives To demonstrate the benefits of integrated an service

Methods A case note review of all women attending PAS from 1st to 29th February 2016.

Results 145 case notes of women accessing PAS were reviewed; median age was 25 years (16–43). 137/145 (94%) had a termination procedure, 1 found not be pregnant, 1 miscarried, 3 transferred to BPAS as >18 weeks pregnant, 3 decided to continue pregnancy. At time of initial consultation, 89/145 (61%) had no form of contraception, 30/145 (21%) used condoms only, 20/145 (14%) were using the Combined Oral Contraception (COC) and 6/145 (4%) the Progesterone Only Pill (POP). At the time of discharge, 77/139 (55%) started a new method of Long Acting Reversible Contraception (LARC). 16/139 (11.5%) were prescribed COC, 25/139 (18%) POP and 1/139 (0.5%), contraceptive patch. 5/139 (4%) declined contraception, 15/139 (11%) wanted to access their GP for future contraception. 144/145 (99%) were offered Sexually Transmitted Infections (STIs) screening, 133/144 (92%) accepted dual Nucleic Amplification Assay Tests (NAATs), 7/133 (5%) had chlamydia, 1/133 (0.8%) had gonorrhoea. All 74/144 (51%) tested negative for syphilis and HIV.

Discussion/conclusion This holistic model of care provides women a more immediate opportunity to address their future contraceptive and sexual health needs, with a 55% increase in uptake of LARC and >5% identification of untreated STIs.

P219

RESPONDING TO THE LGV EPIDEMIC: ARE THE RIGHT PATIENTS BEING TESTED FOR LGV?

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Background UK national guidelines will recommend that samples from all *Chlamydia trachomatis* (CT)-positive men who have sex with men (MSM) with proctitis and all asymptomatic CT-positive MSM with HIV should be tested for Lymphogranuloma venereum (LGV).

Aim To investigate case characteristics and test outcomes of samples referred to the Sexually Transmitted Bacterial Reference Unit (STBRU) for LGV testing.

Methods STBRU and GUMCADv2 data for 2014 in England were matched. Test numbers and outcomes for patients in different risk categories were compared to understand targeting of LGV testing.

Results In 2014, 3,782 CT samples were tested for LGV, and 2,426 (64%) were matched to GUMCADv2. MSM accounted for 77% (1876/2426), heterosexual men 7% (178/2426) and women 11% (277/2426) of LGV tests (Table 1). Overall, LGV prevalence was 15% (366/2426), and was highest among HIV-positive MSM (33%; 230/692) and lowest in women (0.4%; 1/277). MSM accounted for 93% (342/366) of all positive samples, and 67% (230/342) of MSM with LGV were HIV-positive. In 2014, there were 3,434 CT diagnoses reported by GUM clinics in HIV-positive MSM, but we found only 692 HIV positive MSM had a CT sample tested for LGV, while 1,639 CT samples were from MSM without HIV, heterosexual men, or women,

suggesting inadequate testing of CT samples from HIV-positive MSM.

Conclusion Although miscoding in GUMCADv2 may partially explain some LGV testing in heterosexual men and women and HIV negative MSM, these data still suggest that LGV testing might be targeted more effectively to conserve resources and maximise identification of LGV.

Abstract Table 1 The distribution of LGV tests and test outcomes by sexual orientation and HIV status for patients whose CT samples were referred for LGV testing in England in 2014

| | LGV Positive | LGV Negative | Total | % of all LGV tests done in group | % of all positive LGV test results in group | LGV prevalence in group (%) |
|-------------------------|--------------|--------------|-------------|----------------------------------|---|-----------------------------|
| Total | 366 | 2060 | 2426 | 100 | 100 | 15.1 |
| MSM | 342 | 1534 | 1876 | 77.3 | 93.4 | 18.2 |
| HIV positive | 230 | 462 | 692 | 28.5 | 62.8 | 33.2 |
| HIV negative | 112 | 1,072 | 1,184 | 48.8 | 30.4 | 9.5 |
| Heterosexual men | 14 | 164 | 178 | 7.3 | 3.8 | 7.9 |
| HIV positive | 7 | 29 | 36 | 1.5 | 1.9 | 19.4 |
| HIV negative | 7 | 135 | 142 | 5.8 | 1.9 | 4.9 |
| Women | 1 | 276 | 277 | 11.4 | <0.1 | 0.4 |
| HIV positive | 0 | 1 | 1 | <0.1 | 0 | 0 |
| HIV negative | 1 | 275 | 276 | 11.4 | <0.1 | 0.4 |
| Unknown | 9 | 86 | 95 | 3.9 | 2.5 | 9.5 |
| HIV positive | 6 | 19 | 25 | 1.0 | 1.6 | 24.0 |
| HIV negative | 3 | 67 | 70 | 2.9 | 0.8 | 4.3 |

P220

THE UPTAKE OF HIV SCREENING AMONG PREGNANT WOMEN AT A GRENADIAN CLINIC

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Background/introduction In Grenada, almost 70% of patients diagnosed with HIV are of reproductive age, however this group is often the least educated about the disease. To prevent vertical transmission, access to testing and treatment is free. Screening for HIV occurs at booking and at 32 weeks gestation. Awareness of HIV status is not only important for the mother and child but also for healthcare professionals involved in her care. Despite this, women continue to opt out of HIV screening. This audit will seek to determine the uptake of HIV screening among pregnant women at a Grenadian clinic and discuss potential barriers to screening.

Aim(s)/objectives Determine the uptake of HIV screening among pregnant women. Explore possible barriers to screening.

Methods Optimal adherence to the screening programme was set at 100%. Retrospective data from women attending the antenatal clinic between 01/06/14 and 01/06/15 were included. Screening status was obtained from the visiting book. Data was then analysed against the set standard.

Results 140 women attended the clinic. 110/140 had opted in for HIV screening giving a screening rate of 79%. Reasons why women opted out of screening were discussed and included: Denial, Ignorance to susceptibility, Fear of discrimination, Confidentiality concerns, Screening at separate location and being unable to breastfeed with HIV-positive status.