Abstract P3.310 Table 1 (Continued)

	NHBS* N % (95% CI)		SFCC* N % (95% CI)
CHLAMYDIA (PAST YEAR)			
NO	468	93.0% (90.4–95.1)	87.8% (86.2–89.3)
YES	35	7.0% (4.9–9.5)	12.2% (10.7–13.8)
GONORRHEA (PAST YEAR)			
NO	458	90.7% (87.8–93.1)	88.6% (87.0–90.0)
YES	47	9.3% (6.9–12.2)	11.4% (10.0–13.0)
SYPHILIS (PAST YEAR)			
NO	494	97.8% (96.1–98.9)	95.2% (94.1–96.1)
YES	11	2.2% (1.1–3.9)	4.8% (3.9–5.9)

* Column totals do not sum to sample totals because of missing values.

municipal STD clinic might serve as a proxy population during non-survey years.

Methods We compared select questions from the 510 participants of the NHBS MSM-San Francisco survey (07/21–12/19/2011) to similar measures from 1807 MSM who visited the San Francisco City Clinic (SFCC) during the same time period. One visit was randomly selected among clients who had multiple SFCC visits during the study period. We compared the two groups' demographics and HIV/STD-related history. Data were self-reported except SFCC STD history, which was laboratory-confirmed.

Results SFCC clients were more likely to be younger, non-white, un-insured, and self-identify as straight. NHBS participants were more likely to report a lifetime history of injection drug use and 12-month non-injection drug use of cocaine, crack, poppers, and erectile dysfunction medications. Methamphetamine use was not statistically different. Approximately 44% of both samples reported ≥ 6 male partners in the past year. The two groups did not differ on history of HIV testing, HIV-positive status, current HAART use among known HIV positives, or PEP use in the past year among HIV negatives. Self-reported syphilis or chlamydia was less likely among NHBS participants than laboratory-confirmed diagnoses among SFCC clients; gonorrhoea positivity did not differ statistically.

Discussion NHBS and SFCC MSM similarly reported several key behavioural surveillance factors. Readily available non-survey surveillance data may be useful for monitoring trends among the San Francisco MSM population and informing policy and programmes. Future efforts should explore how STD clinic data can be used to supplement behavioural surveillance.

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Background Men who have sex with men (MSM) comprise the most vulnerable group for HIV infection.

Aim of this study was the estimation (1) of HIV prevalence and (2) sexual behaviours among MSM in Cyprus.

Sample and Methods time location sampling has been used to recruit a representative sample of MSM in Cyprus during January 2011 to January 2012. Self completed questionnaires and Orasure oral fluid collection kits were distributed to men who were frequented in gay venues. Ethical approval was obtained by the Cyprus National Bioethics Committee.

Results 200 MSM participated in the study. The response rate was quite high (89%). HIV prevalence was 2.5%. The mean age was 29 ± 6.6 years old while 74.9% of MSM identified themselves as gay. The prevalence of last unprotected anal intercourse was 30% while the last unprotected oral sex was 87.7%. The percentage of the participants who reported they have used alcohol and cocaine before or during the last sexual contact were around 60% and 10% respectively. One out of three has not been tested for HIV the last 12 months neither they know where they can get tested for HIV. Concerning HIV transmission modes knowledge, 22% of MSM answered correctly in the 5 questions, according to UNGASS guidance. In the univariate analysis, cocaine use, education level and type of sexual partner were independently associated with the unprotected anal intercourse.

Conclusion The prevalence of HIV infection in MSM in Cyprus remains stable at low levels similar to other Central European countries. The high response rate indicates the broad acceptance of such studies. Knowledge awareness campaigns should be implemented regarding the transmission modes and risky sexual behaviours as well as interventions for the promotion of HIV testing.

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Background There are very limited number of literatures on cross-border communities and HIV/AIDS. The objective of this study is to assess the situation of HIV/AIDS among populations in the main transport corridors along Djibouti to Addis Ababa.

Methodology The study was conducted in three hot spots along Djibouti to Addis Ababa rout, namely. Both qualitative and quantitative approaches employed in order to explore HIV/STI situations.

Result A total of 120 truck drivers and their assistance were interviewed at 3 hot spots. 81.7% were truck drivers and 18.3% were truck drivers' assistants. A wide variety of health problems were reported; of all Malaria (98.3%), STI (81.1%), URTI (65.1%) and diarrhoea (63.3%). From all participants, 31.7% could not identify any STI symptoms, while the rest, 28.3%, 14.2% and 5.8% of them were known one, three and five symptoms, respectively. 48.3% of the participants have sought treatment, of whom 81% of them were treated at private clinics.

The majority of FSWs are mobile with truck drivers (38.3), and 31.7 of them were not travel with truck drivers. The FSWs clients found to be truckers, port workers, uniformed services, government employee. Common health problems reported by FSWs were STI (95.2%), HIV/AIDS (74.8%), and malaria (22.1%). As symptoms, genital sores identified by 40%, vaginal discharge by 60%, burning sensation by 70%.

Conclusion The highways were carrying relatively high volumes of traffic. Mobility of truckers and FSWs was high. Transactional sex is already at high level and condom use is low. There were high prevalent of self reported cases of STIs by truckers and FSWs. There is a need for targeted HIV programmes for FSWs and Truckers.

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Background Inattention to symptoms of mental disorders and substance abuse in patients with HIV/AIDS and other at risk groups, may lead to irreversible damages. Present research aimed at comparison of psychopathological dimensions in substance abusers with and without HIV/AIDS and healthy matched groups.

Methods In a cross-sectional and analytical study, selected samples by available, consecutive, and objective methods were 43 HIV positive substance abusers, 49 HIV negative substance abusers under Methadone Maintenance Therapy (MMT) in counselling clinic of behavioural diseases and addiction abandonment and 45 ordinary individuals. All of them were evaluated by matched confounding variables via symptom check list-90-Revised (SCL-90-R). Results analysed by chi-square (χ^2), independent t test, one-way analysis of variance (ANOVA) and Gabriel post hoc.

Results Findings indicated significant difference between these groups in Global Severity Index (GSI), Positive Symptom Distress Index (PSDI) and Positive Symptom Total (PST) ($P < 0.0001$). Two by two comparison of the three groups from psychopathological dimensions revealed that substance abusers with HIV/AIDS persistently suffer more mental problems in all dimensions compared with healthy ones ($P < 0.05$) and in other dimensions including somatization, interpersonal sensitivity, depression, anxiety, phobia, and psychoticism in comparison with HIV negative substance abusers ($P < 0.05$). Yet, the difference in paranoid ideation, hostility and obsessive-compulsive case was insignificant. Two by two comparison of healthy ones and substance abusers without HIV/AIDS showed higher levels of depression and Psychoticism in substance abusers ($P < 0.05$) but no difference in other dimensions.

Conclusion Comorbidity of substance abuse and HIV diagnosis intensify mental disorders symptoms. Moreover, lack of prevention and implementation of appropriate psychological and psychiatric interventions after substance abuse and HIV lead to extended establishment of mental disorders symptoms. Some implications of these results are discussed results may direct future researches.

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Background Chlamydia testing data are often used for prevalence monitoring to evaluate screening programmes; however, trends in positivity are impacted by changes in screening coverage and criteria, independent of changes in population prevalence, and thus are difficult to interpret. Given limited resources, many chlamydia control programmes in the US target screening to improve cost-effectiveness. We explored the potential impact of focusing screening on high prevalence (i.e., > 3%) clinics on trends in chlamydia positivity.

Methods We analysed line-listed data on women tested for chlamydia in family planning clinics participating in the Infertility Prevention Project (IPP) during 2000–2011. Trends in annual positivity in family planning clinics participating in IPP who reported at least 120 tests restricted to patients aged 15–24 years were examined among two cohorts: (1) all clinics and (2) all clinics, with testing data removed from subsequent years for clinics where positivity fell below 3%.

Results Positivity trends for both cohorts are shown in the table, along with overall percent change in positivity over the period. All trend lines increased over time; however, trend lines with low prevalence clinics removed had a higher positivity at each year. Similar patterns were seen for both cohorts of clinics, as well as when stratified by geographic region. Percent change in positivity over the 12 year period was 52.2% for cohort 1 and 64.1% in cohort 2.

Conclusion Our analysis of chlamydia data suggests that individual point estimates of chlamydia positivity are likely overestimated when chlamydia screening was targeted to high prevalence clinics; however trends over time were similar in the two analytic groups. Data used for programme monitoring and evaluation may bias point estimates of prevalence. Caution should be used when using prevalence monitoring data to evaluate impact of screening without considering clinic-level confounders.

YEAR All Clinics Below 3% Removed

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Background Recent studies using setting-specific health insurance or clinical datasets have demonstrated the importance of considering

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Abstract P3.314 Table 1

YEAR	All Clinics				Below 3% Removed			
	Point Estimate	95% CI		Testing Volume	Point Estimate	95% CI		Testing Volume
2000 (baseline)	5.77%	5.72%	5.82%	852274	5.77%	5.72%	5.82%	
2001	5.79%	5.74%	5.83%	904906	6.32%	6.26%	6.37%	750,924
2002	6.02%	5.98%	6.07%	923056	6.61%	6.55%	6.66%	752,666
2003	6.37%	6.32%	6.42%	949916	7.09%	7.03%	7.15%	750,525
2004	6.99%	6.94%	7.04%	976398	7.80%	7.74%	7.86%	756,625
2005	6.91%	6.86%	6.96%	985064	7.68%	7.62%	7.74%	768,165
2006	7.11%	7.06%	7.17%	990214	7.99%	7.93%	8.05%	762,244
2007	7.61%	7.55%	7.66%	912142	8.53%	8.47%	8.60%	701,221
2008	7.97%	7.92%	8.03%	887940	8.95%	8.88%	9.02%	685,459
2009	8.18%	8.13%	8.24%	897558	9.16%	9.09%	9.23%	693,921
2010	8.34%	8.29%	8.40%	950214	9.09%	9.03%	9.16%	749,957
2011	8.78%	8.72%	8.84%	896104	9.47%	9.40%	9.54%	710,947
Percent change from 2000–2011	52.2%	52.4%	51.9%		64.1%	64.3%	63.9%	