remote history of urethral discharge (past 6 months) was 5.8% among men with MG vs 2.1% uninfected (p=0.10). The prevalence of MG was 13.4% in uncircumcised men vs 8.2% in circumcised men (p=0.06). In multivariable logistic regression, circumcision status nearly halved the odds of MG [adjusted OR=0.54; 95% CI 0.29 to 0.99], adjusted for variables significant at the p<0.05 level: HSV-2 infection [aOR=2.05; 95% CI 1.05 to 4.00], CT infection at enrolment or at follow-up [aOR=2.69; 95% CI 1.44 to 5.02], washing the penis ≤1 h after sex [aOR=0.47; 95% CI 0.24 to 0.95]. The prevalence of MG did not differ by HIV status, age, education, marital status, number of sex partners, condom use, or sex during menses. There were no interactions with circumcision status.

Conclusions Prospective study is needed to verify the potential protective association between MMC and MG. The mechanism by which MMC may protect against MG is unclear. Randomised trials have not found MMC to protect against other urethral infections (NG, CT, TV), though circumcised and uncircumcised men may have different peri-urethral bacteria and penile microbiome. The role of MG in STI morbidity, syndromic management algorithms and antibiotic regimens for men and women in this region should be evaluated.

Social and behavioural aspects of prevention poster session 1: Adolescents

P2-S1.01 BEYOND THE ABC IN HIV/AIDS PREVENTION: A SYSTEMATIC LITERATURE REVIEW OF SEXUAL EDUCATION PROGRAMS FOR YOUNG PEOPLE

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Background Latin-American young people are the fastest growing group living with, or at high risk of acquiring HIV. Young people are vulnerable due to sexual behaviour; use of illicit drugs; lack of access to education and health services; cultural and social-economical factors; structural violence; marginalisation and poverty. Acceptable success for sexual education programs are decrease in adolescent pregnancy, STD and HIV infection rates. This study tried to identify those characteristics of programs that achieved one or more of mentioned success criteria and could be adapted and implemented in Latin America, taking into account its particular historical and contextual conditions.

Methods A systematic literature review of evaluations of HIV educational programs for young people published in international databases within the last 4 years was performed. Specialised educational evaluation books, primary and secondary documents and unpublished literature were also consulted.

Results The review identified 182 documents related to the evaluation of HIV educational programs. Successful programs had at least one of the following characteristics: exceeded the ABC (Abstinence, Be faithful, Condom use) methodology; were supported by national authorities; used participative instruction methods; presented comprehensive information, including general HIV education, risk reduction practices, methods of contraception and condom use, respect for sexual/gender diversity; and guaranteed that young people joined and remained into the educational programs.

Conclusions Successful HIV/AIDS educational programs should promote the acquisition of protective though processes and behaviours by focusing on the historical, contextual, psycho-social, and sexual factors that affect behaviour and health. An education committed to HIV/AIDS prevention should be accessible to young people through the schools and must support life conditions that allow them to take advantage of the different learning opportunities. Literature review suggests that youngs may acquire the knowledge, abilities, competences, values, and attitudes that make possible to overcome the conditions of vulnerability to HIV they face.

P2-S1.02 SAFE SPACES: YOUTH FRIENDLY CENTRE USED TO PROMOTE HIV EDUCATION IN NAIROBI SLUMS

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Background Kenya's National HIV/AIDS Strategic Plan deems youth, 14–24, most-at-risk. Risk is elevated in slums where poverty is prevalent and access to condoms and health education is limited. Peer health educators who come from the community and speak the same language are able to engage trust and confidence of the target population. In 2010 a unique partnership was formed, between youth, AIDS service organizations (ASO), and Goal Kenya, with the objective of increasing HIV education among youth in Nairobi. One outcome from this partnership was the creation of a youth friendly centre.

Methods Peer educators created a safe space within the slum, Lunga Lunga Youth Centre, where youth are invited to "hang-out", engage in off street activities (computer games, theatre, music etc), and receive health education and services. Information on HIV/STI prevention is shared and youth are taught to make informed decisions related to sexual activity and are encouraged to test for HIV /STI at the adjoining clinic.

Results In the first four months of the project 2424 youths, 40% female and 60% male used the centre. 933 youth received health counselling, 98.6% male and 1.4% female. The youth friendly space allowed for a safe and open environment for youth to receive and discuss HIV/STI information as well as access testing and health services. Using non-literature based activities increased HIV/STI knowledge and prevention methods were learnt, barriers to education such as illiteracy were circumvented.

Conclusion Given the overwhelming positive response to the youth specific space more youth friendly spaces in other parts of the slum should be made available, and ASO and youth partner organizations should be supported to enhance services. There needs to be more emphasis on engaging young women in health counselling programs.

P2-S1.03 OUR ADOLESCENTS! MY SEXUALITY MATTERS (MSM) THE LESSONS WE HAVE LEARNT

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Background As in many developing countries, as in Nigeria STI is increasing among the adolescents. While life skills can improve their behavioural practices, traditional training approaches may not be a feasible approach to be reaching the vast number of adolescents that are sexually active, who do not know both STI and HIV status. Many youth initiate sexual risk behaviours in preadolescence, yet STI, HIV prevention programmes are typically implemented in adolescence, missing an important window for prevention. Pre-risk prevention efforts are needed to equip youth with knowledge and skills to make healthy and responsible decisions about sexual behaviour against STIs.

Methods My Sexuality Matters, a re-orientation base programming was employed to reach out to youth early with sexual health prevention messages through the parents. Parent-child communication, we developed and rigorously evaluated program that enables parents to help shape their children's decisions about sexual behaviour. My sexuality Matters (MSM) is base on intervention provided directly by parents who are care givers of children; this gives parents knowledge and skills to communicate about sexuality with their children. Lesson Learnt: Significant cultural taboos exist in Nigeria that bars parents from speaking with children about sexuality and sexual decision making. Additional challenges include rites of passing rituals, and cultural Challenges that the altered the context of sexuality education. Despite these challenges, over 40 000 Nigerian families have participated in My Sexuality Matters (MSM), and the program has been adopted by other countries and many families have continued embracing MSM initiatives.

Conclusion The success of MSM demonstrates that programmes involving parents as sexuality educators and motivators can be implemented and embraced and reduce to the vulnerability of adolescent, youths to STIs. The willingness of parents to rebrand the cultural norms to protect their children's sexual health.

P2-S1.04 ASSOCIATIONS OF SYMPTOMS OF DEPRESSION WITH MULTIPLE SEXUAL RISK BEHAVIOURS IN NOVA SCOTIA ADOLESCENTS

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Background While depression is associated with sexual risk taking in adolescents, Canadian studies are few, many studies have not controlled for other risk factors, and none has examined associations of depression with having multiple sexual risks. We tested associations between multiple sexual risk taking and risk of depression while controlling for other salient factors in high school students in Cape Breton, Nova Scotia, Canada.

Methods We surveyed sexually active male (n=418) and females (n=467) adolescents aged 15–19. Participants were asked about their risk of depression, perception of trust and helpfulness at school (social capital), sexual behaviours, substance use and sociodemographic factors. Logistic regressions were carried out to determine associations of depression with various levels of sexual risk-taking (none, one or two or more).

Results In unadjusted models depression predicted having two or more vs no sexual risk behaviours among both males and females. After controlling for other variables risk of depression remained significantly associated with having two or more sexual risks vs no risks for both males and females [RR Ratios 2.5 (95% CI 1.4 to 4) and 3.5 (95% CI 1.6 to 7.82) respectively] and in relation to one vs no risks for females (RRR=1.9; 95% CI 1.1 to 3.5).

Conclusions These consistent and independent associations of depression risk with multiple sexual risk-taking behaviours should lead healthcare workers interacting with adolescents to consider asking about sexual risk behaviours or testing for sexually transmitted infections among patients showing symptoms of depression. Alternatively, patients engaging in sexually risk taking might be screened for depression.

P2-S1.05 PARENTAL ACCEPTABILITY OF CONTRACEPTIVE METHODS OFFERED TO THEIR TEEN DURING A CONFIDENTIAL HEALTHCARE VISIT

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Background STIs remain epidemic among teens. Parents have a powerful influence on their teens' sexual behaviours, yet their role in preventing adolescent STIs and unplanned pregnancies has been largely ignored in clinical practice and research.

Objective To explore parental acceptability of different contraceptive methods, including condoms, offered to their teen during a confidential healthcare visit (CV).

Methods A cross-sectional phone survey of 261 randomly selected parents/caregivers of girls 12–17 years enrolled in two large diverse clinic systems. Parental acceptability of 7 different contraceptive methods was assessed on a 4-point likert scale (1=very unacceptable to 4=very acceptable). We examined if parental acceptability varied according to a variety of demographic factors, perceived likelihood of teen's sexual activity, and parental knowledge of STIs using bivariate analyses (χ^2 for categorical correlates, t tests for continuous correlates).

Results Parents surveyed were 27–69 years old (mean 45 yrs), 70% married; 86% female; and diverse (46% Latino, 23% White, 16% Black, 11% Asian, 3% Other). 15% of household incomes were $20 K or less and 25% over $100 K. 36% attended religious

Abstract P2-S1.04 Table 1 Adjusted multinomial regression of cumulative sexual risk-taking, depression risk and other correlates for males and females (RRs and 95% CI's)

	One sexual risk vs no sexual risks		Two or more sexual risks vs no sexual risks		Two or more sexual risks vs one sexual risk	
	Females (n=418)	Males (n=382)	Females (n=418)	Males (n=382)	Females (n=418)	Males (n=382)
Alcohol binge ≥3 times in past month	1.7 (1.0 to 3.2)*	1.6 (0.9 to 3.2)	3.5 (2.0 to 6.4)‡	5.3 (2.9 to 9.6)‡	2.0 (1.2 to 3.5)***	3.3 (1.9 to 5.8)***
Marijuana use ≥3 times past month	3.2 (1.5 to 7.0)†	1.2 (0.6 to 2.5)	3.6 (1.7 to 7.7)‡	3.5 (1.9 to 6.7)‡	1.1 (0.6 to 2.0)	2.9 (1.6 to 5.4)***
Not living with both parents	0.7 (0.4 to 1.2)	0.9 (0.5 to 1.7)	1.1 (0.6 to 1.8)	1.2 (0.7 to 2.2)	1.6 (0.9 to 2.7)	1.3 (0.7 to 2.4)
Lower family wealth	0.26 (0.1 to 0.8)*	0.9 (0.3 to 2.9)	0.7 (0.3 to 1.6)	0.6 (0.2 to 1.8)	2.8 (0.8 to 9.0)	0.6 (0.2 to 1.6)
First vaginal sex at age <15	1.8 (0.9 to 3.6)	1.3 (0.6 to 2.6)	5.1 (2.6 to 9.9)‡	1.1 (0.6 to 2.2)	2.8 (1.5 to 5.2)***	0.9 (0.5 to 1.6)
Last partner >2 years older	1.0 (0.6 to 1.7)	0.7 (0.2 to 2.4)	0.8 (0.5 to 1.4)	1.6 (0.6 to 4.3)	0.8 (0.5 to 1.4)	2.3 (0.7 to 7.3)
Average school grade <80%	1.2 (0.7 to 2.0)	2.0 (1.1 to 3.6)*	1.6 (0.9 to 2.8)	2.4 (1.3 to 4.4)†	1.4 (0.9 to 2.3)	1.2 (0.6 to 2.3)
Low perceived trust	1.5 (0.9 to 2.7)	1.4 (0.7 to 2.9)	2.0 (1.1 to 3.7)*	1.2 (0.6 to 21)	1.3 (0.7 to 2.3)	0.78 (0.4 to 1.4)
Low perceived helpfulness	1.1 (0.7 to 2.0)	1.0 (0.4 to 1.9)	1.5 (0.9 to 2.6)	1.5 (0.7 to 2.9)	1.3 (0.7 to 2.2)	1.6 (0.8 to 3.1)
Depression risk positive screen	1.9 (1.1 to 3.5)*	2.0 (0.8 to 4.8)	2.5 (1.4 to 4.5)‡	3.5 (1.6 to 7.82)‡	1.3 (0.7 to 2.4)	1.6 (0.8 to 3.3)