matched with the Puerto Rico Central Cancer Registry (PRCCR) database. AIDS and non-AIDS related malignancies standardised incidence rate (SIR) and 95% CI in three time periods, defined as: 1992–1995 (pre-HAART), 1996–2002 (early-HAART), and 2003–2009 (late-HAART) were established. SIR evaluates a measure of risk related to the general population, and is defined as the ratio of observed to expected number of cancers. Expected counts were estimated by applying gender, age, and calendar years PRCCR’s specific cancer incidence rates to our cohort.

**Results** Of the 296 malignancies found; 29.3% were women, 39.5% were injecting drug users and 42.9% were AIDS related cancers. The SIR for all malignancies in the pre-HAART period (10.15) decreased to 5.35 in the early-HAART, and to 2.04 in the late-HAART period. AIDS related malignancies SIRs decreased after HAART from 91.99 to 16.48; however, Kaposi’s sarcoma (KS) and invasive cervical carcinoma (ICC) SIRs remained significantly higher in the late-HAART period (50.52 and 9.17). Non-AIDS related malignancies’ SIRs of the oral cavity/pharynx, liver, anus, vaginal, testis, Hodgkin’s lymphomas (HL) and non-HL (NHL) were significantly higher (SIRs > 5.30) in the late-HAART period.

**Conclusion** Availability of HAART in this Hispanic HIV/AIDS cohort has significantly decreased the malignancies risk. However, the higher incidence of KS, ICC and non-AIDS related malignancies in the late-HAART is suggestive of the role of additional oncogenic factors including sexual transmitted and injecting drug use infections. Aggressive intervention in the form of vaccines, risky practise reduction, early screening intervention and education needs to be incremented in this vulnerable population. Granted by 8G12MD007583, 8U54MD007587 and NPCR-CDC

**Conclusions** Our results indicate a disproportionately high and rising HIV infection prevalence among MSM that has increased above 5% in 2011. HIV infection prevalence among pregnancies has remained rather low, however, the highest ever (0.5%) has been estimated in 2011. Promotion of safer sexual behaviour and HIV testing among MSM as well as positive prevention among MSM with HIV diagnosis are urgently needed. The introduction of HIV screening of pregnancies should be considered.

**Methods** Two self-administered sexual behaviour surveys were conducted on mobile phones using ODKit: one with adolescents in Cape Town and Port Elizabeth, South Africa (n = 4485, median age 15 years, 146-item questionnaire); one with adult male soccer players in Bulawayo, Zimbabwe (n = 663, median age 24 years, 71-item questionnaire). Ten focus group discussions (FGDs) were conducted with participants and survey teams to assess acceptability. Additionally, participants were asked survey questions related to their comfort, understanding and satisfaction with this method of questionnaire administration. Non-response rates are reported for selected sensitive questions asked on both questionnaires.

**Results** FGDs found that participants and facilitators were comfortable and engaged when using the mobile phones. There was a strong feeling that using the mobile phone provided increased privacy and confidentiality when answering sensitive questions, compared to self-administered paper-based sexual behaviour surveys. In all, 4015 (78.1%) participants reported preferring the mobile-phone-based survey to a pen-and-paper survey, while 716 (13.9%) reported preferring pen-and-paper. Low non-response was observed in both studies for reported HIV testing (SA: 2.7%; Zim: 1.8%), condom use ever (SA: 8.7%; Zim: 2.0%), and previous STI experience (SA: 8.1%; Zim: 2.6%).

**Conclusions** Data capture on mobile phones using ODKit had high acceptability among both South African adolescents and Zimbabwean men. Researchers conducting sexual behaviour surveys should consider data collection on mobile phones using ODKit software as a potential data capture method.
making timely screening imperative for infection control. While enough evidence exists on diagnostic accuracy measures for point-of-care tests (POCTs), the quality of evidence on measures beyond accuracy is poor. We reviewed evidence on these implementation research outcomes (IROs) and summarised their quality.

**Method** Two reviewers systematically searched 10+ electronic databases for the period: January 1980-September 2012, independently abstracted data and synthesised outcomes narratively. Over 10,000 citations were screened and a final set of 191 studies identified for inclusion.

**Results** Of 191 studies, almost half 46%(n = 127) in HIV and 41%(n = 64) in syphilis, reported IROs. IROs included acceptability, preference, feasibility and impact. Across 16 studies, acceptability measure was reported as proportions, rates, without confidence intervals often without clear definitions. Across 9 studies, preference was reported as proportion, without definitions or comparators. Feasibility metric across 7 studies, was ill-defined and heterogeneously reported as either completion of strategy, or test procedure, often as a statistic without confidence intervals or a definition or a quantifiable metric. Impact measure (n = 15) was best quantified in clinical trials-reported as either time to treatment initiation, or time to receiving a test result, or change in numbers newly infected or screened with a POCT strategy. Unclear definitions of other IROs, lax measurement resulted in deficient documentation and weak quality ratings on STROBE and CONSORT checklists, raising concerns about the quality of the evidence presented.

**Conclusion** Poor reporting of IROs (i.e, feasibility, acceptability, preference) in POCT diagnostics masked evidence and pointed to the need for standardised definitions, quantification and reporting for them. A framework for documenting metrics beyond accuracy and impact is urgently needed to improve evaluation of true benefits of POCT diagnostics in implementation research.

**P3.324** **Prevalence of Chlamydia Trachomatis in the United States After Adjusting for Sensitivity and Specificity of the Screening Test**


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According to the Centers for Disease Control and Prevention (CDC), Chlamydia trachomatis infection is among the most prevalent of all sexually transmitted diseases (STDs), and since 1994, has comprised the largest proportion of all STDs reported to CDC. In the past, researchers have used nationally representative surveys, such as, the National Health and Nutrition Examination Survey to estimate chlamydial prevalence and trend under the assumption that the test used to screen for chlamydia has perfect sensitivity and specificity. Under such assumption, the prevalence of chlamydial infection in the U.S. is 2.2% (CI, 1.8% to 2.8%). However, chlamydia screening tests are not perfect tests and thus prevalence estimates must account and adjust for these imperfections. Statisticians have shown that estimates of disease prevalence based on the assumption that screening tests have perfect sensitivity and specificity can be severely biased. In this work, we use Bayesian methods to provide sensitivity and specificity adjusted estimates of chlamydia prevalence. Based on this method, the adjusted prevalence estimate of chlamydia in the U.S. is 1.1% (CI, 0.002% to 2.02%).

**P3.325** **Evaluating Consistency in Repeat Surveys of Men Who Have Sex With Men (MSM) Using Respondent-Driven Sampling in Zanzibar Island, Zanzibar - Tanzania**


This study assessed the comparability of respondent-driven sampling (RDS) as a sampling and recruitment method by comparing two cross-sectional surveys conducted among MSM in Zanzibar using RDS in 2007 and 2011.

**Methods** We conducted community-based behavioural surveillance studies in Zanzibar using respondent-driven sampling (RDS) to recruit 509 MSM in 2007 and 344 in 2011. We used crude and RDSAT-adjusted descriptive statistics to assess differences between the samples.

**Results** Compared to 2007, participants in 2011 were significantly younger (51.4% vs 9.9% were younger than 19, p < 0.001), more likely to have been tested for HIV in the last year (53.7% vs 10.6%, p < 0.001), ever tested (68.2% vs 18.8%, p < 0.001), and less likely to have injected drugs in the last 3 months (1.0% vs 23.2%, p < 0.001). In 2011, 12 (2.6%) tested positive for HIV, in 2007, 65 (12.3%) were positive (p < 0.001).