BASHH

vBASHH 2021

12th & 13th October 2021 Online event

CONFERENCE GUIDE

BASHH

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PROGRAMME

Tuesday 12th October 2021	
10:00	**Welcome address** *John McSorley, BASHH Chair*
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11:15	*MSD sponsored video break*
11:18- 11:45	*Comfort break*
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	MSD PDF drop at end before Disco Bingo
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Wednesday 13th October 2021		
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11:15	*Roche Sponsored video break*	

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16:25-16:40	**Conference Close** *Dr Claire Dewsnap*

The programme consisted of 2 days of Scientific Sessions.

Royal College of Physicians CPD Number: 137914 - CPD Credits Awarded: 14 points

FACULTY

Hosts

Claire Dewsnap is a Consultant Physician in Genitourinary Medicine at Sheffield Teaching Hospital NHS Foundation Trust. She has worked in a variety of leadership roles, including clinical lead across two departments and lead for quality improvement across Outpatient services. Claire currently acts as a training programme director in the UK trainee scheme. Research interests include management of bacterial STIs and PrEP. Organisational areas of interest included change implementation, quality and service improvement and teaching and training. She has lead and been involved in numerous quality improvement and change implementation projects within the field both strategically and operationally. Claire is the current BASHH conference organiser.

Stuart Flanagan is a Consultant in GU/HIV & Blood Borne Virus (BBV) Medicine at CNWL Trust's Mortimer Market Centre in Central London and Honorary Consultant at University College London Hospital. He is Viral Hepatitis Lead for CNWL Trust.

Stuart was an NIHR Clinical Research Fellow in Hepatology on the HepFREE study (testing for HBV and HCV in Primary care), which was published in Jan 2019 in the *Lancet Gastro & Hep*. He is chair of the BASHH HIV/BBV Special interest Group and the organising committee for the annual BASHH HIV Masterclass conference.
Stuart has been a medical broadcaster for the BBC (BBC Radio 1 Surgery, CBBC's Newsround, BBC Breakfast). He wrote and presented a BBC Radio 4 documentary on antimicrobial resistance *The Path Of Least Resistance*. *Sex Talk*, a podcast made in association with Public Health England and Terrence Higgins Trust, is available to download from podcast platforms.

Anne Oliver has been a sexual health specialty doctor in Newcastle Upon Tyne for 16 years. She also pursues her interest in medical education and is the current chair of the BASHH Annual SAS Doctors' Conference Organising Committee.

Chairs

Elizabeth Carlin is a Consultant in Sexual Health and HIV Medicine at Sherwood Forest Hospitals NHS Foundation Trust and Nottingham University Hospitals NHS Trust. She is also the Service Director for the Integrated Sexual Health Service at Sherwood Forest Hospitals and is Chair of the Local Negotiating Committee. Elizabeth has worked widely across the specialty, in various roles in BASHH, including as Past President, as the Chair of the RCP / BASHH Joint Specialty Committee for Genitourinary Medicine, and as a member of the RCP Advisory Group on Health Inequalities.

She is the author of UK and European Guidelines on Sexually Acquired Reactive Arthritis, has written national job planning guidance, and contributed to several national standards including the BASHH Standards for the Management of Sexually Transmitted Infections, as well as the recent Vision Statement for Sexual Health endorsed by BASHH, BHIVA and the RCP.

Patrick French is a Consultant Physician in Sexual Health and HIV at the Mortimer Market Centre in London. He is an honorary Senior Lecturer at University College London Medical School and a member of the BASHH Syphilis Guideline Group.

Jo Gibbs is a Senior Clinical Research Associate in the Institute for Global Health at UCL and an Honorary Consultant in Sexual Health & HIV at Mortimer Market Centre. Her research interests include digital health, developing and evaluating complex interventions, health service delivery and public health. Her current research focus is on the development and evaluation of online clinical care pathways from diagnostics to online management of STIs and HIV, understanding the complex legislation and regulation in this area, and the impact of remote service delivery on health inequalities.

Emma Harding-Esch is an epidemiologist, with a focus on diagnostics and prevalence surveys for sexually transmitted infections (STIs) and neglected tropical diseases (NTDs). She is Associate Professor at the London School of Hygiene & Tropical Medicine (LSHTM), and Chief Scientist for Tropical Data (www.tropicaldata.org). She is co-director of LSHTM's STI Research Interest Group (https://www.lshtm.ac.uk/research/centres-projects-groups/stirig), LSHTM's WHO Collaborating Centre for STIs (https://www.lshtm.ac.uk/research/centres-projects-groups/whocc-sti), and Bristol Health Partners' Sexual Health Improvement Programme (SHIP) Health Integration Team (https://www.bristolhealthpartners.org.uk/health-integration-teams/sexual-health-improvement-hit/). Previously, she was Senior Trials Coordinator for the *e*STI^2 Consortium based at Public Health England in collaboration with St George's University of London (SGUL), and Programme Manager and Epidemiology Lead for the Applied Diagnostic Research and Evaluation Unit (SGUL).

David Phillips is a consultant in Sexual Health & HIV in Croydon, South London for Croydon Health Services NHS Trust. He is the current BASHH General Secretary. He graduated from Cambridge University Medical School in 2002. For his third year specialist degree, he chose "Anatomy B: Disease Society & Sexuality". This nurtured his interest in Genitourinary & HIV Medicine (GUM) and its impact on individuals and marginalised groups. He trained in general medicine in East Anglia before undertaking specialist training in GUM at St George's Hospital South London; 2005-2009.

He was appointed as consultant at Croydon London in 2009 and became Clinical Lead in 2015. During the 2010s he has been a prominent figure in the SW London GUM-HIV network, chairing service delivery groups and leading training: he also played an active role in the clinical steering group for the Integrated Sexual Health Tariff. David is particularly interested in services for young people and vulnerable groups, as well as innovations to enhance efficiency whilst delivering high quality services: this includes the use of electronic record systems and other technologies that improve patients' access to information and care.

He has been Co-Chair of the Joint BASHH-FSRH Information Group since 2016 and has been involved in numerous consultations, and joint projects with PHE. He is a co-author of the 2019 edition of the Standards for the Management of Sexually Transmitted Infections and the new Standards for Remote and Online Services (joint with FSRH).

Daniel Richardson is a Consultant and Reader in sexual health & HIV medicine in Brighton and is interested in sexual health of men who have sex with men and education having served as the BASHH conference organiser in the past. He has worked in London, Brighton and Sydney Australia in sexual health & HIV.

Chris Ward is a consultant in Sexual Health and HIV at Manchester University NHS Foundation Trust. He studied medicine at Manchester University and then trained in Genitourinary Medicine in the North West. He has an MSc in Public health and focused on Child Sexual Exploitation through a yearlong PHE fellowship. He is the Chemsex and PrEP lead for Manchester. He is the treasurer for the HIV SIG and currently organises and runs the BASHH DipHIV revision course.

Speakers

Tristan Barber is a Consultant in HIV Medicine at the Ian Charleson Day Centre, Royal Free Hospital, and Honorary Associate Professor at the Institute for Global Health, University College London. He a British HIV Association (BHIVA) Trustee and Executive Committee member, as well as Chair of the BHIVA Education and Scientific Subcommittee. He has a research background in HIV-related neurocognitive impairment and phase 3 clinical trials, having been awarded his doctorate by the University of Cambridge in 2019, as well as running a dedicated frailty service for ageing patients with HIV infection (The SAGE Clinic). He is passionate about supporting global HIV educational and research programmes.

Beatrice Cockbain is an Academic Clinical Fellow and Specialist Registrar in Genitourinary Medicine and HIV. Prior to starting this post she spent a year as a sub-investigator on the DISCOVER and IMPACT PrEP trials at Barts Health NHS Trust. Her other research interests include LGBTQ+ and sex worker healthcare and their promotion within medical education.

Emily Dema I've just started my PhD in the UCL-Birkbeck MRC Doctoral Training Programme. Prior to this, I worked as a research assistant with the Natsal-COVID team (https://www.natsal.ac.uk/natsal-covid-study) investigating the impact of the COVID-19 pandemic on sexual and reproductive health in Britain.
I hold a B.A. in Molecular Biology and an MSc in Applied Infectious Disease Epidemiology. My research interests are in sexual health/STIs and molecular epidemiology.

Rageshri Dhairyawan is a Consultant in HIV Medicine at Barts Health NHS Trust, carrying out outpatient and inpatient HIV care and leading the HIV/hepatitis and HIV/lymphoma services. She is an Honorary Senior Lecturer at Queen Mary University of London, and her research and advocacy focus on reducing health inequalities, particularly around gender and ethnicity. She has held national roles at BHIVA and BASHH and is currently a trustee of SWIFT, the Supporting Women with HIV Network. She has roles at several community organisations including NAZ, 4M Mentor Mothers CIC, the South Asian HIV Advisory Resource and the Race and Health Collective. She is currently undertaking a MSc in Social Epidemiology at UCL.

Jennifer Dhingra is a GP trainee, sexual health advocate, and youth expert. She is a UCL alumnus, receiving her MSci in Biological Sciences in 2013 and her MBBS Medicine in 2018. Alongside her medical career, she has worked with organisations such as Sexpression: UK, BASHH, Brook and the British Fertility Society, and was a guest lecturer for the UCL Women's Health and Reproductive Science Masters programme. She currently helps run the BASHH Public Panel and social media, and enjoys working in the field of sexual health journalism and media medicine. Through her work, she aims to spread a message of sex and pleasure positivity, and empower people to make informed decisions about their sexual health.

Sophie Forsyth is a consultant in Sexual health and HIV and deputy academy medical dean at the Great Western Hospital in Swindon. She is the current chair of the BASHH Education committee and previous Adolescent Special Interest Group chair.

Joseph Heskin is a Specialist Registrar in sexual health and HIV working at Chelsea and Westminster Hospital. He is the trainee representative on the BASHH BBV SiG and is currently the BASHH/PHE Research Fellow with the Prison SIG focusing on the epidemiology of STIs within the UK Prison System.

Paddy Horner is an Associate Professor in Sexually Transmitted Infections at Bristol University and works, half-time, as a clinician at Unity Sexual Health. He has long standing research interests in the epidemiology, diagnosis and treatment of Chlamydia trachomatis, Mycoplasma genitalium, non-gonococcal urethritis and the chronic pelvic pain syndrome in men on which he has published widely.

Dwayne-Wilson Hunt graduated as a nurse from Kings College London in 2017. He is now a nurse practitioner working in an integrated sexual / reproductive health and HIV clinic, in London. His passions include: advocating for issues surrounding racial inequalities within the United Kingdom and plans to use his platform to improve the care and health outcomes of this cohort.

Hannah Loftus is a consultant in Sexual Health and HIV at Sexual Health Sheffield and the Stonegrove centre. She was a co-investigator in the PROUD and IMPACT trials and has used this experience to become PrEP lead in Sheffield. She is interested in medical education and is Joint-TPD for the Yorkshire and Humber GUM training programme.

John McSorley has been a Consultant in in Genitourinary & HIV Medicine since 2002, at what is now called London North West Healthcare NHS Trust. This is an integrated healthcare organisation in Outer North West London and included 3 District General Hospitals, Central Middlesex, Northwick Park & Ealing, as well as community services and general practice provision of care. He is also Honorary Clinical Senior Lecturer at Imperial College London, Faculty of Medicine. His interests include, sexual healthcare access and service provision, care of LGBTQ+ populations, HPV vaccination, young peoples services and undergraduate medical education.

Marian Nicholson is director of the Herpes Viruses Association. She started as a helpline volunteer in 1985 and worked in the office part-time. From 1995 she has been running the charity. She provides talks on 'Helping you to Help your Patients with Herpes' for staff at sexual health clinics - currently these are virtual. This independent

charity has delivered patient-friendly, accurate information on herpes simplex since 1985. It runs a website, Facebook pages, a helpline and offers many patient resources. It provides patients self-help advice as well as explaining antiviral treatment. The helpline and messaging services support patients with their emotional reaction to the herpes stigma: they can talk for as long as they wish. The HVA has surveyed and published on patient experiences. It offers expert advice and runs workshops on the topic of disclosure. The HVA is optimistic that good information can reduce stigma and normalize patients' lives.

Achyuta V Nori is a consultant physician in Sexual Health & HIV and the lead for sexual health research at Guy's and St Thomas' NHS Foundation Trust. He is the Deputy lead for Infectious diseases research and the STI research champion for the NIHR South London Clinical Research Network. His clinical interest is delivering accessible specialist sexual health services that prioritise antimicrobial stewardship. His research interests include diagnostics, antimicrobial resistance, host-pathogen interactions and epidemiology of STIs.

Zoch Nwaosu is a Trainee Health Psychologist at UWE Bristol and a Sexual Health Adviser in a GUM/HIV service. He has a particular interest in the sexual health of marginalised groups, including young people and Black people, and is passionate about addressing the sexual health inequalities observed among these groups. Zoch is in the final year of his doctoral programme, with his current research exploring the sexual health experiences and motivators of Black heterosexual men in London**.**

Rachel Pitt has been working in STI microbiology for over 12 years with particular focus on antimicrobial resistance and difficult to culture organisms. Rachel is currently the Acting Section Lead for the Antimicrobial Resistance in STIs section of the Antimicrobial Resistance and Healthcare Associated Infections reference laboratory at the UK Health Security Agency (formerly Public Health England).

Lewis Ruddock is an Adult and Mental Health Nursing student at the University of Leicester alongside being a member of the Sexpression:UK national committee and the Branch Coordinator for the local branch in Leicester. Being with Sexpression for over 3 years now Lewis has won awards from participation including Sexpressioner of the Year 2020 for outstanding involvement in Sexpression, upholding its values and supporting its aims.

John Saunders is Deputy Head of the Programme Delivery and Service Improvement Section in the Blood Safety, Hepatitis, STI & HIV Division at the UK Health Security Agency, a Senior Clinical Researcher in the Centre for Clinical Research in Infection and Sexual Health at University College London, and an Honorary Consultant in Sexual Health at The Mortimer Market Centre in central London. He is the UKHSA lead for the NIHR Health Protection Research Unit in Blood-Borne and Sexually Transmitted Infections. John's research interests are in HIV and STI prevention and delivery of care. He is a coinvestigator for the PrEP Impact Trial in England, LUSTRUM and Sequence *digital*, both five-year NIHR funded programmes of research aiming to improve sexual health through preventing transmission of STIs and ensuring equitable delivery of digital sexual health services.

Lorraine Stanley formerly a fitness instructor, woke up paralysed in 2007, after a flu-type bug developed into M.E. and forced her to stop trading. Seeking support on sex and disability, Lorraine found very little accessible help. She discovered that there are often only a handful of sessions covering the subject of sex and intimacy across several years of formal training for health care and social care professionals. Lorraine decided to be pro-active, and ran several sex and disability discussion groups at her local independent living centre.
Fast forward to 2021, and her not-for-profit training organisation SWAD has been featured in a book, she has launched her web-based training services, won business awards for innovative and progressive work, and has been an invited speaker at events local, national and international.
Lorraine has lived experience of being bisexual and a swinger, and a professional background in training and development.

Victoria Tittle is a GUM/HIV consultant at 56 Dean Street, Chelsea and Westminster NHS Trust. She runs the Complex PrEP service at Dean Street and leads the Chelsea and Westminster PrEP MDT.

Malachi Willis: Is a research associate within the MRC/CSO Social and Public Health Science Unit and The University of Glasgow. He primarily researches nuances of sexual consent.

VBASHH21 – ON DEMAND

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Program code	Presenting author	Title
V1	Ella Heath	Evaluating the awareness of sexual health knowledge and needs of mental health patients in mental health staff.
V2	Azjad Yasmin Elmubarak	How can the cervical screening of HIV-positive patients at Heartlands Hospital be improved?
V3	Daniel Richardson	The contribution of Contact Tracing to the diagnoses of HIV, syphilis & Gonorrhoea in MSM
V4	Jessica Gaddie	Assessing quality of service provision and evaluation of outcomes for patients diagnosed with Vulvodynia referred to a Psychosexual Clinic.
V5	Hannah Charles	Investigating recent trends of S. flexneri among men who have sex with men in England: dominance of three genotypic clusters
V6	Tamilore Sonubi	How has the COVID-19 pandemic affected chlamydia screening of 15-24 year-olds in England?
V7	Manik Kohli	Audit of sexual and reproductive health measures in women living with HIV: comparing face-to-face and virtual consultations.
V8	Yee Suh Teh	An audit investigating routine contraceptive enquiry for Women Living with HIV of reproductive age at an integrated sexual health service during the COVID-19 pandemic.
V9	Mary Brown	Remote epidemiological treatment (RET) for contacts of sexually transmitted infections (STIs) using a regional online sexual health service (e-SHS)
V10	Katie Callaghan	Use of a regional online sexual health service (e-SHS) for sexually transmitted infection (STI) and HIV testing by individuals taking pre-exposure HIV prophylaxis (PrEP)
V11	Jack Brown	Changes in STI risk behaviour and testing among MSM during COVID-19 restrictions: Results from two large, community-based cross-sectional surveys in the UK
V12	Tika Ram	Using STI testing positivity to understand STI trends and patterns in England
V13	Owain Williams	Service evaluation of virtual and face to face HIV clinics during the covid-19 pandemic
V14	Jonathan Shaw	Moving progestogen-only pill provision online: will additional needs be missed? A retrospective review of additional services offered, and risks identified during telephone consultations for the progestogen-only pill at an integrated sexual health service

V15	Helen Corkin	“It wasn’t the egg sandwich”: experiences of illness and case management of sexually transmitted shigellosis among gay men in England during COVID-19
V16	Qudsia Enayat	Implementing national surveillance of disseminated gonococcal infection: preliminary findings from cross-sectional survey data in England, 2020-2021
V17	Eleanor Cochrane	Auditing PrEP service provision and outcomes before and during the COVID pandemic. Were standards maintained as the service changed?
V18	Darren Cousins	What is the response to an "active offer" in PrEP recall following relaxation of COVID restrictions in those thought lost to follow up?
V19	Louise Kerr	HIV post exposure prophylaxis attending the emergency department: should we be dispensing 28 day packs
V20	Jozef Shaw	Shigella during the COVID-19 era: Review of Clinician History Taking as a Marker of Awareness for Sexual Transmission Risk
V21	Ana K. Harb	Use of the National HIV and Syphilis Self-Sampling Service during the national lockdowns in England, 2020-21

SPONSORS

We would like to acknowledge and thank our sponsors for their support towards the vBASHH 2021 conference

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ABSTRACT BOOK

O1: Syphilis/chlamydia co-infection and antimicrobial antagonism between benzathine penicillin (BPG) and doxycycline

Daniel Richardson[1,2], Ali Siddiqi[1], Kuhuk Parashar[1], Colin Fitzpatrick[1], Nicholas Pinto-Sander[1], David Goldemeier[3,4]

[1]University Hospitals Sussex NHS Foundation Trust, Brighton, United Kingdom. [2]Brighton & Sussex Medical School, Brighton, United Kingdom. [3]Jefferiss Wing, Imperial College Healthcare NHS Trust, London, United Kingdom. [4]Imperial College of Medicine, London, United Kingdom

Introduction: Penicillins are bactericidal whereas doxycycline is bacteriostatic; simultaneous use has been shown to cause antimicrobial 'antagonism', and associated treatment failure in cases of pneumococcal meningitis, scarlet fever and neurosyphilis. The SmPC recommend the avoidance of simultaneous use of Benzathine penicillin(BPG)/doxycycline. There is no data on syphilis/chlamydia co-infection despite increasing rates of STIs in MSM.

Methods: We aimed to estimate the prevalence of chlamydia co-infection in MSM with early syphilis in 2019 and describe the clinical features, management, and outcomes compared to MSM diagnosed with syphilis alone.

Results: In 2019, 6613 individual MSM attended for STI testing and 155 MSM were diagnosed with early syphilis. Fifty three(34%) were HIV positive, the median age was 43 years (IQR=34-53), the median VDRL at baseline was 1:32, none had neurological syphilis and all were treated with BPG. 21(14%,95%CI=8.6-20.1) were simultaneously diagnosed with chlamydia (rectal: 17/21(81%), urethra: 4/21(19%)) and none had LGV. MSM with syphilis/chlamydia co-infection were the same age (43.v.44-years, p=0.426), had similar baseline VDRL titres (1:32.v.1:32,p=0.586), were diagnosed at similar stages of syphilis, but were significantly more likely to be HIV-positive than MSM diagnosed with syphilis alone(p=0.004). Thirteen out of 21 with co-infection were not treated simultaneously either because of delays in laboratory results(N=10) or clinician concerns about antimicrobial antagonism(N=3). Eight out of 21 MSM were inadvertently treated simultaneously with BPG/doxycycline. There were no treatment failures: overall 108/155(70%) attended for at least one follow up VDRL and all had at least a 4-fold reduction in VDRL titre(median 1:1) at a median of 101-days.

Conclusions: We have shown that a small proportion of MSM diagnosed with syphilis are diagnosed with chlamydia simultaneously. Although we did not demonstrate any treatment failure, caution is needed with co-prescribing BPG/doxycycline for syphilis.

O2: The effect of melanocortin-4 receptor agonism on sexual brain processing in women with hypoactive sexual desire disorder

Tia Hunjan[1], Layla Thurston[1], Edouard Mills[1], Matthew Wall[2], Natalie Ertl[2], Maria Phylactou[1], Beatrice Muzi[1], Bijal Patel[1], Emma Alexander[1], Sofiya Suladze[1], Manish Modi[1], Pei Eng[1], Paul Bassett[3], Ali Abbara[1], David Goldmeier[4], Alexander Comninos[1], Waljit Dhillo[1]

[1]Imperial College London, London, United Kingdom. [2]Invicro, a Konica Minolta Company, London, United Kingdom. [3]Statsconsultancy Ltd, Amersham, United Kingdom. [4]Imperial College Healthcare NHS Trust, London, United Kingdom

Introduction: Hypoactive sexual desire disorder (HSDD) is characterized by a persistent lack of sexual desire and sexual fantasies, causing marked interpersonal distress. It is the most common global female sexual health problem, affecting up to 1 in 10 women. Despite its significant social and economic burden, the pathophysiology of this condition remains unknown. Existing treatment options are limited by their efficacy and side effects. Melanocortin-4 receptor (MC4R) agonists are a promising therapeutic avenue, although their mechanism of action remains unknown. Investigating the neural pathways through which MC4Ra's exert their effect in women with HSDD will deepen our knowledge of normal and abnormal sexual behaviour, and hence provide information which could contribute to the development of novel treatment strategies.

Methods: We performed a randomised, double-blind, placebo-controlled crossover study in 31 premenopausal women with HSDD. A combination of psychometric, functional neuroimaging and hormonal analyses was used to investigate the effect of MC4R agonism on sexual brain processing.

Results: MC4R agonism increased self-reported sexual desire for up to 24-hours following administration, when compared with placebo (P=0.007). In response to visual erotic stimuli, MC4R agonism led to increased activation of the supplementary motor area and cerebellum, alongside deactivation of the secondary somatosensory cortex, when compared with placebo (P<0.05). Additionally, a reduction of functional connectivity between the amygdala and insula in response to erotic stimuli was prevented by MC4R agonism (P=0.025). MC4R agonism led to a small mean increase in LH of 1.1iU/L and FSH of 0.35iU/L during the study, with no effect on oestradiol or progesterone levels.

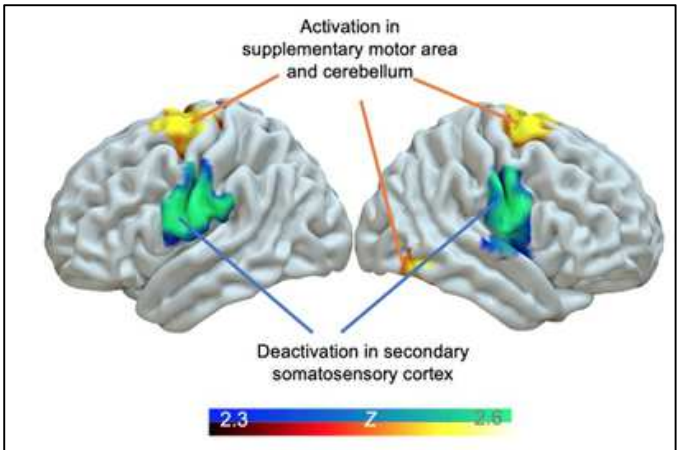

Figure 1: Functional MRI image demonstrating brain activation and deactivation areas with melanocortin-4 receptor agonism in response to erotic stimuli, compared to placebo.
Clusters corrected for multiple comparisons, Z=2.3, $P<0.05$, $n=31$.

Discussion: These results shed light on the neural substrates through which MC4R agonists increase sexual desire. The observed changes in brain activation may serve to ease self-consciousness, enhance sexual imagery and disinhibit the sexual response in women with HSDD. This information is important for the ongoing development of therapies for HSDD.

O3: Difficulties in the management of syphilis in a women's prison during the COVID pandemic

SY Chan

CNWL, London, United Kingdom

Introduction: In 2019, there were only 4 cases of syphilis in a women's prison. Cases increased between 2020 to 2021. This coincided with the COVID-19 pandemic and a reduction of face to face appointments permitted. All residents in the prison are offered screening for syphilis as part of blood borne virus screening, although this decreased during lockdown.

Methods: An audit was done of all residents testing positive for syphilis antibody by dried blood spot from July 2020 to July 2021. The screening test does not include RPR, this has to be done in a face to face blood clinic.

Results: 34 women tested positive for syphilis antibody. 8/34 had past treated syphilis and a negative RPR. There was 1 false positive. 5/34 were released before we could inform them. We managed to inform 3/5 people after release. 20 people were treated for syphilis in prison, mean age of 41, 10/20 were commercial sex workers (CSW), 12/20 were people who inject drugs (PWID). 5/20 were given Doxycycline due to lack of appointments for injections during lockdown. 15 were given benzathine penicillin. 9/20 had early syphilis and 10/20 had late latent syphilis. 1/20 had syphilis uveitis. Partner notification was done for 2/20 people.

Discussion: It was very difficult to manage syphilis in prison during the Covid-19 pandemic. The number of people who could be seen in face to face clinics was very limited. It was difficult to follow patients up after they were released as many of them were homeless, PWID and worked as CSWs. We worked together with local drug units, the find and treat team, as well as other GUM clinics to try to ensure that patients were followed up and informed of their diagnoses.

O4: Trends of sexually transmitted infections (STIs) in England during COVID-19: a snapshot of laboratory surveillance data

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Public Health England, London, United Kingdom

Introduction: Between 2010-2019, STI diagnoses in England steadily increased. To perform real-time assessments of STI trends, we established and maintain a monthly report using laboratory surveillance. We aimed to describe the impact of COVID-19 on reported diagnoses.

Methods: We extracted records of chlamydia, gonorrhoea, herpes, shigellosis and syphilis diagnoses from the Second Generation Surveillance System (SGSS) laboratory database, and lymphogranuloma venereum (LGV) from SGSS and PHE's National Reference Laboratory. For each STI we plotted monthly diagnoses from January 2019-June 2021. Average diagnoses in periods corresponding to different lockdown restrictions (Period 1: March-May 2020, Period 2: June 2020-October 2020, Period 3: November 2020-March 2021 and Period 4: April-June 2021) were compared to the same months in 2019, with the comparator for Period 3 including Jan-Mar 2020. We compared laboratory reporting to GUMCAD data (2019-2020) as the gold standard to assess completeness and reliability of trends.

Results: Following a decrease in STI diagnoses in Period 1, diagnoses recovered slightly in Period 2 (59% and 50% lower) (Figure 1). Regional and national lockdowns during Period 3 corresponded with dips in diagnoses but not to the extent observed during Period 1 (47% lower). While STI diagnoses increased during Period 4, the levels remained below April-June 2019 (49% lower). Despite differences in numbers of diagnoses, laboratory data from 2019-2020 mirrored trends seen in GUMCAD.

Discussion: Laboratory surveillance identified reductions in STI diagnoses since March 2020. While trends in 2021 have shown an increase in diagnoses, the gradual easing of restrictions has not yet led to pre-pandemic levels. The impact of the pandemic on STIs may be explained by a combination of behavioural changes, reduced access to testing, and changes in reporting. We have shown that laboratory data can monitor trends in real-time, improving our understanding of the pandemic's impact on STIs.

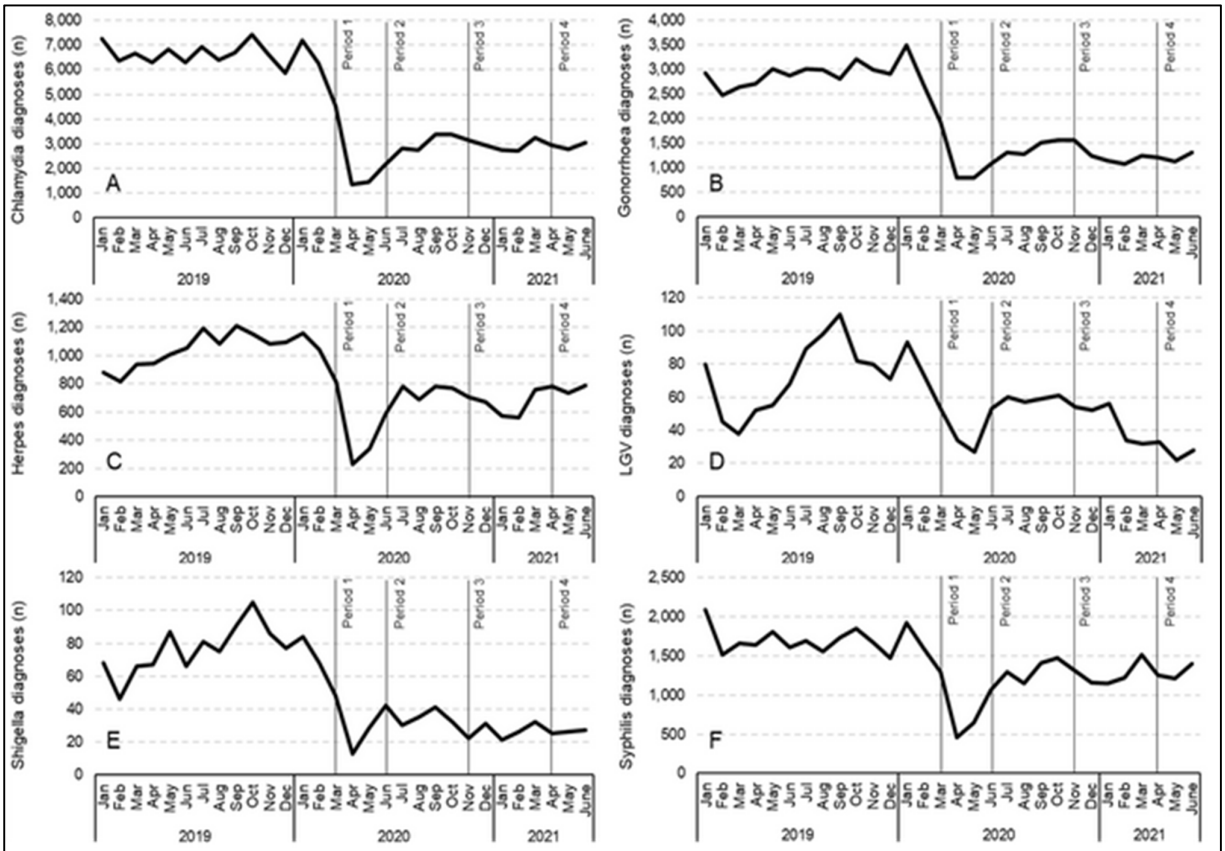

Figure 1. Trends in laboratory diagnoses* for chlamydia, gonorrhoea, herpes, LGV, shigella and syphilis, January 2019 to May 2021, England**

*Diagnoses include adults over 15 years; Herpes includes anogenital diagnoses only; LGV and *Shigella* include men only; *Shigella* includes *S. flexneri* and *S. sonnei* only.

**Chlamydia, gonorrhoea, herpes and LGV are underestimates, and syphilis is an overestimate of the overall diagnoses for England, however they closely follow trends seen in GUMCAD. *Shigella* trends from laboratory sources have not been compared to GUMCAD because most diagnoses are reported from settings other than sexual health services.

O5: Impact of the first year of the COVID-19 pandemic on syphilis testing among gay, bisexual and other men who have sex with men in England

Freddy Green, Hannah Charles, Mateo Prochazka, Helen Fifer, Hamish Mohammed, Katy Sinka

Public Health England, London, United Kingdom

Introduction: Syphilis in England has increased in recent years, particularly among gay, bisexual and other men who have sex with men (MSM). Increasing testing leads to earlier treatment and reduces transmission. During 2020, the COVID-19 pandemic hindered access to sexual health services, including syphilis testing. We compared the trends in and patterns of syphilis testing among MSM before and during the COVID-19 pandemic in England.

Methods: Data on syphilis testing of MSM were obtained from the GUMCAD STI Surveillance System over two time-periods: before (1 April 2019 to 31 March 2020) and during (1 April 2020 to 31 March 2021) the COVID-19 pandemic. We compared the number of syphilis tests, test positivity (proportion positive) and modality (in-person vs. internet). We also compared the distribution of tests by HIV status, ethnicity and index of multiple deprivation (a classification of relative residential area-level deprivation).

Results: The number of all syphilis tests among MSM decreased by 24.2% during the pandemic (254,115 to 192,630), with a large increase in the proportion of syphilis tests that were delivered via the internet (47,115 to 99,082, 18.5% to 51.4%). Test positivity was similar before (2.8%) and during (2.9%) the pandemic. The proportion of tests among HIV negative or undiagnosed MSM was similar in the two time-periods (91.8% to 93.9%). The proportion of tests by ethnicity and index of multiple deprivation were similar between both periods.

Discussion: A doubling in the number of internet tests, albeit with a reduction in the total number of tests, suggests a marked change in how MSM accessed syphilis testing during the COVID-19 pandemic. These findings show the scale up of internet testing for syphilis among MSM in England. Further work is needed to assess the extent of missed diagnoses, the impact of this shift in service provision and to understand the scale of digital exclusion.

Table 1. Number and proportion of syphilis tests among men who have sex with men (MSM) before and during the COVID-19 pandemic by test modality and risk group, and overall test positivity

	Period 1 (1 April 2019 – 31 March 2020)	Period 2 (1 April 2020 – 31 March 2021)
Total number of syphilis tests	254,115	192,630
Testing modality		
In-person	207,000 (81.5)	93,548 (48.6)
Internet	47,115 (18.5)	99,082 (51.4)
Test positivity	2.80%	2.91%
HIV status		
HIV negative or undiagnosed	233,361 (91.8)	180,832 (93.9)
Living with HIV	20,754 (8.2)	11,798 (6.1)
Ethnic group		
White	192,101 (75.6)	146,298 (75.9)
Asian or Asian British	12,847 (5.1)	9,490 (4.9)
Mixed	10,915 (4.3)	9,069 (4.7)
Black or Black British	9,991 (3.9)	8,007 (4.2)
Other ethnic groups	28,261 (11.1)	19,766 (10.3)
IMD		
1 – Most deprived	50,538 (20.3)	38,361 (20.5)
2	78,860 (31.6)	59,504 (31.8)
3	54,170 (21.7)	40,478 (21.7)
4	39,005 (15.7)	28,958 (15.5)
5 – Least deprived	26,693 (10.7)	19,788 (10.6)

O6: Introducing undiluted RPRs to online sexually transmitted infection (STI) self-sampling screening

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Introduction: Online self-sampling is an important strategy to increase access to STI testing which has been accelerated during the COVID-19 pandemic. Increased access to testing for syphilis is a public health priority as incidence continues to rise and untreated infections have serious complications.

SH:24, an online self-sampling STI screening service, introduced an undiluted RPR screening test to routine STI testing for those with a previous history of syphilis. Prior to this only syphilis EIA was available, meaning anyone with a history of syphilis was required to attend clinic to complete syphilis screening.

Methods: We retrospectively reviewed electronic notes and testing data from the SH:24 database during a 4-month period before and after undiluted RPR screening was introduced. We examined whether tests were requested appropriately and whether the introduction of this novel self-sampling screening test reduced overall clinic attendances.

Results: 25,778 tests for syphilis were completed within the study period; of these 494 were RPR tests, of which 134 (27.1%) were reactive. 100% of RPR tests were requested appropriately by service users reporting previous syphilis diagnosis. Of the group requesting RPR, 244 (82.2%) were MSM, 22 (7.4%) reporting taking pre-exposure prophylaxis, and 69 (23.2%) reported unprotected sex within the window period for the RPR test. In 2019, pre-RPR, 147 (100%) of reactives were referred to clinic for further testing. After the introduction of undiluted RPR testing, 299/659 (45%) were referred to clinic.

Summary Table	May-Aug 2019	May-Aug 2020
Total STS run	16,477	25,778
Total RPR run	-	494
Total EIA run	16,477 (100%)	25,297
Total Positivity Rate	Only EIA performed	1.15% (n=297)
RPR Positivity	-	27.1% (n=134)
EIA Positivity	0.89% (n=147)	0.65% (n=165)

RPR Reactives	No.
Gender	
Male	280 (94.3%)
Female	17 (5.7%)
Age	
16-25	49 (16.5%)
26-35	121 (40.7%)
36-45	68 (22.9%)
46-55	38 (12.8%)
56-65	17 (5.7%)
66-75	4 (1.4%)
Sexual Preference	
MSM	244 (82.2%)
Bisexual Men	27 (9.1%)
Heterosexual Women	17 (5.7%)
Heterosexual Men	9 (3.0%)
PreP	
Reports PreP Trial No.	22 (7.4%)
UPSI in last 5 days	
Yes	69 (23.2%)
No	228 (76.8)
History of SH clinic attendance in the last 12 months	
Yes	234 (78.8%)
No	61 (20.5%)

Discussion: The introduction of undiluted RPR tests increased access to online testing for those with a previous diagnosis of syphilis and avoided clinic referrals for those who would otherwise test positive on EIA. Accessible screening for this high-risk population is important with 3-monthly screening recommended in national guidelines. Those receiving RPR testing instead of EIA did so appropriately, but regular screening remains important for those who have unprotected sex within the window period.

O7: The Sex Agenda - Digital Sex Education Intervention

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Introduction: The Sex Agenda is a digital project with in person events to deliver sexual and reproductive (SRH) health information to young Black and Brown communities including through a podcast, the delivery of online seminars and the creation of SRH zine to be circulated in both online, sexual health clinics and to sex educators.

Our previous work (1) suggests that Black and Asian young people particularly those that are gender non-conforming or LGBTQI+ have different relationship, sexual education needs compared to their white counterparts. That they require sex education is both culturally sensitive and specific. The project was grounded in feminist approaches and reproductive justice scholarship; centering issues that intersect with sexual health but are commonly overlooked (2).

Methods:

- Podcasts guests were identified and recruited using previous project partners, community leaders and topical issues raised through the course of the project.
- 15 episodes of the podcast were recorded on a range of topics including Herpes stigma, Trans access to healthcare, Black women and childbirth
- 10 free workshops throughout the year have been implemented so far, the majority of these being only using Zoom. We collaborated with other community groups.
- We collected feedback from participants using surveys which were advertised during the podcast, using a QR code during workshops and in the zine.

Results:

- We received feedback from participants from all three aspects of our project.
- People appreciated having direct contact with doctors and the opportunity to ask questions in an informal setting.
- The zine provided an opportunity to elevate marginalised voices receiving input from LGBTQI participants who were less likely to attend our workshops.

Discussion: The use of social media for SRH and relationship education is increasing in popularity. There is some evidence to suggest that there is better engagement from some marginalised groups who have digital access online as it allows for anonymity.

O8: Chemsex, sexual behaviour and STI-PREP during the COVID-19 pandemic

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Introduction: The COVID-19 pandemic and social distancing restrictions have been associated with changes in HIV pre-exposure prophylaxis(HIV-PrEP) USE and sexual behaviour including chemsex behaviour amongst men who have sex with men(MSM). Recent preliminary data on the use of doxycycline for prophylaxis to prevent sexually transmitted infections(STI-PrEP) has led to MSM using STI-PrEP.

Methods: As part of a local service needs assessment for the provision of services for MSM using PrEP and engaging in chemsex, we asked MSM to complete a short anonymous electronic survey after their PrEP monitoring appointment.

Results: Of the 269 MSM who attended for HIV PrEP monitoring between May-June 2021, 109(41%) completed the survey; 105 cis-men and 4 trans-gender individuals. 34(31%) reported using recreational drugs in the previous 3 months, of which 18(17%) used drugs for sex (chemsex) and 12(11%) as part of group sex; and 2(2%) reported injecting drug use. All 18 were poly drug users: 9/18 used Crystal methamphetamine, 9/18 gamma-hydroxybutyrate (GHB), 4/18 mephedrone, 3/18 ketamine and 4/18 PDE5-inhibitors. 5/109(5%) reported buying doxycycline online for use as STI-PrEP. During the COVID-19 pandemic 10(9%) reported having the same or more non-household non-steady sexual partners than before the pandemic, 57(52%) less than before the pandemic and 41(38%) reported not meeting partners for sex at all during the pandemic. MSM engaging in chemsex were more likely to use doxycycline PrEP (22%.v.1%,p=0.003) and to have continued to see casual sexual partners (50%.v.1%, p=0.0001) throughout Covid-19 pandemic.

Conclusion: A small but significant proportion of MSM using HIV-PREP during the COVID-19 pandemic continued to see the same or increased number of non-steady sexual partners. These MSM were more likely to have engaged in chemsex and used STI-PrEP: provision needs to be made by services to facilitate adequate harm reduction interventions for this group.

O9: Recreational drug use, chemsex and antiretroviral prescribing

Zoe Adler[1], Colin Fitzpatrick[1], Nicholas Broadwell[2], Duncan Churchill[1], Daniel Richardson[1,2]

[1]University Hospitals Sussex NHS Foundation Trust, Brighton, United Kingdom. [2]Brighton & Sussex Medical School, Brighton, United Kingdom

Introduction: Ritonavir and cobicistat inhibit both cytochrome P450-CYP3A4 and CYP2D6 and are co-prescribed with protease inhibitors and elvitegravir to increase the bio-availability and effectiveness of the antiretroviral regimen. The chemsex drugs, GHB/GBL, and crystal methamphetamine are substrates of CYP3A4 and CYP2D6; patients taking cobicistat or ritonavir experience higher levels of the chemsex drugs and risk causing inadvertent overdose/death due to drug-drug interactions.

Methods: We aimed to describe recreational drug use in our population of HIV in particular chemsex drugs, and review their prescribed antiretrovirals to highlight any potential harmful drug-drug interactions.

Results: 2202/2501(88%) patients attending for HIV care were asked about recreational drug use in the previous 3 months. We found that 514(23%) disclosed recreational drug use; of these 498(97%) were male, and 461(90%) were men who have sex with men (MSM). Eighty two drug users disclosed recent chemsex; 73(83%) used crystal methamphetamine 51 (61%) used GHB/GBL, and 63(76%) reported injecting drug use. The chemsex users were all cis-male MSM and they were older (53 years.v.46,p=0.04), and more likely to have had previous syphilis (73%.v.28%,p<0.01) than patients reporting other recreational drug use. All 82 chemsex users were prescribed antiretroviral therapy and 74(90%) had an undetectable HIV viral load. Of the 8 patients with a detectable viral load the median viral load was 1853(IQR=131-5276). Thirty one patients (38%) were taking either ritonavir(N=12) or cobicistat(N=19) as part of their antiretroviral regimen and this was similar to other patients attending for HIV care (768/2419(31%).

Discussion: 38% of the chemsex users were prescribed either cobicistat or ritonavir potentially leading to harmful drug-drug interactions. All HIV patients should be routinely asked about recreational drug use and those using chemsex drugs should ideally not be prescribed cobicistat or ritonavir containing regimens to avoid harm.

O10: Implementing a remote clinical images service during the COVID-19 pandemic in a community sexual health clinic

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[1]St George's University Hospitals NHS Foundation Trust, London, United Kingdom. [2]Central London Community Healthcare NHS Trust, London, United Kingdom

Introduction: The imperative to minimise contagion of COVID-19 in the community presented significant operational challenges for sexual health clinics during the pandemic. To protect patients and staff, face-to-face appointments were replaced by remote telephone consultations where possible. We herein report our experience in a busy sexual health clinic of a novel, remote, consultant-led, telemedicine service intended for the assessment of visible genital lesions.

Methods: We carried out a single-centre, retrospective study evaluating diagnoses and outcomes for patients assessed remotely between 15/06/2020 and 18/03/2021. Patients were telephone-triaged by a clinician and, where appropriate, invited to send images for consultant review.

Results: 230 patients were invited to submit images for review, of which 174 did so. 127 patients (73%) were able to be managed remotely, including with a remote prescription / treatment plan (n=65), or reassurance (n=51) (Figure 1). 47 patients (27%) required face-to-face review, which in all cases was due to poor-quality images precluding accurate remote assessment. The median time between the patient contacting the service and receiving the results of their assessment was 6 days (Table 1a). The most common diagnosis was genital warts (n=81); other diagnoses are shown in Table 1b.

Total Patients	**230**
Female : Male	**99 : 131**
No. of Patients who sent Images	**174**
Timescale (weeks)	**42**
Clinicians Involved	**31**
Face-to-Face Appointments Avoided	**127**
Needed Face-to-Face Anyway	**47**
Mean Wait (days)	**6.2**
Median Wait (days)	**6**
Maximum Wait (days)	**28**

Table 1a - Summary of Results

Genital warts	**81**
Normal anatomy / No abnormality	**34**
Folliculitis	**22**
Fungal Dermatosis	**13**
Molluscum Contagiosum	**11**
Genital herpes	**7**

Table 1b - Commonest diagnoses made

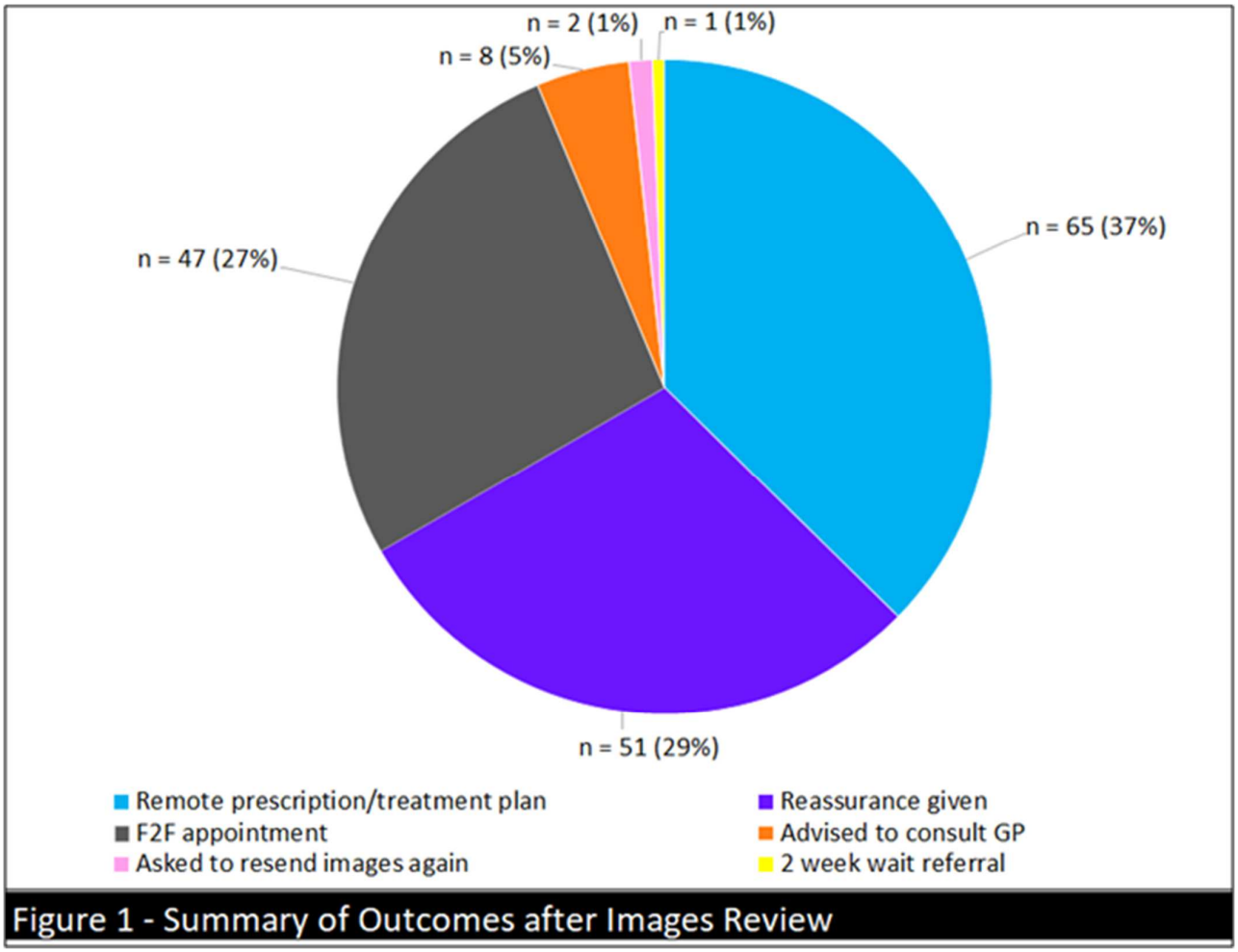

Figure 1 - Summary of Outcomes after Images Review

Discussion: In summary, our novel clinical images service allowed us to remotely diagnose and safely manage many patients with non-urgent genital dermatoses, thereby avoiding 127 face-to-face appointments. Together with eliminating risk of COVID-19 transmission, remote consultations can offer convenience for patients and efficiency for providers. Limitations of telemedicine include risk of missed diagnoses, perceived lack of choice for patients, worsening of digital inequalities, and missed opportunities for sexual infection screening. Our service is not currently suitable for urgent lesions due to the 6-day median waiting time, and poor image quality was sometimes an issue. Moving forwards, images services implemented adjunctively, alongside face-to-face consulting, could diversify sexual healthcare provision, improve accessibility, and enhance patient experience.

O11: Using a messaging service to offer sexual health advice and support

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Introduction: Digital access to healthcare has increased in recent years, accelerated by the COVID-19 pandemic and encouraged by the NHS Long Term Plan for digital-enabled care to go mainstream. This abstract explores the use of messaging by a sexual health service to offer advice and support to local populations.

Methods: The dedicated 'Chat Sexual Health' messaging helpline - commissioned by a local NHS organisation and powered by the award-winning NHS messaging platform, ChatHealth -is promoted locally using printed and digital communications. Service users can send a confidential message for advice and support, anonymously if they wish. Staff are trained to use the safe and secure web-based ChatHealth portal to respond and manage incoming messages from service users.

Results: The sexual health messaging service receives a monthly average of 350 incoming messages across 76 messaging conversations. 41% of the messaging conversations relate to STI's, 26% to genital symptoms, and 16% to contraception. Around 85% of contacts have appropriate care delivered entirely within the messaging conversation, with others are signposted, offered follow-up care (via telephone or face-to-face), or referred to another service.

Feedback from one service user, "Thank you. What a wonderful service this is. I had a fear of explaining myself! You've made this so easy!"

The service lead said, "ChatHealth has opened up a whole world of people that I'm not sure we were seeing before. The pandemic has given us permission to work in a different way and recognise that not everybody needs to be seen face-to-face."

Discussion: There is evidence to suggest that the use of messaging services to offer sexual health advice and support is welcomed by service users. Uptake of the service has been good and positive feedback from service users shows that they feel it is an approachable and discreet way to seek sexual health advice. It can enable sexual health services to work in an efficient way; all messaging enquiries can be triaged at the point of contact. This provides stretched teams with the capacity to offer universal access for all whilst reserving clinical time for face-to-face/telephone appointments for the service users most in need.

O12: An evaluation of GP offered HIV testing in an ethnically diverse and economically challenged inner city UK area

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Introduction: HIV testing is recommended in all patients accessing primary care in areas of high HIV seroprevalence and for people belonging to groups at increased risk of exposure to HIV.

HIV testing is seldom offered outside of sexual health settings.

Methods: A group of GP practices with a resident population of 34,535 funded a one-off HIV testing offer for their adult population, distributed via text.

The combined practice area was more ethnically diverse (36.2% non-white) and economically deprived than the city as a whole. People who responded and were identified as higher risk (MSM and those from high prevalence countries) were sent a self-test. Others were redirected to the free national HIV online testing programme

Results: 80 patients were identified as higher risk of whom 44/80 (55%) were MSM and 43/80 (54%) were white British. 29/80 (36%) had never tested before. 38/80 (47%) last tested > a year earlier. Results were available for 27/80 (result registration still in progress). 1/27 tested positive (one white cis male, CD4 count 180, not on PrEP, last test 5 years ago). 143 people at lower risk were redirected to the national postal testing programme.

Not all practices joined the pilot from the outset. Reasons for initial reluctance included concern that patients would not understand the text and impact on practice workload.

Discussion: The single offer of HIV test to an adult primary care population by text was acceptable and prevented at least one hospital admission with advanced HIV. Most individuals testing were white MSM of whom a significant number had not tested recently, but there was significant ethnic diversity. Challenges regarding HIV stigma and outdated HIV testing practices were evident in the planning discussions. The project contributed to the normalization of HIV testing in routine clinical practice, outside of this pilot.

O13: Comparison of the demographics of asymptomatic and symptomatic users ordering through an online STI testing service during the Covid-19 pandemic

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Background: In response to the Covid-19 pandemic, online testing services (e-SHS) have increased to allow asymptomatic individuals to test for sexually transmitted infections (STIs). Individuals with mild symptoms were newly able to use e-SHS to test, while those with complex symptoms were referred to clinics.

This study looks at the demographics of mildly symptomatic and asymptomatic groups, to determine if individuals most at risk for sexual health inequalities access symptomatic testing.

Method: Retrospective analysis was performed on 596,637 orders, by users who were asymptomatic (n=484,139) and mild symptomatic (n=112,498), placed between 26 March 2020 and 30 June 2021. We examined sex, ethnicity, deprivation decile, and age of individuals placing test kit orders in the symptomatic and asymptotic cohorts, exploring the difference in the proportions of demographics between the cohorts.

Results: We found a higher proportion of symptomatic to asymptomatic users in testing kit orders from deprived areas (deciles 1, 2 and 3) compared with affluent areas.

There was a higher proportion of symptomatic females testing (74.4% [83,731/112,498]), compared to the proportion from the asymptomatic cohort (53% [256,491/484,139]). Whereas, there was a lower proportion of men in the symptomatic cohort (25.2% [28,311/112,498] of symptomatic orders were from men) compared to the proportion of men in asymptomatic cohort (46.2%, [223,467/484,139]).

With ethnicity, there was a higher proportion of symptomatic Black Caribbean and Black African individuals testing, compared to asymptomatic orders. When looking at age, 10.5% (50990/484,139) of asymptomatic orders were from 18-21-year-olds, whereas they made up 16% (18049/112,498) of orders in the symptomatic cohort.

Sex	Asymptomatic orders	Proportion of asymptomatic orders	Symptomatic orders	Proportion of symptomatic orders
Female	256491	53.0%	83731	74.4%
Intersex	131	0.0%	27	0.0%
Male	223467	46.2%	28311	25.2%
NonBinary	2035	0.4%	205	0.2%
Other	1044	0.2%	143	0.1%
Trans	7	0.0%	1	0.0%
Trans-Female	637	0.1%	37	0.0%
Trans-Male	327	0.1%	43	0.0%

Ethnicity	Asymptomatic orders	Proportion of asymptomatic orders	Symptomatic orders	Proportion of symptomatic orders
White British	205839	42.5%	40835	36.3%
White Irish	9614	2.0%	1713	1.5%
Other White Background	84604	17.5%	19799	17.6%
White and Black Caribbean	16906	3.5%	4844	4.3%
White and Black African	6502	1.3%	1793	1.6%
White and Asian	6692	1.4%	1493	1.3%
Other Mixed Background	13667	2.8%	3470	3.1%
Indian	9750	2.0%	2380	2.1%
Pakistani	3565	0.7%	1035	0.9%
Bangladeshi	3054	0.6%	1122	1.0%
Other Asian Background	9769	2.0%	2624	2.3%
Caribbean	42900	8.9%	11922	10.6%
African	43034	8.9%	11748	10.4%
Other Black Background	5133	1.1%	1451	1.3%
Latin American	3351	0.7%	1101	1.0%
Chinese	5684	1.2%	1275	1.1%
Other Ethnic Group	10214	2.1%	2865	2.5%
Not Stated	3851	0.8%	1026	0.9%
(blank)	10	0.0%	2	0.0%

Deprivation decile	Asymptomatic orders	Proportion of asymptomatic orders	Symptomatic orders	Proportion of symptomatic orders
1	13088	2.7%	3746	3.3%
2	84787	17.5%	21696	19.3%
3	103738	21.4%	24682	21.9%
4	81353	16.8%	17960	16.0%
5	55080	11.4%	12426	11.0%
6	50062	10.3%	11033	9.8%
7	33586	6.9%	7596	6.8%
8	28685	5.9%	6072	5.4%
9	22194	4.6%	4899	4.4%
10	9354	1.9%	1955	1.7%
(blank)	2212	0.5%	433	0.4%

Age range	Asymptomatic orders	Proportion of asymptomatic orders	Symptomatic orders	Proportion of symptomatic orders
16-17	3521	0.7%	1502	1.3%
18-21	50990	10.5%	18049	16.0%
22-24	83034	17.2%	21964	19.5%
25-29	154254	31.9%	33611	29.9%
30-34	93998	19.4%	19017	16.9%
35-44	71809	14.8%	13954	12.4%
45-54	20064	4.1%	3454	3.1%
55+	6469	1.3%	947	0.8%

Discussion: Over 100,000 people with symptoms accessed online STI tests as a result of the change in service provision. It appears that this symptomatic service is accessible to those demographics associated with the poorest access to sexual health services. More research is needed into the impact of symptomatic STI testing online.

O14: Attitudes and Experiences of South Asian Women with Sexual Health Services in the UK: A Qualitative Study

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Introduction: Many South Asian women face difficulties accessing sexual health services due to faith and cultural taboos. Therefore, there is a need to understand South Asian women's attitudes towards and experiences with sexual health service provision to recognise how healthcare providers can develop culturally appropriate initiatives and facilitate equality of access.

Methods: Fourteen semi-structured interviews with South Asian women over the age of 18 and living in the UK were conducted and video-recorded online. Interviews explored participants' experiences of accessing sexual health services, including discussions around contraception, smear tests and STI tests. Thematic analysis was used to analyse the data.

Results: Five themes were identified:

1) Interactions with healthcare professionals: Participants were often met with judgement and a lack of partnership from clinicians.

2) Stigma and shame: Many participants felt shame in accessing services and discussing their sexual health.

3) Confidentiality concerns: Many participants conceal their sexual activity and expressed concerns around the confidentiality of services.

4) Accessibility of sexual health services: Long waiting times and poor availability of services created a sense of panic.

5) Information provision: Due to limited knowledge around sexual health and local sexual health services, participants stated a need for better provision of information.

Discussion: This research highlights the cultural and social factors that underpin engagement with sexual health services. Formal training in cultural competence for service providers may facilitate a greater understanding of cultural issues pertinent to the South Asian community. Service providers should collaborate with community-based organisations to develop culturally appropriate initiatives.

O15: *"It was difficult to offer same day results"*: Evaluation of community-based point-of-care testing for sexually transmitted infections among youth using the GeneXpert platform in Zimbabwe

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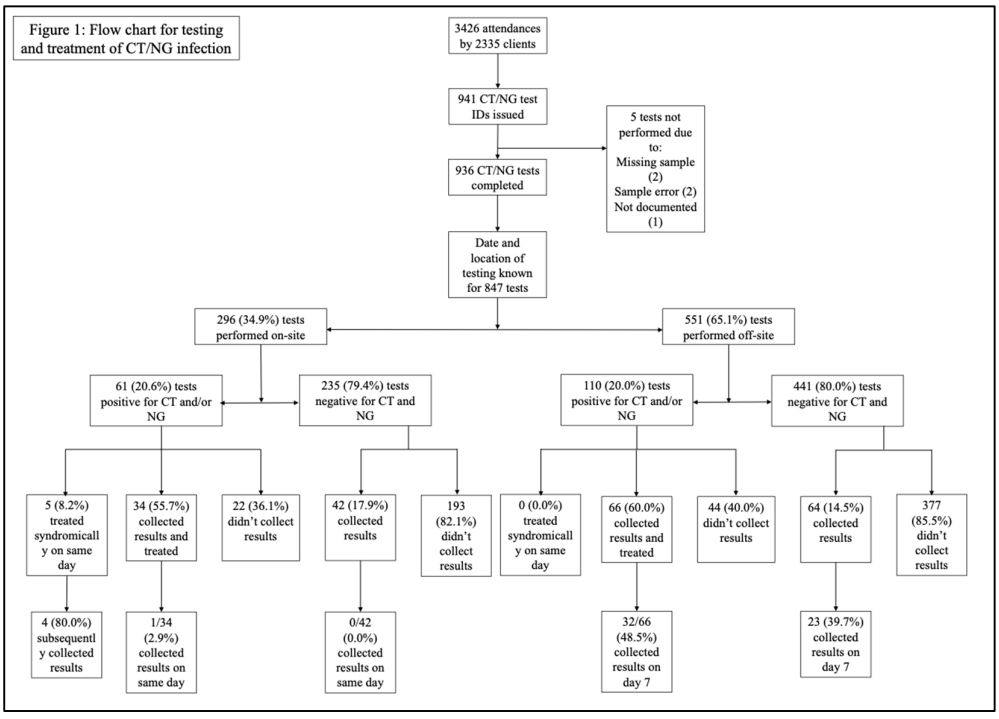
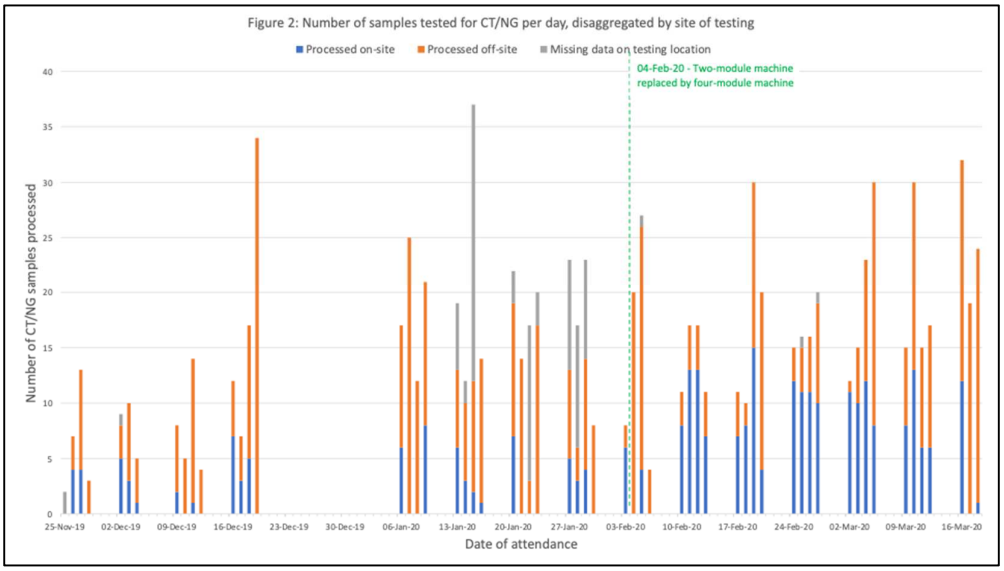
Background: Point-of-care testing for sexually transmitted infections (STIs) may improve diagnosis and treatment of STIs in low- and middle-income counties. We explored the facilitators and barriers to point-of-care testing for *Chlamydia trachomatis* (CT) and *Neisseria gonorrhoea* (NG) for youth in community-based settings in Bulawayo, Zimbabwe.

Methods: Testing of urine samples for CT/NG using the GeneXpert platform was nested within a cluster randomised trial of community-based delivery of integrated HIV and sexual and reproductive health services for youth aged 16 to 24 years. On-site testing was defined as sample processing on the same day and site as sample collection. Outcomes included proportion of tests processed on-site, time between sample collection and collection of results, and proportion of clients receiving treatment. In-depth interviews were conducted with nine service providers and three staff members providing study co-ordination or laboratory support and analysed using thematic analysis.

Results: Of 847 CT/NG tests, 296 (35.0%) were performed on-site. Of these, 61 (20.6%) were positive for CT/NG; one (1.6%) received same day aetiological treatment; 33 (54.1%) presented later for treatment; and 5 (8.2%) were treated as part of syndromic management. There was no difference in the proportion of clients treated whether their sample was processed on or off-site (64% (39/61) vs 60% (66/110); p = 0.61).





The interviews revealed four themes related to the provision of on-site testing associated with the i) diagnostic device ii) environment, iii) provider, and iv) clients. Contributing factors included insufficient testing capacity, inadequate space, as well as reluctance of clients to wait for their results.

Discussion: On-site testing was feasible in a challenging operational environment; however, barriers remain to providing same day results. In addition to further research to optimise implementation, new platforms are needed to reduce analytic time to be able to scale up testing and reduce the attrition between testing and treatment.

O16: Developing a training package to improve partner notification outcomes.

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[1]University Hospitals Sussex, Brighton, United Kingdom. [2]University Hospitals Sussex, Crawley, United Kingdom

Introduction: Partner Notification (PN) is an integral part of STI management[1]. Traditionally, PN is undertaken by Health Advisers (HAs), however, BASHH advise that any 'appropriately trained medical staff may contribute to the PN process'[2]. With increasing STI rates and stretched services[3] PN for uncomplicated infections could be implemented by nurses. Although Low et al[4] found that PN completed by appropriately trained nurses was equally as effective as PN delivered by HAs, Herzog[5] found that in many cases, PN was poorly documented and incomplete, and clinicians felt unconfident.

Following a local audit of nursing notes, it was decided to undertake an improvement programme to address poor PN outcomes.

Methods: An initial audit (fig1) showed that nurses did not meet any of the BASHH auditable outcomes for PN[6].

A standardised educational programme consisting of one-to-one and group teaching, 'quick reference' guides in all clinical rooms, and a change to the template used on clinical IT systems was implemented.

A second audit was undertaken 3 months after initial training using the same criteria.

Nursing/Medical Staff Partner Notification Audit CT/GC: Jan-April 2020

Inclusion Criteria

- Diagnosis of GC/CT in any site, either by microscopy or NAAT sample.
- Seen by Nursing or medical staff for treatment and explanation of diagnosis.
- Any age, gender or sexuality

Exclusion Criteria

- Treated as a contact at initial visit
- Seen by HA for PN
- Lost to follow up

221 Total Audited.
159 Excluded
62 seen by Nurses/Doctors
30 diagnosed with Gonorrhoea
30 diagnosed with Chlamydia
2 Diagnosed with both Chlamydia and Gonorrhoea

Audit outcomes for Chlamydia

Outcome	Number	Performance Standard	Crawley Standard
PN discussed at diagnosis.	28/44	97%	63%
Contact Action agreed with index patient	28/44	97%	63%
No. of contacts reported as treated by index patient	12/44	0.6 (per index case)	0.40
No. of contacts verified as treated by HCW	11/44	0.4 (per index case)	0.25

Audit outcomes for Gonorrhoea

Outcome	Number	Performance Standard	Crawley Standard
PN discussed at diagnosis.	40/46	97%	86%
Contact Action agreed with index patient	41/46	97%	89%
No. of contacts confirmed as treated by either index patient or HCW	24/46	0.6 (per index case)	0.52

Figure 1. Initial Audit report

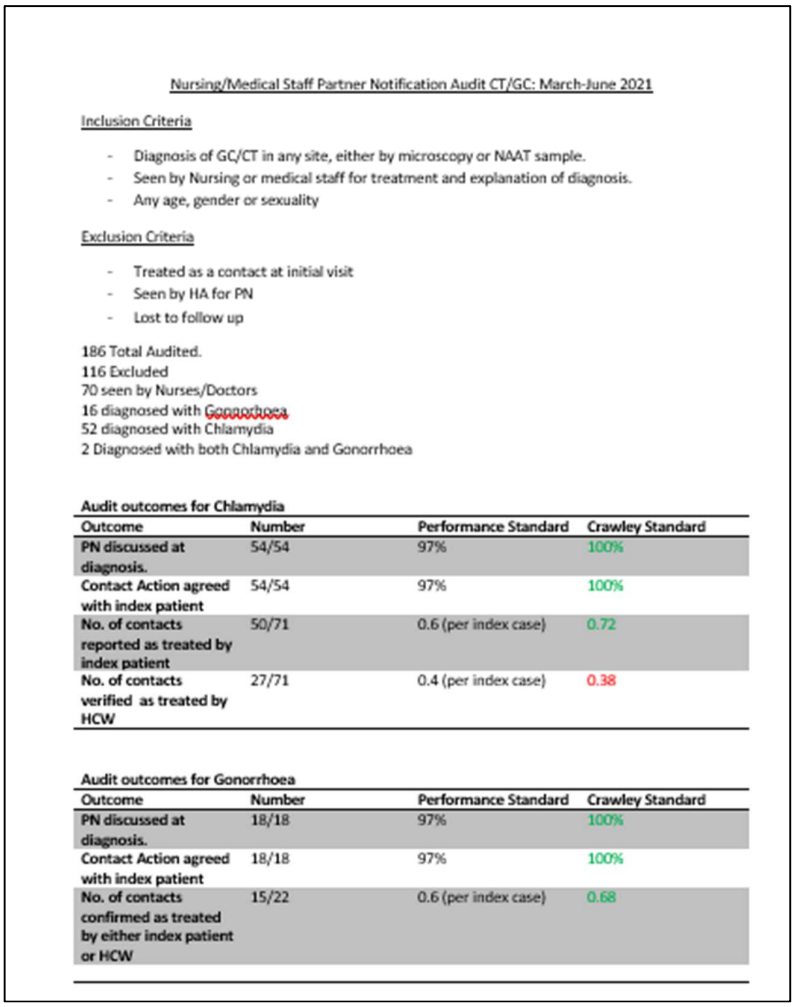
Results: Average time each team member spent in training was 1 hour.

Audit (fig 2) at 3 months post-training showed that all PN outcomes had improved, and almost all BASHH audit standards were met.

100% patients had a documented PN discussion.

Nurses reported increased knowledge and confidence in their ability to manage and document PN.

Health advisers anecdotally reported a decrease in the amount of patients referred to them for a separate PN telephone call.



Nursing/Medical Staff Partner Notification Audit CT/GC: March-June 2021

Inclusion Criteria

- Diagnosis of GC/CT in any site, either by microscopy or NAAT sample.
- Seen by Nursing or medical staff for treatment and explanation of diagnosis.
- Any age, gender or sexuality

Exclusion Criteria

- Treated as a contact at initial visit
- Seen by HA for PN
- Lost to follow up

186 Total Audited.
116 Excluded
70 seen by Nurses/Doctors
16 diagnosed with Gonorrhoea
52 diagnosed with Chlamydia
2 Diagnosed with both Chlamydia and Gonorrhoea

Audit outcomes for Chlamydia

Outcome	Number	Performance Standard	Crawley Standard
PN discussed at diagnosis.	54/54	97%	100%
Contact Action agreed with index patient	54/54	97%	100%
No. of contacts reported as treated by index patient	50/71	0.6 (per index case)	0.72
No. of contacts verified as treated by HCW	27/71	0.4 (per index case)	0.38

Audit outcomes for Gonorrhoea

Outcome	Number	Performance Standard	Crawley Standard
PN discussed at diagnosis.	18/18	97%	100%
Contact Action agreed with index patient	18/18	97%	100%
No. of contacts confirmed as treated by either index patient or HCW	15/22	0.6 (per index case)	0.68

Figure 2. Audit post training package

Discussion: Nursing staff are often willing to undertake PN but lack confidence. Implementing this teaching programme improved PN outcomes, decreased the need for multiple attendances, and had a positive impact on HA workload. A further audit is planned to establish if periodic 'refresher' training would be beneficial.

O17: An online survey of the needs and preferences of young people regarding sexual health services

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Introduction: This paper reports the results of a survey of young people living or attending school within the local borough regarding their opinions on current sexual health services and perceived sexual health needs.

The purpose was to assess the gaps in local services to inform public health planning by the local authority.

Methods: Data was collected with an online survey tool completed by young people aged 13 to 24 living or attending school within the local borough. Participation was anonymous and voluntary. Quantitative data was analysed with descriptive statistics. Qualitative data was explored by thematic analysis. The data captured recommendations regarding accessing services, remote consultations, co-location of services and percieved barriers.

Results:
233 responses were received.

Young people prefer to access services via an app (56.4%), face to face (56%) or via webchat (44.4%). Least popular access routes are telephone (19.7%) and video chat (3.8%).

The majority of respondents believed that young persons sexual health services should be located alongside other young persons services such as mental health (86.8%), drug and alcohol support 67.7%), weight management (66.8%) and education or employment support (54.5%).

The most popular location for collecting condoms, contraception or treatment was via community pharmacy.

Discussion: Whilst COVID-19 necessitated changes in ways of accessing services it is important to recognise that young people generally do not favour telephone or video access. Services should seek to incorporate apps and webchat for young people to make contact and then enable face to face appointments. Ideal services for young people should be in local clinics with a range of support services available. Increasing the availability of services available in a community pharmacy would increase uptake among young people.

The most common theme for improvement was around increasing awareness and ease of access to services.

O18: Barriers to Barriers: A mixed methods analysis of barrier protection usage among women who have sex with women

Aoife Maya Janmohamed[1], Jessica Florence Burt[1], Jane Braunholtz-Speight[2,3], Madeleine Crow[2,3], Harriet Wallace[4]

[1]University of Leeds Medical School, Leeds, United Kingdom. [2]Leeds Sexual Health, Leeds, United Kingdom. [3]Community Healthcare NHS Trust, Leeds, United Kingdom. [4]Leeds Teaching Hospitals NHS Trust, Leeds, United Kingdom

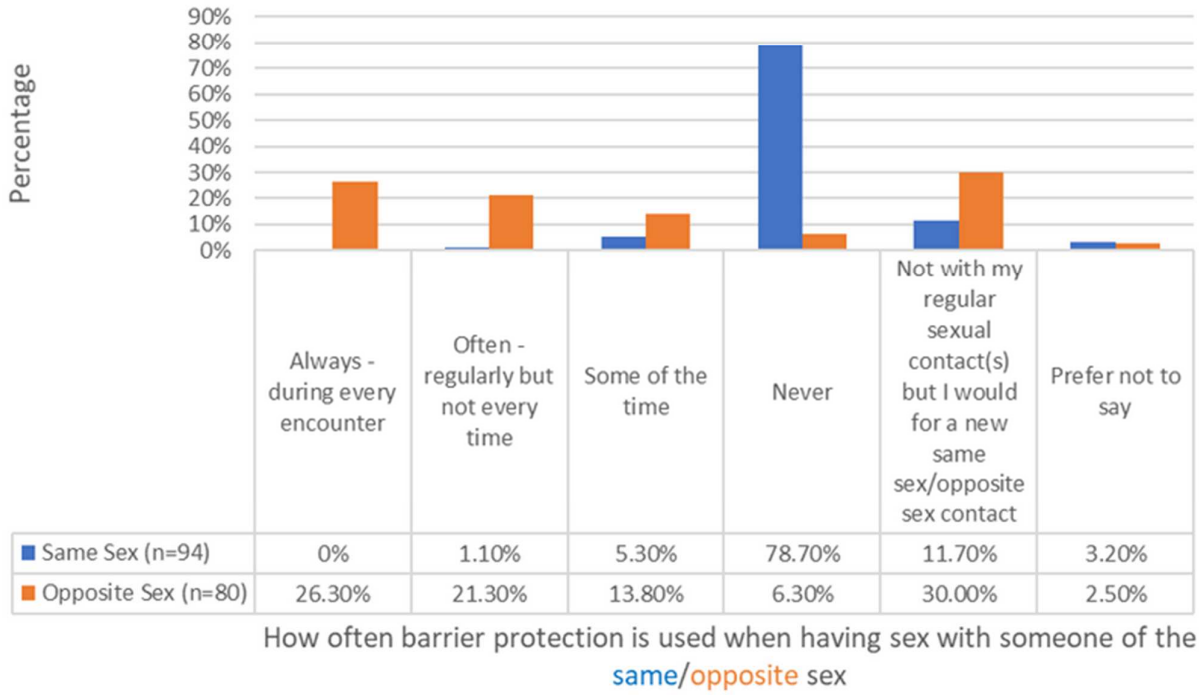
Introduction: The number of women who have sex with women (WSW) who present to sexual health services in the UK is low. However, those attending show increasing prevalence of STIs, with a 68% national increase in gonorrhoea in WSW between 2018-2019, and a 79% increase in chlamydia diagnoses. We planned to explore perceptions of sexual health need and prevalence of barrier method usage amongst WSW in a university city.

Methods: An anonymous online survey was advertised to the local community through networks and social media. Inclusion criteria: 16yrs and over, links to the city, assigned female at birth, self-identification as a lesbian/bisexual/queer/gay woman, reporting sexual contact with someone of the same sex as themselves.

Results: 101 survey responses were returned; 94 were analysable. Age range: 18-41yrs. Ethnicity: 91.5% White, 2.1% Mixed, 2.1% Asian/Asian British, 2.1% Black African/Caribbean/British, 2.1% Other. 38.3% had not accessed any sexual health services in the past two years.

78.7% of WSW reported never using barrier protection with same-sex contacts (Fig1), significantly lower as compared to with opposite-sex contacts ($p=<0.001$). Main reasons included 'issues with methods available' (58.7%) including stigma and lack of visibility and 'low STI risk perception' (53.3%). This contrasted to use with opposite-sex contacts, where reasons for not using barrier protection centred on knowledge that they were STI negative (47.5%) through testing or monogamy (Table1).

Figure 1. A bar chart showing how often barrier protection is used when having sex with someone of the same sex versus the opposite sex



	Always - during every encounter	Often - regularly but not every time	Some of the time	Never	Not with my regular sexual contact(s) but I would for a new same sex/opposite sex contact	Prefer not to say
Same Sex (n=94)	0%	1.10%	5.30%	78.70%	11.70%	3.20%
Opposite Sex (n=80)	26.30%	21.30%	13.80%	6.30%	30.00%	2.50%

How often barrier protection is used when having sex with someone of the same/opposite sex

Table 1. Reasons for not using barrier protection			
with same-sex partner (n=75)			
Themes	**Codes**	**Quotations**	***n (%)***
Issues with methods available	Lack of access /availability	*'never seen* [a dental dam] *before or even know where to buy one'*	44 *(58.7)*
		'no obvious choice for protection'	
	Social stigma	*'*[I would] *not feel very comfortable or familiar with suggesting use of protection'*	
Low risk perception	Lack of awareness	*'a lesbian doctor at the sexual health centre said* [STI transmission between two women] *is not really a thing'*	40 *(53.3)*
	Lack of education	*'didn't know about dental dams, gloves etc.'* nor *'how to use it'*	
	Lack of necessity	*'it would be with a girl so don't think I need protection?'*	
STI negative	Tested regularly	*'we both took STI tests and knew we were clean'*	32 *(42.7)*
	Monogamy	*'my only sexual contact is with my partner'*	
No pregnancy risk	Lack of necessity	*'doesn't feel necessary to prevent pregnancy'*	11 *(14.7)*
Knowing partner		*'know a woman quite well before having sex'*	6 *(8)*
	Trust	*'trust enough that they were clean'*	
Forgetting		*'I just forget'*	2 *(2.7)*
with opposite-sex partner (n=40)			
Themes	**Codes**	**Quotation**	***n (%)***
STI negative	Tested regularly Monogamy	*'in a monogamous relationship and we've both been tested'*	19 *(47.5)*
Low pregnancy risk due to use of alternative birth control	Contraceptive pill	*'I'm on the pill to prevent pregnancy'*	14 *(35)*
	Coil	*'I have the Mirena coil to protect against pregnancy'*	
	Implant	*'I'm on the implant so it removes pregnancy risks'*	
Not having to hand		*'neither of us had one'*	6 *(15)*
Forgetting	Drunk	*'forgetting if drunk'*	6 *(15)*
	By accident	*'I often forget'*	
Personal preference		*'I just prefer not to use them'*	2 *(5)*

Discussion: These results highlight a low STI risk perception and low usage of barrier protection among WSW. Qualitative data revealed interesting and actionable reasons as to why this may be the case, including that dental dams and gloves are not widely available nor seen as appropriate for use, alongside a prevailing lack of education on STI risks for WSW.

These findings suggest wider work is needed to address the inequity in access to information and education for WSW on sexual health.

O19: Correlates of hepatitis B vaccination among female sex workers attending sexual health services in England between 2015-2019

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[1]Public Health England, London, United Kingdom. [2]National Institute for Health Research Health Protection Research Unit (NIHR HPRU) in Blood Borne and Sexually Transmitted Infections at University College London in partnership with Public Health England, London, United Kingdom

Background: Hepatitis B (HBV) vaccination is recommended for sex workers and is offered opportunistically at sexual health services (SHS) in England. The objective of this analysis was to determine the correlates of hepatitis B vaccination among female sex workers (FSWs) attending SHS in England.

Methods: Data on all attendances at SHS in England were obtained from the GUMCAD STI Surveillance System. Attendees were eligible if they were female and sex work was first recorded between 2015-2019. HBV vaccination was coded as receiving any HBV vaccination dose on or after first sex work attendance. Bivariable and multivariable logistic regression models were used to investigate sociodemographic factors associated with having received HBV vaccination on or after first FSW attendance.

Results: Among 10,745 attendees recorded as FSWs (median age=30 years [IQR 24-37], 44% UK-born), 30% (n=3,259) had received an HBV vaccination dose at a SHS, 70% (n=2,285) of whom received their vaccination the same date that sex work was first reported. In the multivariable analysis, being aged 15-24 (39%; aOR 1.59 [95%CI:1.44,1.76]), being born in South America (36%; 1.38 [1.17,1.62]) and residing in the North East (46%; 2.00 [1.51,2.65]), South East (35%; 1.35 [1.13,1.61]) or South West (36%; 1.37 [1.12,1.69]) were associated with HBV vaccination. Being aged 35-44 (25%; 0.71 [0.61, 0.83]) or 45 and over (23%; 0.82 [0.73,0.92]), of Asian ethnicity (19%, 0.58; [0.42,0.81]), born in North America (16%; 0.42 [0.20,0.91]), or being HIV-positive (15%; 0.43 [0.22, 0.84]) were associated with reduced odds of HBV vaccination. Fourteen FSWs were diagnosed with HBV who had not received an HBV vaccination and had attended prior to diagnosis.

Discussion: Barriers may exist for some FSWs to receiving an HBV vaccination in a SHS. There is a need to improve vaccination uptake among FSWs generally in order to achieve England's HBV elimination target by the year 2030.

O20: Case report: Novel use of oral chloramphenicol for multi-resistant Mycoplasma genitalium

Jo Smith, Jonathan Goodfellow, Michael Rayment

Chelsea and Westminster Hospital, London, United Kingdom

Introduction: Symptomatic Mycoplasma genitalium (*m.gen)* infection remains a challenging problem to treat; the organism is fastidious and slow to culture, but quick to acquire resistance. *M.gen*'s reported macrolide resistance rate has climbed from 40% four years ago to over 70% now; similarly, doxycycline's efficacy is only around 20-40%. Second-line therapy, fluoroquinolones, may also soon be lost; moxifloxacin's cure rate decreased between 2010 and 2016 from 100% to 89%.

Discussion: We report the case of a 20-year-old heterosexual male with persistent symptomatic non-gonococcal urethritis (NGU) caused by confirmed macrolide-resistant *m.gen*. He failed five lines of treatment over the course of seven months, both symptomatically and microbiologically, including combined doxycycline/azithromycin, moxifloxacin, pristinamycin and minocycline regimes. This exhausted all known evidence-based treatment lines. He denied all risk of community re-infection.

He was declined for a compassionate-use programme of gepotidacin due to lack of in vitro or –vivo efficacy data, but was offered, after local MDT discussion, a trial of 10 days of oral chloramphenicol - having been consented for a significant risk of agranulocytosis. He made a complete microbiological and symptomatic recovery and has has a confirmed 5-week negative test of cure.

This case offers an interesting insight for those managing extremely treatment-resistant symptomatic *m.gen* NGU, and highlights the utility of liaison with microbiological and pharmaceutical colleagues in hard-to-treat cases.

O21: Accuracy of self-reported BMI for remote combined hormonal contraceptive consultation

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Introduction: Body Mass Index (BMI) measurement is recommended before dispensing the combined hormonal contraceptive (CHC). FSRH guidance states that women with a *BMI ≥35 kg/m*^{2} generally should not use CHC (UKMEC3), although it may be prescribed by a specialist provider.

The Covid-19 pandemic has reduced access to face-to-face care, with more reliance on patients self-reporting their biometrics during remote consultations. While remote consultations increase accessibility and convenience for patients, there is a lack of evidence on how accurate self-reported BMI measurements are and therefore the clinical risk that this brings.

We examined how accurate self-reported height and weight measurements were for patients consulting for the CHC for a large digital health service.

Method: A retrospective audit of patients remotely consulting with a large digital health service for the CHC between January and December 2020. We compared self-reported measurements to those checked in pharmacy.

Results: 10,930 patients completed a consultation and required a BMI check in pharmacy prior to dispensing the CHC. All patients identified as female with an average age of 26 years (range: 18 – 49 years). 11% (1202) had a self-reported and pharmacy BMI that matched. 36% (3958) had a self-reported BMI that was higher than the BMI confirmed in pharmacy. 53% (5770) had a self-reported BMI that was lower than the BMI confirmed in pharmacy, of which 0.9% underestimated their BMI resulting in the CHC being deemed unsafe to prescribe.

Discussion: While the majority, of patients did not self-report a BMI that exactly matched the BMI confirmed in pharmacy, only a small proportion underestimated their BMI to a degree that resulted in the CHC not being recommended as the clinically most suitable option. When remotely consulting with patients, it is important to be able to accurately confirm BMI measurements before dispensing the CHC to reduce clinical risk and ensure safe prescribing.

O22: Testing for Trichomonas Vaginalis in asymptomatic and symptomatic females testing through an online STI testing service

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[1]Maidstone and Tunbridge Wells NHS Trust, Maidstone, United Kingdom. [2]Preventx, Sheffield, United Kingdom

Background: Online asymptomatic screening includes chlamydia, gonorrhoea, Syphilis, HIV, Hepatitis B and C. Testing for Trichomonas Vaginalis (TV) is not included as this is usually performed in symptomatic patients referred into clinic.

During the Covid-19 pandemic, this sexual health service implemented an online triage for symptomatic female users. Females who self-identified as having vaginal discharge were offered additional PCR testing for TV. Higher positivity rates for other infections in ethnic minority groups locally, meant that asymptomatic females from these groups were also offered TV screening to assess rates of infection.

Method: In one local authority, two cohorts of patients were tested online through an STI testing service. Cohort 1: females from all ethnic groups who indicated having vaginal discharge; Cohort 2: asymptomatic females who identified being from an ethnic minority group. The sensitivity and specificity of the PCR test was 100% and 99.4%.

TV positivity rate was compared between ethnicity, age, deprivation level, and urban/rural classification for 2188 samples collected between 15 March and 23 August 2021.

Results:

Table 1. A table to show the TV positivity rate in both cohorts

Result	All	Asymptomatic females from ethnic minority groups	Females with vaginal discharge from all ethnicities	All
Negative	2118	694	1424	2118
Unable to process*	15	12	3	15
TV positives	55	16	39	55
TV positivity rate	2.5%	2.3%	2.7%	2.5%

****Sample out of validation or out of protocol***

Overall TV positivity rate was 2.5% (n=55) across both cohorts.

A positivity rate of 2.3% (n=16) was seen in the asymptomatic ethnic minority cohort, and higher in Caribbean (3.4%) and White and Black African (6.5%) users, similarly in <25 years (2.2%) and > 25 years (2.3%). The symptomatic cohort positivity rate was 2.7% (n=36) and was higher in women from ethnic minority groups (3.1%) and people > 25 years (3.8% vs 1.5%).

Discussion: TV positivity rates are consistent with using an online triage to determine symptoms and provide patients with the appropriate tests. TV testing in asymptomatic patients identified infections in ethnic minority users. Further investigation is needed to understand if this may be similar in other asymptomatic populations and geographical areas.

O23: Experience of using Gardasil vaccination as a therapeutic treatment option for Genital HPV Disease

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Introduction: The UK has used Gardasil in a preventative vaccination program since 2012. Data for Gardasil as a therapeutic option for HPV disease is limited, particularly in the sexual health setting. Local approval has been used since 2013 on an individual case basis for vaccination in recalcitrant disease or confirmed genital intraepithelial neoplasia.

Methods: Pharmacy records were searched for Drugs and Therapeutics approved prescriptions of Gardasil, from Jan 2013-20, and case notes were reviewed.

Results: 16 patients were prescribed therapeutic Gardasil;14 male (10 heterosexual, 4 MSM), 2 heterosexual female. Median age 32.5yrs (range 16-57).

Indications for vaccine: AIN/PeIN (n=5, 3 of whom were immunosuppressed), recalcitrant warts despite multiple treatments(n=9) or unknown due to inaccessible records (n=2). All continued, as tolerated, BASHH recommended ablative/topical treatments.

Out of 5 cases with AIN/PeIN:1 had documented clearance of warts <1 year, 3 were receiving treatment 3-6 years later, 1 disengaged.

9/9 (100%) with recalcitrant warts had documented/presumed clearance of warts: 5 <1 year, 2 <2 years, 1 <4 years, 1 >4 years.

The 2 cases with unknown indications had no further presentations for care post vaccination, therefore presumed cleared warts <1 year.

Discussion: Outcomes of therapeutic benefits of Gardasil vaccination are difficult to ascertain, due to overlap with natural clearance or from continued topical/ablative therapies. From the small number of cases in our centre, only 3/16 continue to present with active disease and 2 of these have significant immune suppression and confirmed intra-epithelial neoplasia.

5/9 (55%) cases with recalcitrant warts and no immune suppression had confirmed/presumed clearance within the year following vaccination (7/9 77% within 2 years), indicating a saving in clinic attendance and cost of topical/ablative treatments in this group.

No typing of HPV or formal follow up was performed. More studies are needed to inform future use in this setting.

O24: Does the chickenpox virus give protection against symptomatic genital herpes virus infection? A case-control study

Bret Palmer[1,2], Stephen Winchester[3], Mark Atkins[3], Alan Tang[1], Simon Barton[4], Peter Kelleher[4]

[1]Royal Berkshire Hospital, Reading, United Kingdom. [2]Royal United Hospital, Bath, United Kingdom. [3]St Peters Hospital, Chertsey, United Kingdom. [4]Chelsea & Westminster Hospital, London, United Kingdom

Introduction: Every year over 400 million individuals suffer from genital herpes, a disease caused by the herpes simplex virus (HSV). HSV increases the acquisition of HIV as well as other sexually acquired infections. Current treatments are daily antivirals and there is no treatment as yet that offers a functional cure. This study was set up to examine if there is any relationship between HSV symptomatic status and the level of VZV antibody titre. This study if successful would help to provide evidence for a route to treat symptomatic HSV via VZV vaccination.

Methods: 82 patients were recruited through our Sexual Health Service. 52 in the symptomatic group and 30 in the asymptomatic group. Every patient was asked to complete a questionnaire and a sample of blood was taken to test for HSV antibodies status and VZV IgG antibody titre level.

Results: In patients who have HSV2 positive antibodies, VZV IgG titres in the asymptomatic group with 15 participants were; Mean titre = 2177 and 52 symptomatic patients; Mean VZV IgG titre = 1236 (Two tale, *p*-value is 0.000048). Sample size effect, Hedges' g = 1.3 (>0.8) = large effect. For HSV1 positive patients VZV IgG titres in the asymptomatic group with 23 participants were; Mean titre = 1887 and 34 participants in the symptomatic group; mean VZV IgG titre = 1093 (Two tale, *p*-value = 0.000257), Sample size effect, Hedges' g = 0.95 (>0.8) = large effect.

Discussion: While a single protective level of VZV antibody is not present it is clear that those individuals who have a higher level of VZV antibody are more likely to have an asymptomatic genital herpes infection. A RCT would need to be completed to assess if a VZV vaccine can offer a route to a functional cure.

O25: Time trends in contraceptive prescribing in UK primary care 2000-2018: a repeated cross-sectional study

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Introduction: Over the last 20 years, new contraceptive methods became available and incentives to increase contraceptive uptake were introduced. To assess the effect of these changes, we aimed to describe temporal trends in non-barrier contraceptive prescribing in UK primary care for the period 2000-2018.

Methods: A repeated cross-sectional study using patient data from The IQVIA Medical Research Data (IMRD) Database. The proportion (95% CI) of women prescribed non-barrier contraception per year was captured.

Results: 2,705,638 women aged 15-49 years were included. Between 2000-2018, the proportion of women prescribed combined hormonal contraception (CHC) fell from 26.2% (26.0-26.3) to 14.3% (14.2-14.3). Prescriptions for progestogen-only pills (POPs) and long-acting reversible contraception (LARC) rose from 4.3% (4.3-4.4) to 10.8% (10.7-10.9) and 4.2% (4.1-4.2) to 6.5% (6.5-6.6) respectively. Comparing 2018 data for most deprived vs least deprived areas, women from the most deprived areas were more likely to be prescribed LARC (7.7% (7.5-7.9) vs 5.6% (5.4-5.8)) while women from the least deprived areas were more likely to be prescribed contraceptive pills (20.8% (21.1-21.5) vs 26.2% (26.5-26.9)). In 2009, LARC prescriptions increased irrespective of age and social deprivation in line with a pay-for-performance incentive. However, following its retirement in 2014, LARC prescriptions for adolescents fell from 6.8% (6.6-7.0) in 2013 to 5.6% (5.4-5.8) in 2018.

Discussion: CHC prescribing fell by 46% while POP prescribing more than doubled. The type of contraception prescribed was influenced by social deprivation. Withdrawal of a pay-for-performance incentive may have adversely affected adolescent LARC uptake, highlighting the need for further intervention to target this at-risk group.

V1: Evaluating the awareness of sexual health knowledge and needs of mental health patients in mental health staff

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Introduction: Patients with serious mental health issues are known to be more likely to engage in risky sexual behaviour. This not only leads to a higher risk of contracting a sexually transmitted disease, but also increased rates of unintended pregnancies. Given the increased risk, it is important mental health staff have sexual health conversations, however, no training is currently given in this area within England.

Method: A questionnaire was sent to the staff members of the Early intervention Service (EIS), Core and Recovery teams in Barnsley. In this the frequency and content of sexual health conversations taking place, levels of training and demand for future sexual health training were enquired about.

Results: 19 respondents were included. 68% stated sexual health conversations took place in a quarter of consultations. 47% felt patients were more likely to initiate a conversation than themselves. 42% felt a lack of need was the barrier to sexual health conversations, whilst 26% felt this was a lack of knowledge. 63% had received no sexual health training and 95% wanted further training. Demand was seen across all areas with the most interest in training on sex alongside drug taking (89%).

Discussion: Sexual health conversations are taking place with psychiatry patients, however not frequently. Training levels are inconsistent, and a lack of knowledge is a main barrier to these conversations. With staff stating a demand for more information across sexual health topics, it seems that training for this topic should be introduced to improve care of psychiatry patients.

V2: How can the cervical screening of HIV-positive patients at Heartlands Hospital be improved?

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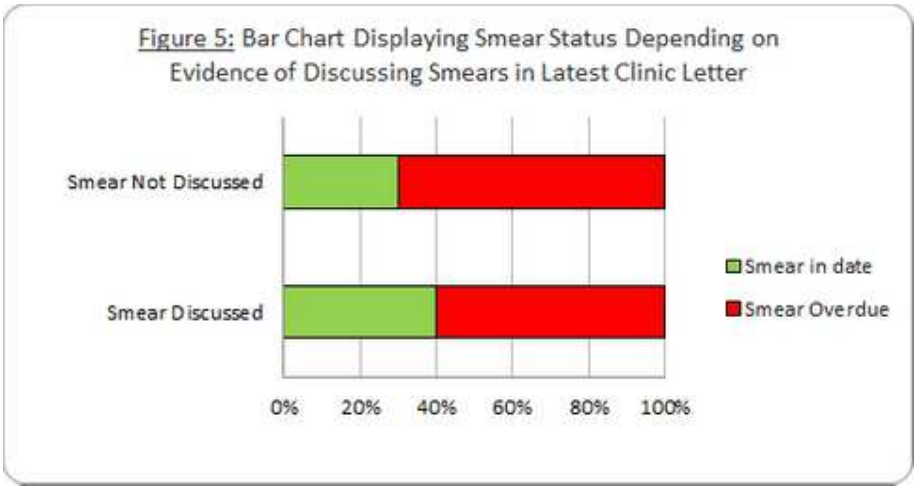
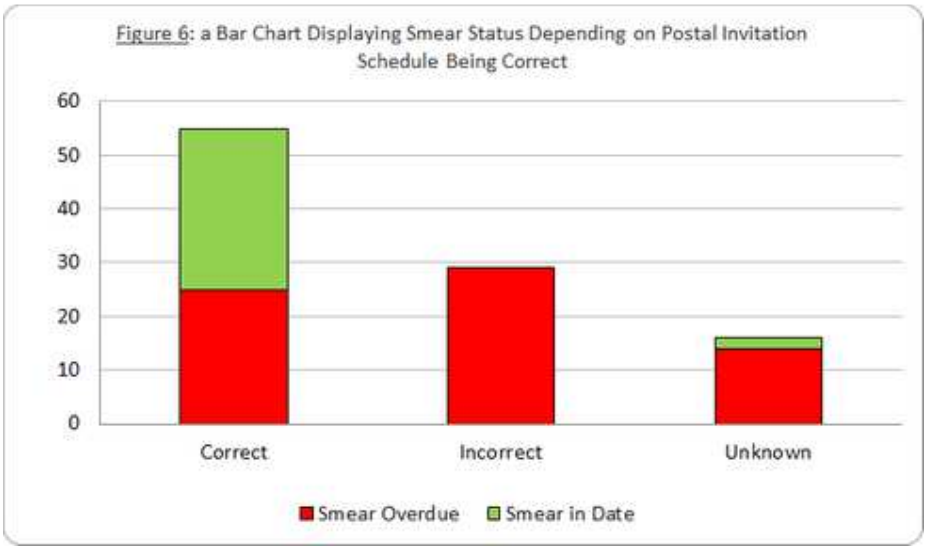
Introduction: This study is an audit assessing how well Heartlands Hospital's HIV service adheres to the British HIV Association's guidelines regarding cervical screening in HIV-positive women. The first aim of this audit is to assess how many patients have up-to-date smears. Secondly, recommendations for service improvements will be discussed.

Methods: The sample patient population was gathered as the most recently treated 100 female patients in April 2021. A spreadsheet of demographic and medical data was collected. Clinic letters were assessed for evidence of a 'discussion of smear status', as well as qualitative reasons which explained overdue smears. Postal invitations were checked for their delivery schedules.

Results: 32% of smears were recorded as 'up to date'. 13% of smear statuses were inaccessible via electronic health records. For 34% of patients, no clear reason was found for overdue smears. Socioeconomic status, age and ethnicity did not appear to be predictors of smear status. 38% of the patients' most recent smears were taken at a GP practice. Of these, 50% were up to date. 49% of the patients' most recent smears were taken at Heartlands Hospital. Of these, 27% were up to date. 10% more smears were up to date when smear status discussion was evident in the latest clinic letter. 55% of the sample population were identified as having annual postal invite schedules. Of these, 46% had overdue smears. 29% of the sample population were identified as having an incorrect postal invite schedule. Of these, 100% had overdue smears.





Discussion: Recommendations included having pre-set subheadings within clinic letters to prompt secondary and primary care clinicians to organise or discuss cervical smears. Another recommendation was to organise a yearly smear invitation via SMS text messaging, independent of the national programme. The method of how to organise this prompt was discussed with the team at Heartlands.

V3: The contribution of Contact Tracing to the diagnoses of HIV, syphilis & Gonorrhoea in MSM

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Introduction: Contact tracing strategies have increased the number of MSM attending clinics as sexual contacts with increasing rates of bacterial STIs. Understanding the outcomes of contact tracing could inform future public health policies to support STI control in MSM.

Method: We aimed to describe the contribution of MSM attending as notified sexual contacts of patients with HIV, syphilis and gonorrhoea to the overall diagnoses of HIV, syphilis and gonorrhoea in MSM in a cross-sectional study. We collected data on all MSM diagnosed with HIV, syphilis and gonorrhoea in 2019 and evaluated which of these MSM were tested due to attending as a sexual contact.

Results: Sexual contacts of HIV, syphilis and gonorrhoea contributed to 20% (95%CI= 17.3-23.7%) of all diagnoses of HIV (3/30,10%), syphilis (28/183,15%) or gonorrhoea (98/420,23%) in the study period. Asymptomatic sexual contacts contributed to 12% (95%CI=9.6-14.9%) of all diagnoses of HIV (3/30,10%), syphilis (16/183,9%) and gonorrhoea (57/420,14%). The proportion of MSM diagnosed with gonorrhoea attending as sexual contacts of gonorrhoea (21%) was significantly greater than MSM diagnosed with HIV, attending as sexual contacts of HIV (3%) or MSM diagnosed with syphilis, attending as a sexual contact of syphilis(4%)($p<0.001$). Furthermore, the proportion of MSM diagnosed with syphilis, attending as a sexual contact of another STI (11%) was significantly greater than MSM diagnosed with HIV, attending as a contact of another STI (7%) or MSM diagnosed with gonorrhoea, attending as a sexual contact of another STI(2%)($p<0.001$).

Conclusion: Contact tracing contributes significantly to the overall diagnoses of HIV, syphilis and gonorrhoea including asymptomatic sexual contacts in our population. Further efforts to increase the yield from contact tracing may continue to reduce the burden of HIV, syphilis and gonorrhoea within sexual networks of MSM.

V4: Assessing quality of service provision and evaluation of outcomes for patients diagnosed with Vulvodynia referred to a Psychosexual Clinic.

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Introduction: Vaginismus, usually with an element of Vulvodynia (vulval pain syndrome) constitutes the majority of referrals to the local Psychosexual Female Sexual Wellbeing (FSW) service. Vulvodynia is a diagnosis of exclusion which is lacking in clear evidence regarding effective treatment strategies. It has significant impact on sexual function and quality of life. A multidisciplinary and multi-stranded approach to treatment is currently recommended by BASHH, amongst other organisations. This review of service provision assessed performance against auditable standards applicable to care of patients with vulval pain syndromes and also looked at patient self-reported outcomes.

Methods: All new patients seen October 2019 to March 2021 in the FSW service were included (67). 53/67 reported an element of vulvodynia impacting sexual function. The notes of these 53 patients were reviewed to assess interventions provided and effectiveness via patient self-reported outcomes at follow up at 3-6 months.

Results: In line with BASHH auditable recommendation, 100% of patients were given written (web-based) information on vulval pain at initial appointment. 100% of patients were also offered a range of interventions in line with BASHH recommendations for best practice of management of vulvodynia. Interventions included information and education, group or individual psychosexual therapy, lidocaine or graded desensitisation (dilators), physiotherapy referral. At follow up, 36/53(68%) reported improvement in symptoms, 10/53(19%) were lost to follow up, and 7/53(13%) reported no improvement.

Discussion: It is helpful and encouraging for patients to be aware that the majority of patients presenting to the FSW service with vulvodynia with or without vaginismus who follow a multi-intervention pathway (which includes education as well as psychosexual or physical therapy) should expect some improvement in symptoms within the 3-6 month follow up period. The service is achieving the auditable standards for care of patients with vulvodynia.

V5: Investigating recent trends of *S. flexneri* among men who have sex with men in England: dominance of three genotypic clusters

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Public Health England, London, United Kingdom

Introduction: *Shigella* spp. is an enteric pathogen, causing bacillary dysentery and transmitted through faecal-oral contact. The majority of domestically acquired infection occurs via sexual transmission among men who have sex with men (MSM). Prior to the COVID-19 pandemic, reported cases of *Shigella* spp. among MSM were increasing, largely driven by *S. flexneri*. The objective of this analysis was to explore trends of *S. flexneri* among MSM in England.

Methods: Data on *S. flexneri* isolates from national reference laboratory referrals (~60% of national data) were enhanced with data from enhanced surveillance questionnaires. We included adult cases (≥ 16 years) sampled between January 2004 and June 2021 for analysis. Presumptive MSM were defined as adult men without recent foreign travel, thus transmission assumed to be sexual. A genotypic cluster was defined as two or more cases whose isolates varied by 10 single nucleotide polymorphisms or fewer using whole genome sequencing.

Results: Reported cases of *S. flexneri* among presumptive MSM increased more than four-fold (from n=10 to n=41) between January 2018 and December 2019.

The number of cases subsequently reduced by 37% between January 2020 and June 2021, coinciding with the COVID-19 pandemic. Yet three genotypic clusters of *S. flexneri* expanded and persisted (designated t10.1189, t10.1580 and t10.642) (Figure 1), such that these clusters contributed 63% of presumptive MSM *S. flexneri* cases in 2020 and the first half of 2021, compared to 33% in 2019.

These three dominant clusters contain more presumptive MSM and hospitalised cases compared to cases belonging to other *S. flexneri* clusters or sporadic cases, and have different geographical distributions and antimicrobial resistance profiles (Figure 2).

Figure 1: Reported cases *S. flexneri* among presumptive MSM in England, highlighting three dominant clusters in red (January 2016 to June 2021)

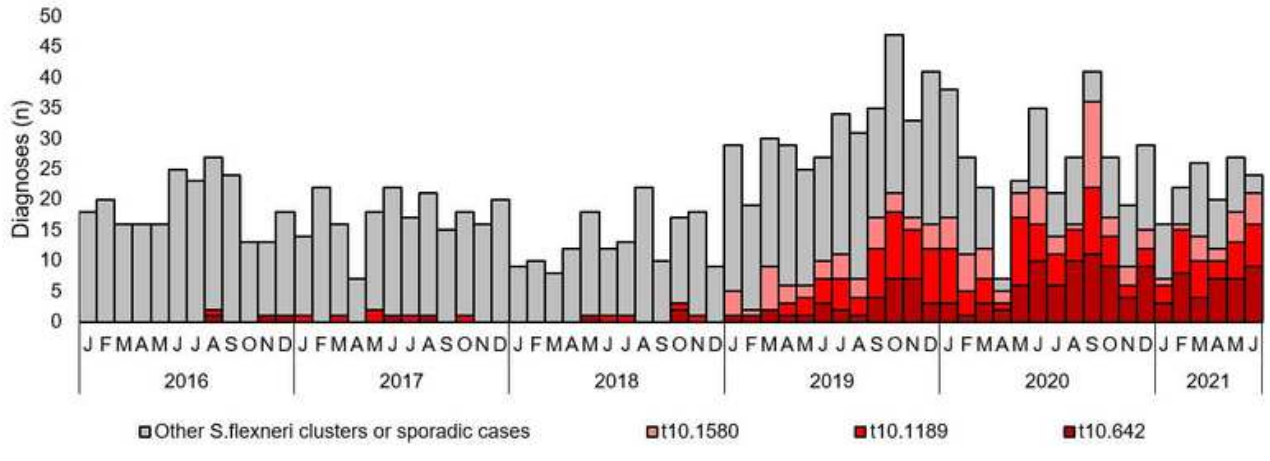

Figure 2: Antimicrobial resistance profiles for three dominant *S. flexneri* clusters of interest (designated t10.1189, t10.1580 and t10.642)

Cluster	Aminoglycosides	Fluoroquinolones	Macrolides	Trimethoprim	Tetracyclines	Sulphonamides	Penicillin	3rd generation cephalosporins	Carbapenems	Chloramphenicol
t10.1189	0%	0%	84%	1%	98%	1%	96%	2%	0%	100%
t10.1580	2%	97%	1%	98%	97%	3%	96%	0%	0%	100%
t10.642	60%	2%	10%	97%	97%	59%	95%	2%	0%	100%

Discussion: It is unclear whether pathogen, human and/or environmental factors enabled these clusters to dominate in 2020 and 2021. Further work to understand the drivers of persistence and transmission would help target interventions and control measures in future.

V6: How has the COVID-19 pandemic affected chlamydia screening of 15-24 year-olds in England?

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Introduction: In response to the COVID-19 pandemic, there was a rapid reconfiguration of sexual health service delivery. The objective of this analysis is to describe the changes in screening delivered through the National Chlamydia Screening Programme (NCSP) between 2019 and 2020.

Methods: Data from the CTAD Chlamydia and GUMCAD STI surveillance systems were used to identify chlamydia tests and diagnoses (from all settings) among 15-24 year-olds in England in 2019 and 2020. We compared the trends in the number and proportion of tests over this period by age-group, test setting, and region of residence.

Results: In 2020, there were 954,636 chlamydia tests in 15-24 year-olds, a 30% decrease relative to 2019 (1,355,485). There was a similar decrease (31%) in chlamydia diagnoses between 2019 (135,361) and 2020 (93,545), but test-positivity remained stable at 9.8%. In 2020, 264,282 tests (28%) were among 15-19 year-olds and 690,354 tests (72%) were among 20-24 year-olds; there was a greater decline in tests amongst 15-19 (38%) vs. 20-24 year-olds (26%) between 2019 and 2020.

Testing declined across all settings except internet services, from which a 34% increase was reported between 2019 (284,050) and 2020 (381,744). Internet testing increased in all regions of England, with the largest proportional increase in the North-East (94.8%; 5,494 more tests). There was a slightly greater increase in internet testing amongst 15-19 (38%) vs. 20-24 year-olds (34%) over this period, but only 22% of all internet tests in 2020 were among the younger age-group.

Discussion: Despite the decrease in tests and diagnoses delivered through the NCSP between 2019 and 2020, test-positivity remained stable and testing via internet services increased across all regions in England. Further investigations are needed to assess the impact of the shift in chlamydia screening to internet services, to understand the scale of digital exclusion, and to monitor inequalities in chlamydia screening.

V7: Audit of sexual and reproductive health measures in women living with HIV: comparing face-to-face and virtual consultations.

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Background: Guidelines for the sexual and reproductive health (SRH) of women living with HIV (WLHIV) recommend annual discussions covering contraception, pregnancy, and sexually transmitted infection (STI) risk. WLHIV aged over 25 should have annual cervical cytology. With increasing virtual consultations during the COVID-19 pandemic, guidance recommended incorporation of strategies to ensure uninterrupted access to contraception and cervical cytology. This audit examined our service against these standards and assessed the impact of moving from face-to-face to virtual consultations.

Methods: 30 WLHIV of reproductive age (18-49) who attended a routine face-to-face HIV appointment between July 2018 and July 2019 were randomly selected for the 2019-F2F audit. 27 WLHIV with a routine telephone appointment in April 2021 were selected for the 2021-Virtual audit. Clinic notes and investigations from the appointment and preceding 12 months were reviewed. Data was collected on pregnancies, contraception, sexual activity, STI testing, and cervical cytology. Chi-squared statistical tests compared differences between 2019-F2F and 2021-Virtual.

Results: Median ages for 2019-F2F and 2021-Virtual were similar (38 and 40 respectively). The majority were born outside the UK (2019-F2F 73%; 2021-Virtual 70%). The 2019-F2F audit found 63% of women had a contraception discussion documented. Of 26 eligible women, 35% had no cervical cytology result or offer documented. In 2021-Virtual, only 37% had a contraception discussion documented – a 26% absolute reduction from 2019-F2F (p=0.047). Among eligible women 78% had no cytology result or offer – a 2.2-fold increase (p=0.002). For 2019-F2F and Virtual-2021, 67% and 70% respectively had missing documentation on pregnancies, sexual activity, regular partners, or country of birth.

Conclusion: Virtual consultations had significantly lower documentation of contraception discussions compared to face-to-face, with a significant fall in cervical cytology offers and uptake. Changes to services due to the COVID-19 pandemic have impacted cervical smear provision, but SRH for WLHIV must be prioritised in the move to remote care.

V8: An audit investigating routine contraceptive enquiry for Women Living with HIV of reproductive age at an integrated sexual health service during the COVID-19 pandemic.

Yee Suh Teh, Joannna Rees, Jeremias Reich, Harriet Beeching, Emily Lord

Oxford University Hospital NHS Foundation trust, Oxford, United Kingdom

Introduction: When providing care for women living with HIV (WLWH) of reproductive age, it is important to enquire about contraception. To adequately address this medical need and allow for optimal preconception planning, national guidelines from BASHH/BHIVA/FSRH recommend a routine contraceptive history. They recommend a discussion about contraceptive options should be completed at every clinic visit. We aim to look at our local HIV service's provision of contraceptive care for WLWH in Oxfordshire during the COVID pandemic.

Methods: In a retrospective study, we collected data of WLWH under the age of 55 who had attended our service within the past 12 months. Our exclusion criteria included any women who had not been seen within the past 12 months, were identified as postmenopausal or with a past history of hysterectomy. We collected data on ARV treatment regimen, contraception history and method of contraception selected.

Results: 98 women were identified and contraceptive discussion was taken in 69% (n=68/98), increasing to 76% (n=43/56) of those <45 years. Where contraception was discussed, the most common method selected was male condom (n=18, 26%), followed by medroxyprogesterone-acetate injection (n=6, 8%). In those where contraception was discussed, 24 (35%) were using no method, with 13 trying to conceive and 8 reported not sexually active.

24% (n=24) WLWH in this cohort were taking an ARV regimen containing dolutegravir and contraception was discussed 67% (n=16/24) in this cohort. Of the 16 patients, 50% (n=8) were using prescribed contraception.

Conclusion: The majority of women had contraception discussed, however the detail of this discussion varied between patients. Of those asked about contraception, 61% of women were either using no method or were using the male condom alone. This suggests that clinicians should continue to prioritise providing information about contraceptive choices for WLWH taking into account the patient's wishes, personal circumstances and ARV regimen.

V9: Remote epidemiological treatment (RET) for contacts of sexually transmitted infections (STIs) using a regional online sexual health service (e-SHS)

Sara Day[1], Mary Brown[1], Sophie Jones[1], Chris Kellett[2]

[1]Chelsea and Westminster Hospital NHS Foundation Trust, London, United Kingdom. [2]Preventx Ltd, Sheffield, United Kingdom

Introduction: Epidemiological treatment for STIs is traditionally provided by sexual health clinics (SHC). To support the region during the COVID19 pandemic when SHC capacity was heavily restricted, our e-SHS offered RET to chlamydia contacts. We explore the outcomes of recipients who accepted RET.

Method: Between 22.4.20–08.06.21 chlamydia contacts who ordered an e-STI testing kit were advised to contact a SHC or call/email the e-SHS for epidemiological treatment. Individuals contacting the e-SHS received a telephonic assessment and, if appropriate, postal medication was dispatched. If RET wasn't appropriate (e.g suspected PID) the user was directed to clinic. Demographics and e-service outcomes of RET recipients were collected.

Results: (3.1%)16657/531520 kits were ordered by chlamydia contacts. 672 users received RET. These were 64.9%(436) male, 35.0%(235) female and 0.1%(1) trans/non-binary and of median age 27yrs. Sexuality and ethnicity are tabulated. 81.3%(547/672) of RET recipients were asymptomatic and 18.7%(125/672) symptomatic. 74.4%(500/672) of kit orders were returned (492 contained chlamydia samples). STI positivity: 24.5%(121/492) chlamydia; 1.4%(7/492) gonorrhoea; 0% HIV/hepatitis B&C/syphilis). All (121) chlamydia cases received follow-up.

Table. Sexuality and ethnicity of RET recipients

Female	**235**
Bisexual	16(6.8%)
Heterosexual	211(89.8%)
Gay	8(3.4%)
Male	**436**
Bisexual	16(3.7%)
Heterosexual	276(63.3%)
Gay	143(32.8%)
Undetermined	1(0.2%)
Trans/non binary	**1**
Undetermined	1(100%)
Ethnicity	**672**
White British	226(33.6%)
Mixed	194(28.9%)
Black Afric/Carib	175(26.0%)
White other	12(1.8%)
Chinese	8(1.2%)
Asian	7(1.0%)
Latin American	5(0.8%)
Any other group	38(5.7%)
Not stated	7(1.0%)

Discussion: Chlamydia RET was predominantly accessed by asymptomatic men and heterosexuals. Higher chlamydia prevalence and similar kit return rates were observed amongst recipients (24.5% and 74.4%) compared to all e-service users (4.7% and 77.9%). Providing RET enhanced access and supported SHCs during the pandemic.

V10: Use of a regional online sexual health service (e-SHS) for sexually transmitted infection (STI) and HIV testing by individuals taking pre-exposure HIV prophylaxis (PrEP)

Sara Day[1], Sophie Jones[1], Chris Kellett[2], Katie Callaghan[1]

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Background: PrEP was made available through England's IMPACT trial and after it became nationally commissioned (2020). STI/HIV testing is required pre-initiation and regularly thereafter however some PrEP providers undertest for STI/HIV. Access to sexual health clinics has been further disrupted by the COVID19 pandemic. We explore the use of e-SHS by PrEP users.

Method: Demographics and e-service outcomes were collected from individuals disclosing PREP use, whilst ordering a postal STI testing kit from a regional e-SHS, between 1/3/21–31/7/21.

Results: 15056 STI kits were ordered by 9942 unique users. Orders came from individuals of male 97%(14610/15056); female 1.2%(171/15056) and trans/non binary 1.8%(275/15056) gender. 88.9%(13380/15056) were gay, 6.9%(1040/15056) bisexual, 2.0%(305/15056) heterosexual and 2.2%(331/15056) sexuality unknown. 83.9%(12630) kits were returned. STI positivity was: chlamydia 7.6%(945/12394), gonorrhoea 9.0%(1114/12401), Hepatitis B 1.6%(48/2957), Hepatitis C 0.2%(10/4318), syphilis 23.6%(2478/10490). Of 0.02%(22/10619) reactive HIV tests, none subsequently confirmed.

STI positivity by age, gender and sexuality

Age	**Chlamydia**	**Gonorrhoea**	**Kit returns**
15-19	10.5%	11.6%	79.6%
20-24	7.5%	11.2%	81.6%
25-29	7.9%	10.0%	83.6%
30-34	8.0%	9.1%	82.8%
35-44	7.6%	8.3%	84.8%
45-54	7.0%	6.7%	86.2%
>55	4.7%	6.4%	87.1%
Sexuality			
Bisexual	7.3%	9.7%	84.1%
Gay	7.6%	9.0%	84.2%
Heterosexual	5.0%	6.0%	73.1%
Undetermined	10.6%	10.3%	81.9%
Gender			
Female	7.6%	2.52%	71.9%
Male	7.6%	9.00%	84.0%
Trans/non binary/other	11.6%	11.60%	84.0%
Total	**7.6%**	**9.0%**	**83.9%**

Discussion: Almost 10,000 PrEP users accessed our e-SHS during the pandemic - a sizeable proportion of the estimated number of PrEP users in England. We observed a similar low proportion of female and non-MSM users compared with IMPACT participants (3% vs 4%). Kit returns were high albeit lower among females and

heterosexuals. STI positivity was high. E-SHS enhanced access to STI/HIV screening but efforts are required to support under-represented groups.

V11: Changes in STI risk behaviour and testing among MSM during COVID-19 restrictions: Results from two large, community-based cross-sectional surveys in the UK

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Introduction: Men who have sex with men (MSM) bear a disproportionate burden of sexually transmitted infections (STI). We determined the impact of COVID-19 restrictions in 2020 on sexual risk behaviours and STI outcomes among a community-recruited sample of MSM.

Methods: Data on STI risk behaviours and sexual health service access were collected using two serial cross-sectional surveys of MSM recruited via social media and dating applications (Survey wave 1 (W1): June/July 2020; W2: November 2020). Eligible participants were UK resident, cis-gender MSM, aged >16 years who reported sex with men in the last year (W1: N=1950; W2: N=1463). Differences in a range of socio-demographic, health, STI testing and sexual behavioural factors were compared between waves using Pearson's chi-squared test. Two outcomes were then considered: recent STI testing (in the last three-months) and unmet STI testing need (in the last three-months; defined as any new male or multiple condomless anal sex (CAS) partners without a recent STI test). Crude and adjusted associations with each outcome and socio-demographic, health and behavioural factors were assessed using separate binary and logistic regression models.

Results: Recent physical sexual activity with a man increased across survey waves (from 62.8% in W1 to 83.5% in W2; $p<0.001$) (Table 1). The proportion of MSM reporting >3 CAS partners more than doubled over the same period (from 11.4% to 24.3%; $p<0.001$). By November 2020, HIV-positive individuals and PrEP users were found to have a greater odds of reporting a recent STI test and reduced odds of having unmet STI testing need (Table 2).

Discussion: There was an increase in unmet STI testing need across waves for all participants although this trend was reversed for men living with HIV and PrEP users. Promotion of PrEP services as COVID-19 restrictions are eased could help facilitate access to STI testing for MSM.

Table 1 Comparison of sexual behaviours, total STI testing & unmet STI testing need of RiiSH-COVID survey participants across waves 1 and 2

Sexual Behaviour, STI testing and unmet STI testing need *in the last 3 months*	**Summer 2020 (W1) % (n)**	**Autumn 2020 (W2) % (n)**	**p-value** *for difference between W1 & W2*
Reported STI testing	N: 1950	N: 1463	<0.001
Yes	25.0 (487)	37.2 (544)	
Unmet STI testing need	N: 1950	N: 1463	<0.001
Yes	25.6 (499)	32.4 (474)	
Sexual contact with a man	N: 1950	N: 1463	<0.001
Virtual only	14.4 (280)	6.1 (89)	
Physical only	43.0 (839)	58.9 (861)	
Physical & Virtual	19.8 (386)	24.6 (360)	
No. of physical sexual contact partners	N: 1950	N: 1463	<0.001
None	37.2 (725)	16.5 (242)	
One	26.0 (506)	19.8 (289)	
Two	10.6 (207)	12.7 (186)	
Three or more	26.3 (512)	51.0 (746)	
No. of new physical sexual contact partners	N: 1949	N: 1460	<0.001
None	63.0 (1227)	38.3 (559)	
One	13.6 (264)	14.4 (210)	
Two	8.3 (161)	12.0 (175)	
Three or more	15.2 (297)	35.3 (516)	
No. of CAS partners	N: 1950	N: 1463	<0.001
None	62.1 (1211)	43.2 (632)	
One	20.4 (398)	23.7 (346)	
Two	6.1 (119)	8.9 (130)	
Three or more	11.4 (222)	24.3 (355)	
Chemsex	N: 1950	N: 1463	0.002
Yes	3.7 (72)	6.0 (87)	

Table 2 Adjusted ORs for reported STI testing and unmet STI testing need in the last 3 months[§ ¶]

	Reported STI test *in the last 3 months*[†]						**Unmet STI testing need** *in the last 3 months*[††]					
	Summer 2020 (W1) % (n)	**aOR (95% CI)**	**p-value**	**Autumn 2020 (W2) % (n)**	**aOR (95% CI)**	**p-value**	**Summer 2020 (W1) % (n)**	**aOR (95% CI)**	**p-value**	**Autumn 2020 (W2) % (n)**	**aOR (95% CI)**	**p-value**
Age *(years)*			0.001			0.173						
Under 45	28.5 (333/1167)	1		40.2 (378/941)	1							
Over 45	19.7 (154/783)	0.67 (0.52-0.85)		31.8 (166/522)	0.82 (0.62-1.09)							
Sexual Identity			0.004			0.243			<0.001			0.014
Gay	26.5 (444/1678)	1		39.3 (479/1220)	1		24.3 (408/1678)	1		30.5 (372/1220)	1	
Bisexual*	15.8 (43/272)	0.58 (0.40-0.84)		26.8 (65/243)	0.81 (0.56-1.16)		33.5 (91/272)	1.69 (1.27-2.24)		42.0 (102/243)	1.44 (1.07-1.92)	
Residing in England			<0.001			0.001			<0.001			0.062
Yes	27.0 (454/1679)	1		39.8 (491/1233)	1		24.3 (408/1679)	1		31.0 (382/1233)	1	
No	12.2 (33/271)	0.37 (0.25-0.56)		23.0 (53/230)	0.53 (0.36-0.78)		33.6 (91/271)	1.65 (1.25-2.19)		40.0 (92/230)	1.33 (1.00-1.79)	
Born in the UK			0.559			0.004						
Yes	24.2 (368/1523)	1		33.9 (381/1125)	1							
No	27.9 (119/427)	0.92 (0.70-1.21)		48.2 (163/338)	1.55 (1.15-2.10)							
Employed *Inc. Furlough*									0.012			0.712
Yes							26.9 (403/1497)	1		31.8 (348/1095)	1	
No							21.0 (93/442)	0.71 (0.55-0.93)		34.2 (126/368)	1.05 (0.81-1.36)	
HIV Status			0.935			<0.001			<0.001			0.034
Negative/Unknown	25.2 (442/1753)	1		36.0 (471/1308)	1		24.5 (429/1753)	1		33.0 (432/1308)	1	
Positive	22.8 (45/197)	0.98 (0.67-1.45)		47.1 (73/155)	2.64 (1.77-3.93)		35.5 (70/197)	2.08 (1.50-2.89)		27.1 (42/155)	0.66 (0.45-0.97)	
Any PrEP use *in the last 3 months*			<0.001			<0.001			0.195			<0.001
No	19.9 (333/1677)	1		25.2 (284/1125)	1		25.4 (426/1677)	1		36.7 (413/1125)	1	
Yes	57.2 (151/264)	4.09 (3.01-5.56)		77.2 (260/337)	7.51 (5.43-10.39)		26.9 (71/264)	1.22 (0.90-1.65)		18.1 (61/337)	0.38 (0.28-0.52)	
No. of CAS partners *in the last 3 months*												
None	18.9 (229/1211)	1		21.0 (133/632)	1							
One	27.9 (111/398)	1.66 (1.25-2.21)	0.001	30.6 (106/346)	1.51 (1.08-2.11)	0.015						
Two or more	43.1 (147/341)	2.03 (1.49-2.77)	<0.001	62.9 (305/485)	3.36 (2.47-4.57)	<0.001						

[§] adjusted for socio-demographic, health related characteristics and STI risk behaviours

[¶] including only variables significantly associated with the outcome (reported STI test or unmet STI testing need) in the bivariable logistic regression for W1 and/or W2

[†] adjusted for age, sexual identity, place of residence, born in the UK, degree educated, living with partner, HIV status, PrEP use, No. of CAS partners, chemsex

[††] adjusted for age, sexual identity, place of residence, employment status, HIV status, PrEP use

** includes 'straight' (W1 n=8; W2 n=14) and 'other' (W1 n=44; W2 n=50) identifying cis-gendered men*

V12: Using STI testing positivity to understand STI trends and patterns in England

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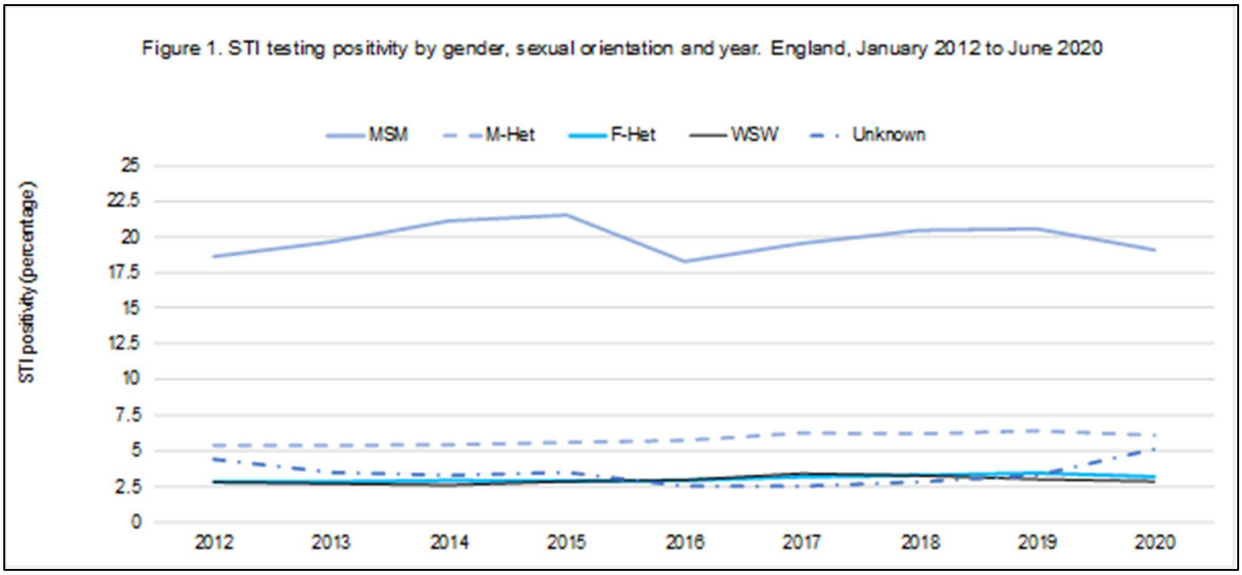
Introduction: A composite measure of STI testing positivity is used to help understand the burden of STIs at local authority (LA) level alongside testing and diagnoses data. The STI testing positivity indicator on PHE's Sexual and Reproductive Health (SRH) Profiles previously used the total of individual tests recommended for routine STI testing in sexual health services (SHS) rather than the total episodes of testing. We describe a modification of the indicator to measure STI testing positivity at person-level.

Methods: Testing and diagnoses data for chlamydia (excluding <25 year-olds), gonorrhoea, syphilis, and HIV at all SHSs in England from 01/2012-06/2020 were obtained from the GUMCAD STI Surveillance system. STI testing positivity at national and LA level was calculated using the total number of diagnoses of the aforementioned STIs per total number of episodes of testing for one or more of these STIs. Descriptive analysis of positivity trends and variation by residential LA and sexual orientation were undertaken.

Results: From 2012 to 2019, STI diagnoses rates rose faster than testing rates nationally resulting an in increase in STI testing positivity per person from 5.1% to 6.5%. Between January and June 2020, STI positivity remained similar to 2019 (6.5%) throughout disruptions to SHS during COVID-19 restrictions. A wide variation in positivity was observed between LAs (1.6% to 12.7%) in 2019. The highest STI positivity was consistently in MSM *vs.* other men or women (Figure 1).



Discussion: There has been a gradual increase in STI testing positivity at the person level. The reasons for this will vary in different settings. Local variations in STI testing positivity can be explored using this modified indicator on PHE's SRH Profiles.

V13: Service evaluation of virtual and face to face HIV clinics during the covid-19 pandemic

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Introduction: The purpose of this service evaluation is to consider virtual HIV clinics created in response to the covid-19 pandemic, compared with face to face clinics between 24/05/21 and 18/06/21 in terms of demographics and experiences.

Methods: Service evaluation. Online questionnaire sent via text following a virtual HIV clinic. A paper questionnaire was provided to patients who attended a face to face (F2F) HIV clinic during the same period.

Results:

58 patients received a questionnaire following a virtual consultation, we received 18 responses (31% response rate.) 57 patients received a questionnaire following a face to face clinic, we received 49 responses (86% response rate).

Higher proportion of patients attending virtual clinics male (86.7% virtual, 70.3% F2F), white (73.3% virtual, 64.9% F2F), and gay/lesbian (66.7% virtual, 59.5% F2F) compared with face to face clinics. Commonest age group in virtual clinics 35-44 (33.3%), compared to 45-54 (37.8%) in face to face group.

In response to the virtual clinic questionnaire, 88.9% felt they were able to hear the healthcare provider throughout, 90% felt the picture quality was good or very good and 100% of the respondents felt their privacy was respected throughout. 87% felt they had the same level of support and advice as a face to face consultation. 46% favoured a virtual consultation, 20% did not mind and 33% favoured face-to-face.

In response to our face to face questionnaires, 41% of respondents received an offer for a virtual clinic.

Commonest reasons for not accepting offer	
Doctor/nurse decision	10
Personal preference	9
Blood test	5
Phone issues	2
Internet issues	2
Privacy fears	1
Communication needs	1

Of those that did not receive offer, 25.9% would have preferred a virtual appointment.

Common reasons for choosing the F2F service over the virtual service	
Internet issues	2
Phone issues	2
Personal preference	9
Communication needs	1
Examination requirements	1
Privacy concerns	1
Doctor/nurse decision	10
Blood test	5

Conclusion: The virtual service provides a high quality, efficient and convenient service, but there is a role for the face-to-face service, ensuring that the clinic can be accessed by everyone. Greater role required in securing the promotion of virtual clinics due to significant proportion who didn't receive virtual clinic offer.

V14: Moving progestogen-only pill provision online: will additional needs be missed? A retrospective review of additional services offered, and risks identified during telephone consultations for the progestogen-only pill at an integrated sexual health service

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Introduction: Progestogen-only pill (POP) provision is changing with digital-only, digital-first and over the counter provision now available. Our aim was to identify if replacing our current telephone-based approach for routine POP provision with a digital-first model would lead to increased clinical risk or missed opportunities for integrated care.

Methods: From date of data extraction patient records pertaining to the preceding 500 POP prescriptions from an integrated UK sexual health service were assessed (16.02.21 – 23.06.21). Included consultations (n=268) were reviewed with opportunistic non-POP service offers identified during the clinical assessment recorded in a bespoke spreadsheet. POP interactions not transferable to digital-only provision were excluded (n=232): age <18 years, given at face-to-face, primary reason for review was not to access POP, complex medical history.

Results: In the review period 70/268 (26.1%) of adult patients receiving routine POP provision had at least one additional service offered / risk identified during telephone consultation, excluding the offer of sexually transmitted infection (STI) testing. Six patients received >1 extra service offer, with 1/6 of these patients receiving three extra offers in a single consultation. Extra service offers were varied, with the most prevalent being POP requests when patients had run out. A majority (171/268, 86.5%) were offered STI testing, with 61/268 (22.76%) accepting.

Table 1: offers of extra services / risks identified

Extra service / information offered, or risk identified	Number of times offered / identified	% of total consultations
Had run out of POP	25	9.3% (25/268)
Extended use LARC advice (COVID)	12	4.5% (12/268)
Double dose POP for bleed control	9	3.4% (9/268)
Identified symptoms for clinical review	9	3.4% (9/268)
Generic branding change explained	6	2.2% (6/268)
Identified smear overdue	4	1.5% (4/268)
Drug interaction concern identified	3	1.1% (3/268)
Loss of libido advice	2	0.8% (2/268)
Need for EC identified	2	0.8% (2/268)
Delayed POP start due to recent EC	1	0.4% (1/268)
Planning pregnancy advice	1	0.4% (1/268)
Perimenopasual POP use advice	1	0.4% (1/268)
Offered emergency coil fit after recent EC issued from pharmacy	1	0.4% (1/268)
Nut allergy concern	1	0.4% (1/268)
Any extra service offered	**77**	**26.1% (70/268)**

Discussion: In our cohort a move to digital-first POP provision would create a significant number of missed opportunities. Although some could be counteracted with digital signposting, especially postal testing, not all can be. Patients running low on POP present risk, especially if we continue to run a postal-supply model. Services should consider retrospective analyses of this kind when introducing digital-first provision to assess the potential impacts of removing a human clinician interaction and create digital alternatives [where possible] for identified shortcomings. Ease of access needs to be considered against opportunistic timely interventions generated by discussion with clinicians.

V15: “It wasn’t the egg sandwich”: experiences of illness and case management of sexually transmitted shigellosis among gay men in England during COVID-19

Helen Corkin, Mateo Prochazka, Claire Jenkins, Katy Sinka

Public Health England, London, United Kingdom

Introduction: Continuous transmission of shigellosis among gay men in England during COVID-19 highlights the need for targeted interventions. We aimed to explore experiences of illness and case management to inform both the design of compelling public health messages, and care pathway improvements.

Methods: Between March-August 2021, we conducted in-depth qualitative interviews among gay men with *Shigella flexneri* in London and Manchester. Participants were identified from HPZone, a case information management system, and invited to participate via SMS. Interview guidelines focused on experiences of illness and case management during COVID-19; data was analysed thematically.

Results: Eighteen gay men from diverse backgrounds, partnership configurations, and circumstances were interviewed. Acute and disruptive symptoms (diarrhoea, fever, and fatigue) varied in severity and duration, leading to hospitalisation in seven cases. Most participants experienced uncertainty and alarm about their symptoms, attributing them to food-borne infections. Participants often highlighted lack of awareness among GPs, which led to delays in accessing stool cultures and antimicrobials. While most symptoms resolved after treatment, many reported mild symptoms lasting for two weeks or longer. Upon realising the infection was sexually transmitted in discussions with health care workers, most participants were able to identify a unique transmission event within the incubation period, often with casual partners met online. Several participants had complex needs, including harm reduction for chemsex, and counselling for psychological support. Participants reported that COVID-19 challenged in-person access to primary care; however, the pandemic did not stop known contexts that facilitate shigellosis transmission, including group sex, chemsex, or casual sex coordinated through geospatial applications.

Discussion: Sexually transmitted shigellosis can present as a severe and disruptive experience. Lack of knowledge among patients and providers continues to hinder timely access to case management. Points of contact between the health system and these patients are missed opportunities to provide comprehensive care targeting chemsex and mental health needs.

V16: Implementing national surveillance of disseminated gonococcal infection: preliminary findings from cross-sectional survey data in England, 2020-2021

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Introduction: Disseminated gonococcal infection (DGI) is caused by the spread of *Neisseria gonorrhoeae* (NG) into the bloodstream and can lead to severe illness. This abstract describes the distribution of DGI cases detected during the initial year of surveillance in England.

Methods: In June 2020, all sexual health clinicians in England were asked to retrospectively (<1 year) and prospectively report DGI cases. Clinical case information was actively sought for NG isolates confirmed by the national reference laboratory from sterile sites from June 2019 onwards. A secure web-based survey was shared with clinicians to collect enhanced data on DGI cases. Individuals with culture-positive or 16S rDNA-positive NG at a sterile site were classified as confirmed cases. Probable cases were defined as individuals with culture-positive or nucleic acid amplification test-positive NG from a non-sterile site with clinical manifestations of DGI. We present the results of a descriptive analysis of this DGI case series.

Results: Thirteen cases of DGI (nine confirmed, four probable) were reported from June 2020 to August 2021. Among the confirmed cases, NG was identified in joint or synovial fluid in seven (78%). Twelve of thirteen (92%) were men, eight (67%) of whom identified as gay or bisexual. The median age of those diagnosed was 32 years (IQR: 25-43 years) and three of 13 (23%) were living with HIV. Eleven of thirteen (84%) were hospitalised, for a median of 10 days (IQR: 7-15 days), and tenosynovitis (seven of 13 cases, 54%) and polyarthralgia (six cases, 46%) were the most commonly reported symptoms.

Discussion: The initial year of DGI surveillance serves as a baseline for assessing trends in this complication of gonorrhoea in England. Awareness of the ongoing need to report DGI should be promoted to clinicians, including those working in non-sexual health settings due to the variety of clinical presentations.

V17: Auditing PrEP service provision and outcomes before and during the COVID pandemic. Were standards maintained as the service changed?

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Introduction: The COVID-19 pandemic invoked a real-time response necessitating a pragmatic approach to change management. This article reports the audit of a large city PrEP service, comparing quality of care before and after COVID-19 protective measures were introduced.

Methods: The rapid implementation of telemedicine has presented an opportunity for several iterations of action, observation, reflection and planning, much like the Action Research Cycle. Retrospective analysis was conducted using Millcare to audit outcomes of patient care from March 2020-2021 compared to March 2019-2020. Fifty PrEP initiation appointments and 50 follow-up appointments were randomly selected from the pre-COVID and post-COVID periods, totalling 200 audited appointments. Quality of care was audited against BHIVA/BASHH guidelines.

Results: Post-COVID, STI and Hepatitis virus testing met guideline standards less frequently. Pre-COVID, urinalysis and eGFR were tested more frequently than recommended by guidelines. The post-COVID delivery model used telephone appointments (72.0%), eConsult forms (10.0%) and proactively consulting patients attending face-to-face in the integrated sexual health clinic (8.0%). STI testing was completed via home self-sampling (20.0%), face-to-face (72.0%) or a combination (8.0%). In the first nine months following introduction of COVID-19 protective measures, the clinic waiting list was eliminated with reduction from 115 people to zero and number of monthly PrEP consultations surpassed pre-COVID rates (high of 111 vs 100). Through normalising PrEP among staff members, new patient flows became common practice. Those attending the integrated sexual health clinic for PEP, diagnosed with a rectal STI or reporting condomless anal sex were enabled to commence taking PREP with ease.

Discussion: A hybrid telemedicine and face-to-face PrEP delivery model can maintain patient safety and quality of care while improving practice efficiency. There have been no HIV, severe renal disease or Hepatitis diagnoses suggesting that the service remained safe. These findings call for reflection upon the guidance for minimum safe standards for PrEP provision.

V18: What is the response to an "active offer" in PrEP recall following relaxation of COVID restrictions in those thought lost to follow up?

Cecily Bloom[1], Eleanor Cochrane[1], Sophie Crescenzio[2], Nicola Lomax[2], Darren Cousins[1,3]

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Introductions: Retention of patients in PrEP services has been a challenge since widespread provision in sexual health services. The COVID pandemic may have worsened this and patients may experience uncertainty as to what services are providing PrEP. Some evidence suggests that sex with casual partners was markedly reduced during the pandemic.

Many stopped PrEP during the COVID pandemic and clinicians speculate whether behaviours changed or whether there remains risk of acquiring HIV. As social distancing restrictions reduce, there is concern that people who would benefit from PrEP have not re-engaged and would benefit from an "active offer" to restart.

Methods: A sample of patients who attended the sexual health service for PrEP prior to COVID but not attended since April 2020 were identified and contacted through "cold calling" to assess their risk and offer restart or continuation of PrEP. They responses were categorised and demographics compared with those who continued to request services during the pandemic and the PrEP attendees pre-COVID.

Results: 471 patients attended for PrEP between 01/04/2019-01/04/2020 compared with 465 in the following 12 months. 52% of those patients were lost to follow up. the median age for those lost to follow up was 32.

95 patients who attended prior to COVID but not since the pandemic were called to offer further PrEP. The age structure of those contacted was similar to the general group lost to follow up.

Of these 31 (33%) restarted PrEP and 19 (20%) declined due to changes in circumstances. 21 were unable to be contacted and 15 moved out of area.

Discussion: Numbers lost to follow-up were similar to other published studies. A significant minority of those contacted were at high risk of HIV acquisition and benefited form the proactive offer. There may be public health benefit to this activity being an integral component of PrEP services.

V19: HIV post exposure prophylaxis attending the emergency department: should we be dispensing 28 day packs

Louise Kerr, Fiona Cresswell

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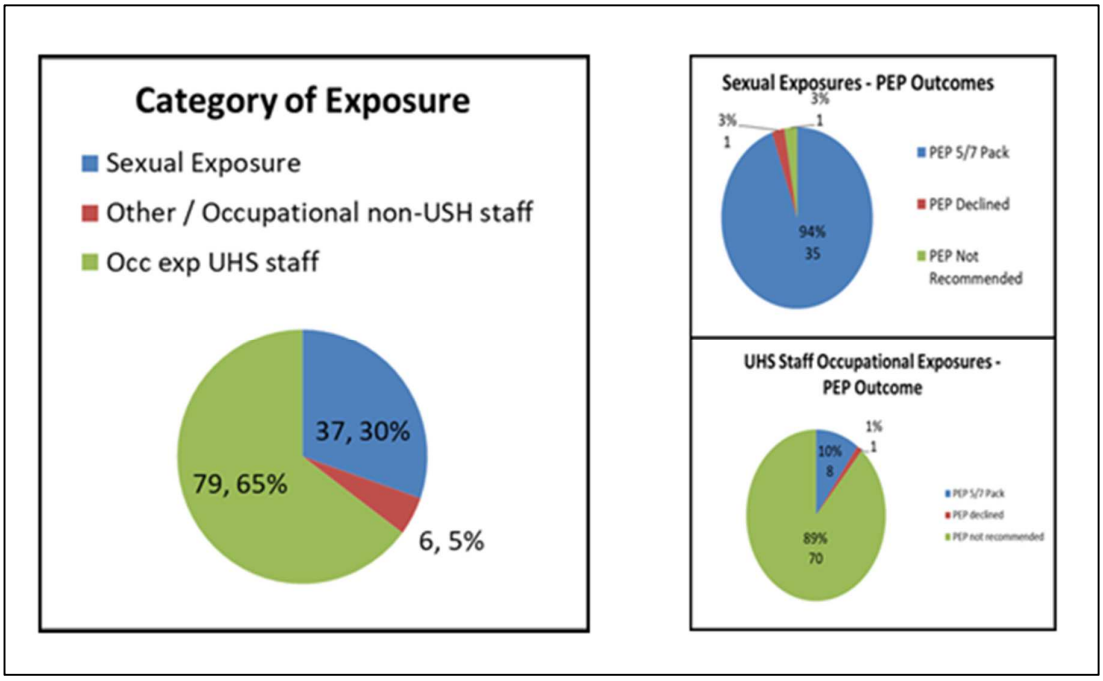
Introduction: New BASHH PEP guidelines (2021) and plans for OD raltagravir PEP regimes prompted a review of PEP activity and patient pathways from our local emergency department (ED) The aim was to assess PEP activity in ED and inform service improvements. Patients who initiate PEP are given a 5-day starter pack of raltegravir BD and Tenofovir/Emtricitibine and are reviewed in the sexual health clinic within 5 days.

Method: All patients who were assessed and initiated on PEP presenting to ED over 16 months were reviewed.

Results: 122 patients were assessed in ED in the time period. 70% (n=85) were for occupational exposures (PEPO) and 30 % (n=37) for sexual exposures (PEPSE). 10% (n=7) were assessed as requiring PEPO and 94% (n=35) required PEPSE and a 5-day starter pack issued. 71% (n=25) of the PEPSE episodes involved UPAI: 24 between MSM. Five PEPSE patients starting PEP in ED (all involving UPAI between MSM), did not attend follow-up in the sexual health clinic. Of the PEP discontinued in the sexual health clinic, 73 % (n=11) was for PEPO.



Discussion: Most presentations in ED for PEPO do not require PEP, suggesting the indications for occupational PEP are poorly understood. Overall, 77% of PEP initiated in the ED needs to be continued. Thus, making individuals attend the sexual health clinic within 5 days for further medication supplies may not be user friendly or efficient. Given that 5 individuals started on PEPSE in ED needing the full course, did not attend the clinic for follow up, dispensing all 28 days of medication at initiation may be preferable. This would also align with medication supply options for OD raltegravir (a minimum of 30 day pack) and streamline care pathways for patients.

V20: Shigella during the COVID-19 era: Review of Clinician History Taking as a Marker of Awareness for Sexual Transmission Risk

Jozef Shaw, John Thornhill, Jane Hutchinson, Robert Serafino Wani

Barts Health NHS Trust, London, United Kingdom

Introduction: Despite travel restrictions imposed during the COVID-19 pandemic in the UK in 2020-2021, Shigella infections continued at a high rate, particularly amongst the MSM population. Sexual transmission now represents the predominant mode of Shigella transmission in the UK. Awareness amongst UK clinicians of change in predominant transmission mode for Shigella is unclear, and may be illustrated in the type of questions asked by clinicians in consultations.

Methods: Retrospective case note review for all laboratory–confirmed adult cases (>16 year) of *Shigella* from January 2020 to July 2021 at from Barts Health NHS Trust, in East London. Demographic and clinical data was collected retrospectively. Data was analysed with Prism.

Results: 48 patients were identified with laboratory-confirmed Shigella infections: S flexneri (75%), S sonnei (20.83%) and S dysenteriae (4.17%). Median age 36 years (IQR 29-46), 42 (88%) were male and in total 15 patients required hospital admission (31%). 11 patients (23%) were HIV positive (100% male), and of these 6 required hospital admission (54%). Of the HIV negative cohort, only 9 patients required hospital admission (9/37 vs 6/11- P value =0.0745).

83% (40/48) of all patients had a travel history documented, compared to only 17% (8/48) having a sexual history documented (83% vs 17% - P value <0.0001). Amongst the HIV positive cohort, 10/11 had a documented travel history compared to 1/11 having a sexual history documented (91% vs 9% - p value = 0.0003)

Discussion: Sexual history taking amongst UK clinicians for confirmed shigella cases is very uncommon, whilst asking about travel remains high, including for HIV positive adult male patients. This may represent poor awareness among clinicians regarding changes in predominant mode of Shigella transmission. This is likely to have a significant impact on risk assessment for sexual behaviours, investigations for STI co-infections, referrals to relevant services and partner notification for a potential serious illness.

V21: Use of the National HIV and Syphilis Self-Sampling Service during the national lockdowns in England, 2020-21

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Public Health England, London, United Kingdom

Introduction: The National HIV and Syphilis Self-Sampling Service (NHSSSS) is an online service jointly commissioned by Public Health England (PHE) and local authorities (LAs) providing testing for HIV and syphilis for gay, bisexual and other men who have sex with men (MSM), people of black African ethnicity, and other groups with a higher or emerging burden of HIV infection. We compared the number, characteristics and reactivity of service users between October 2019 and March 2021 to assess the impact of the COVID-19 pandemic on the service.

Methods: Using data from the NHSSSS from October 2019 to March 2021, we performed a descriptive analysis by ethnicity, sexual orientation and time-period (during PHE-funded vs. signed-up LAs periods).

Results: HIV and Syphilis testing activity were highest (65.9% and 74.4%) during PHE-funded periods (vs. signed-up LAs periods). Testing activity during signed-up LAs periods increased by 36% for HIV and 86% for syphilis between Jan-Mar 2020 and April-June 2020 (i.e. during lockdown). The proportion of Black African ethnicity decreased from 7.5% in the October-December 2019 National HIV Testing Week (NHTW) to 3.5% in the Break The Chain Campaign (June-July 2020) and to 3.6% in the NHTW 2021 campaign. HIV reactivity was similar in all periods and syphilis reactivity was higher during campaign periods (Table 1). For all periods, the highest HIV and syphilis reactivity observed were in MSM vs. other gender identities and sexual orientations (0.7% for HIV and 2.2% for syphilis in January-March 2021).

Table 1. National HIV and Syphilis Self-Sampling Service. Kits ordered and returned, testing and reactivity. England 2019-2021

Orders created period	NHTW campaign: October to December 2019	January to March 2020	April to June 2020	BTC Campaign: 5 June to 3 July 2020	July to September 2020	October to December 2020	NHTW campaign: 11 January to 12 February 2021	January to March 2021	October 2019 to March 2021
Funding source	PHE	signed-up LAs	signed-up LAs	PHE	signed-up LAs	signed-up LAs	PHE	signed-up LAs	Total
Orders	19,866	3,794	4,498	9,747	7,607	7,361	30,629	6,148	89,650
Dispatched Kits	19,147	3,528	4,185	9,381	7,163	6,989	29,806	5,739	85,938
Returns	10,095	2,108	2,842	6,053	4,860	4,863	20,162	4,013	54,996
Return Rate	52.7%	59.8%	67.9%	64.5%	67.8%	69.6%	67.6%	69.9%	64.0%
Service users	19,052	3,476	4,273	9,559	7,066	6,922	29,755	5,688	85,791
HIV Tests	10,095	2,061	2,812	5,739	4,860	4,860	20,163	4,013	54,603
Reactive	82	20	13	38	25	22	142	25	367
Reactive Rate	0.8%	1.0%	0.5%	0.7%	0.5%	0.5%	0.7%	0.6%	0.7%
Syphilis Tests	8,887	713	1,329	5,084	2,594	3,473	17,895	2,844	42,819
Reactive	162	4	19	107	26	49	269	27	663
Reactive Rate	1.8%	0.6%	1.4%	2.1%	1.0%	1.4%	1.5%	0.9%	1.5%

The first national COVID-19 lockdown took place between 23 March and the end of June 2020; NHTW: National HIV Testing Week campaign; BTC: Break the Chain campaign

Discussion: Variations in users accessing the NHSSSS at different periods may be explained by the COVID-19 restrictions on access to sexual health services and more MSM-focused health promotion activities for some periods. Online self-sampling services are an important tool for sexual health service delivery. Further research is needed to understand how well they meet the needs of groups with higher burden of HIV infection.

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