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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[1]D Langille, [1]M Asbridge, [2]S Kisely. *[1]Faculty of Medicine, Dalhousie University, Halifax, Canada; [2]Faculty of Medicine, University of Queensland, Brisbane, Australia*

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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[1]L Hartman, [1]M A Shafer, [1]L Pollack, [2]C Wibbelsman, [1]F Chang, [1]K Tebb. *[1]University of California San Francisco, San Francisco, USA; [2]Kaiser Permanente, USA*

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)

Abstract P2-S1.05 Table 1 Parental acceptability of contraceptive methods

Contraceptive method	Overall parental acceptability (N=261)	Parental acceptability if teen is very unlikely to have sex in next year (n=195)	Parental acceptability if teen has any likelihood of having sex in next year (n=62)	Differences in acceptability by likelihood of teen having sex
Condom	51%	43%	76%	p<0.001
Oral contraceptive pill (OCP)	59%	53%	75%	p<0.01
Depot medroxyprogesterone Acetate (DMPA)	46%	42%	58%	p<0.05
Patch	42%	39%	51%	NS
Implant	32%	30%	37%	NS
Intrauterine Device (IUD)	18%	17%	20%	NS
Emergency contraception (EC)	45%	39%	63%	p<0.001

NS, not statistically significant.
p>0.05.

services at least once/week. When parents were asked about their own experiences as teens, 40% reported sexual intercourse, 4% had an STI, 14% had a teen pregnancy, and 25% used birth control. The majority of parents lacked STI knowledge (56% correctly answered 0-1 out of 5 basic knowledge questions). Overall acceptability of contraception provided to their teen was highest for oral contraceptive pills (OCP) 59% and condoms 51% and lowest for IUDs 18% (see Abstract P1-S2.05 table 1). Only 24% thought there was any likelihood their teen would have sexual intercourse in the next year. Acceptability of OCPs, condoms, and emergency contraception was higher among parents who report a likelihood their teen would have sex.

Discussion This is the first study to examine parental acceptability of contraception offered during a CV. This study shows that parents lack basic STI knowledge and underestimate their teens' sexual activity. Only half found condoms, the only method that offers both STI and contraception protection, to be acceptable. In the context of providing confidential health services for teens, these findings highlight the need to better understand influences on parental attitudes and to improve communication with parents about sexual health topics, STIs, and condom use.

P2-S1.06 ADOLESCENTS' WILLINGNESS TO PARTICIPATE IN HIV VACCINE CLINICAL TRIAL PREPAREDNESS IN NIGERIA

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[1]N Otuonye, [1]R Onwuatuelo, [1]C Onwuamah. [1]*Nigerian Institute of Medical Research, Yaba, Nigeria*

Background Routine vaccination of recommended vaccines in adolescents/children from 1999 would prevent >14 million disease cases and 33 000 deaths over the lifetime of each birth cohort. Data from National sero-prevalence surveys estimate the prevalence of HIV among 15—24 years old to be 5.2%. Therefore including adolescents in HIV vaccine trials makes them an important target for research in primary prevention of HIV infection which they are increasingly at risk of. This study evaluated adolescent perception towards HIV vaccine trial in Nigeria.

Methods Two hundred and ninety one consenting adolescents were randomly selected for this study. They were recruited from some secondary schools class rooms, university undergraduates' hostels and some traders at the shopping malls within Lagos State Metropolis. Data were collected using semi-structured questionnaire. Information was obtained from knowledge of HIV status, willingness to participate in vaccine trial in future were obtained. Additionally, sexual risk behaviour, stigmatisation, obtain parental permission (required or not required), and function of efficacy of HIV vaccine and perceived self risk of HIV vaccine were collated and analysed using EPI INFO 2002 software (CDC, USA).

Result Of the 291 respondents interviewed, 96% were single. 72.7% who were willing to participate in the HIV vaccine trial (p<0.05), were educated (97.5%) have Knowledge of HIV vaccine (73.5%), and have no perceived risk of HIV vaccine infection from immunisation (66.2%). Few respondents (31.3%) know their HIV status. Contrarily, those seeking parental permission (66.2%) would significantly reduce willingness to participate (p>0.05).

Conclusion Efforts should be made on sustained education campaigns on HIV vaccine involving adolescents/parents' consent, otherwise there would be potential obstacle to hypothetical vaccine acceptance and believe. Sexual high risk behaviour is an important factor in the retention of adolescents in future vaccine. studies. A number of other ethical and social issues need to be addressed before adolescent HIV vaccine trials in Nigeria.

P2-S1.07 SADNESS, POOR SCHOOL WORK, RUNNING AWAY, AND SEXUAL RISK BEHAVIOUR AMONG URBAN FEMALE AFRICAN AMERICAN ADOLESCENTS

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M Safran, L Hui Tian, M Hogben, J Braxton, R Robitz, E Koumans. *Centers for Disease Control and Prevention, CDC, Atlanta, USA*

Background Correlations between delinquency, poor school performance, and poor sense of emotional well-being among adolescents are often recognised, but their correlation with risky sexual behaviour has not been as well explored, particularly in African American female populations.

Methods We surveyed 743 sexually active females, age 13 to 19 (mean 16.6 years), attending a predominantly African American urban adolescent clinic. We asked about sexual activity and about poor school work, delinquency (running away from home), poor emotional well-being (feeling unhappy, sad, or depressed), and receiving counselling. To assess associations, ORs were calculated with 95% CIs. A respondent was classified as having correct and consistent condom use if her responses indicated that, during the past 90 days ALL of the following were true: she had engaged in vaginal sexual intercourse at least once, a condom had been used during all vaginal sexual intercourse, the condom was always put on prior to genital contact and remained on throughout sexual intercourse, a condom had never broken while being worn, and a condom had never been put on inside out and then flipped over and put back on again.

Results Approximately 10% of females had 0 sexual partners in the past 90 days, 54% had 1 partner, and 36% had 2 or more partners. Those responding true to whether they felt unhappy, sad, or depressed in the past 6 months (12% of the sample) were more likely to report more than one sexual partner compared to those responding "not true", OR=2.13 (95% CI 1.33—to 3.39), and less