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.

P3.314 **CAN CHLAMYDIA PREVALENCE MONITORING DATA BE USED TO EVALUATE IMPACT OF SCREENING? THE US CDC INFERTILITY PREVENTION PROJECT EXPERIENCE**

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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

P3.315 **DOES ADJUSTING FOR SEXUAL BEHAVIOUR IMPROVE THE ACCURACY OF POPULATION-BASED CHLAMYDIA INCIDENCE AND SCREENING RATES AMONG ADOLESCENTS IN BRITISH COLUMBIA, CANADA?**

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

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%	