Methods We conducted in-depth interviews with 52 adults from two HIV clinics. Participants were purposively sampled to achieve variation in: time since diagnosis and demographic characteristics. Data were examined using thematic analysis.
Results Three-quarters of the sample were virally undetectable, financially stable and generally healthy, although some experienced psychological problems and/or other STIs including HCV. Having adjusted well to the medical regimen they tried to 'normalise' their life by a combination of: asserting control over their virus by staying informed about their immunological status and scientific developments; using 'othering' methods to assure themselves of the uniqueness of their situation; and keeping their seropositive status hidden from most others. Gay men felt keeping HIV secret was similar to keeping their gayness secret, and being virally undetectable gave some respondents medical legitimacy to not disclose even to sexual partners. By contrast, a quarter of the sample felt the need for frequent contact with the HIV clinic, either because of co-morbidities or other vulnerabilities. Half of this group reported relations with their clinicians suggesting emotional dependency.
Discussion The chronic disease model of HIV management transforms HIV from a collective and political phenomenon into an individualised concern. While patients with complex needs continue to have frequent clinic contact, others isolate and conceal their HIV-positive identity to avoid experiencing stigma in their day-to-day lives.

Undergraduate Oral Presentations

UG1 MANAGEMENT OF SYMPTOMATIC PATIENTS ATTENDING OPEN ACCESS SEXUAL HEALTH WALK-IN CLINICS IN THE UK

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Introduction Following the NHS Act 2012, Sexual Health services (SHs) have been radically reshaped. Anecdotally many places report problems in maintaining open access services, particularly since local authorities became responsible for commissioning SHs as of 1 April 2013.
Aims To assess whether SH walk-in clinics can accommodate symptomatic patients and if there is a difference in waiting time between male and female patients. To determine whether the expectations of lead clinicians working in SHs concur with the experience of front line services.
Methods A postal questionnaire was sent to 262 UK SH clinics to assess lead clinicians' predicted waiting times. Four researchers; 2 males and 2 females attended clinics as 'patients' reporting symptoms suggestive of an acute STI, clinic waiting time was recorded. 50% of clinics in each of the 17 BASHH branches were visited. SPSS v23 was used to analyse the data.
Results Of the 131 clinics visited, 97.7% could accommodate symptomatic 'patients' on the same day. The observed waiting time ranged from 5-285 minutes. The median wait was 54 minutes respectively. There was no significant difference in waiting time between male and female 'patients' ($p=0.110$). 68/262 questionnaires were returned; 31 were from clinics which were visited. 13% of clinics underestimated the walk-in waiting time, while 23% over-estimated the walk-in waiting time, when compared with actual walk-in waiting time established during clinic visits.
Discussion Despite strains on SHs, most clinics visited could accommodate patients on the same day. However, there is discrepancy between lead clinicians' expectations and services provided.

UG2 THE ASSOCIATION BETWEEN BIRTH ORDER AND SEXUAL HEALTH OUTCOMES:HOW IS BIRTH ORDER ASSOCIATED WITH LEARNING ABOUT SEX, EARLY SEXUAL EXPERIENCE, AND SEXUAL RISK BEHAVIOUR?

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Introduction While the effect of birth order on psychosocial outcomes has been widely discussed in the literature, little research examining birth order effects on sexual health has been undertaken. This analysis identifies the associations between birth order and learning about sex, first sexual experiences and sexual risk behaviours.
Methods This analysis uses data from Natsal-3, a stratified probability sample survey of 15,162 men and women aged 16–74 in the UK. Bivariate logistic regression was conducted to identify crude odds ratios for the association between birth order and sexual health outcomes. Multivariate logistic regression was performed adjusting for socio-demographic factors and sibling number.
Results Middle-born and last-born men were less likely to have found it easy to speak to their parents about sex around age 14 (OR 0.59, p=0.003; OR 0.69, p=0.009) and to have learned about sex from their mothers (OR 0.64, p=0.014; OR 0.76, p=0.045). Last-born women were less likely to report a parental main source of sex education (OR 0.64, p=0.003). Being a last-born male was associated with decreased odds of having had 5+ lifetime heterosexual partners (OR 0.75) and reporting ever had heterosexual anal sex (OR 0.77).
Discussion These results provide the basis for further research on the association between birth order and learning about sex, and highlight later-born males in particular as being less likely to report parental involvement in sex education. Qualitative research is recommended in order to gain a broader understanding of the ways in which birth order effects manifest in learning about sex.

UG3 CONNECT EMAIL – 8 YEARS' EXPERIENCE OF AN EMAIL CLINIC IN AN HIV OUTPATIENT SETTING

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Introduction With advances in HIV therapy, many people are living longer healthier lives. Simultaneously our cohorts are ageing with 42% of individuals locally aged over 50. Our service looked for innovative ways of reducing visits for stable patients while increasing capacity to manage complex patients.