Background 
Casual sex among travellers is common. It is unknown whether travellers use condoms differently with local versus western casual partners when visiting HIV endemic areas. We determined the number of casual sexual partners and consistency of condom use among Dutch long-term, non-expatriate travellers to (sub)tropical regions according to the ethnicity of their casual sexual partners, and estimated the incidence of HIV and syphilis on their return.

Methods 
A prospective mono-centre study of Dutch long-term travellers ≥ 18 years, attending the Public Health Service travel clinic in Amsterdam (2008–2011) and travelling to any (sub)tropical country for ≥ 12 and ≤ 52 weeks, was conducted. Travelers reported their travel purpose, duration, destinations(s), number and nature of sexual contacts while travelling: ethnicity, gender, partner type (steady/casual) and consistency of condom use with each partner. Analyses were conducted using Poisson regression (generalised estimating equations to account for multiple partnerships). Blood samples, taken before and after travel, were tested for HIV and Treponema pallidum antibodies.

Results 
There were 552 respondents and 11671 person-weeks of follow-up (median age: 25 years, 36% male, median travel time: 20 weeks, 45% for work/study), Post travel, 34% (n = 190/552) reported ≥ 1 casual sexual partner, men a median of 3 (range: 1–8) and women 2 (range: 1–7) partners. Of 462 casual sexual partnerships, 42% (n = 192) were with local partners at travel destination. Equally, 59% of partnerships with western and local partners were unprotected. Single travellers (IRRwork/study (ref): 2.2, 95% CI: 1.2–4.0) and those on holiday (IRRsteady/casual (ref): 1.9, 95% CI: 1.2–3.0) had more unprotected casual sex. Partner’s ethnicity was not significant in predicting condom use. No HIV or syphilis seroconversions were recorded.

Conclusion 
Unprotected casual sex was common among Dutch, long-term travellers, occasionally with multiple local partners in HIV-endemic regions. Single travellers and those travelling for holiday purposes were most at risk. These groups should be advised on the need for safe sex while abroad.
programmes among these vulnerable people so that they can embrace safe and healthy behaviour, such as consistent use of condoms anytime they want to have sex.

**P4.092 BARRIERS TO ANTIRETROVIRAL TREATMENT FOR HIV PREVENTION AMONG HIV+ MEN WHO HAVE SEX WITH MEN IN THE UK: A QUALITATIVE STUDY**


'S Wayal, 'G Hart, 'S Edwards, 'J Cassell. 'University College London, London, UK; 'NHS Camden Provider Services, London, UK; 'Brighton and Sussex Medical School, Falmer, UK

**Background** UK and USA guidelines recommend offering antiretroviral treatment (ART) for HIV prevention to patients at risk of sexually transmitting HIV irrespective of CD4 cell count. We explored the attitudes of HIV+ men who have sex with men (MSM) towards use of ART, and ART for HIV prevention.

**Methods** 24 men (16 on ART and 8 not on ART) attending an HIV clinic in central London, UK participated in semi-structured interviews (May 2010-February 2011). Thematic analysis was conducted.

**Results** Era of HIV diagnosis, and meanings ascribed to CD4 cell count and ART influenced men’s attitudes towards starting ART. Men diagnosed with HIV before 2001 considered themselves to be fortunate to be on ART, while those diagnosed later were more likely to have fatalist attitudes and perceived starting ART as resigning to “popping pills for life” and “getting closer to death.” They also experienced resentment and lack of control over their health if they felt physically well but were told to start ART due to low CD4 cell count. Most men believed being on ART with undetectable viral load reduces HIV transmission and engaged in nCUI. Men usually discussed their ART/viral load status with partners prior to engaging in nCUI, and engaged in ncUAI. Men diagnosed with HIV before 2001 considered themselves to be physically well but were told to start ART due to low CD4 cell count and ART influenced men’s attitudes towards starting ART. Interventions concentrated on demystifying myths about drug use and HIV while strengthening peer networks. BCs in DUs, RSP, families and in their localities going beyond awareness and education. DUs and RSP reduced individual risk behaviours, promoted and practised safer sex practices (ex: condom use), motivated to get medical assistance for symptoms and suspected exposure to STDs and if engaged in risky behaviour, to be tested. Changing behaviours related to drug use itself results in HIV risk reduction and prevention.

**P4.094 RELATIONSHIP BETWEEN SOCIAL COGNITIVE THEORY CONSTRUCTS AND SELF-REPORTED CONDOM USE: THE SAFE IN THE CITY TRIAL**


M C Sneed, A M O’Leary, M G Mandel, A P Kourtis, J Wiener, D J Jamieson, L Warner, SHC Team (Jeffrey Klausner, Kevin Malotte, Lydia O’Donnell, Kees Rietmeijer, Andrew Mangurian), CDC, Atlanta, GA, United States

**Background** Previous studies have found Social Cognitive Theory (SCT)-framed interventions successful for improving condom use and reducing STIs. We conducted a secondary analysis of behavioural data from the Safe in the City trial to investigate the influence of social cognitive theory constructs on study participants’ self-reported use of condoms at last intercourse.

**Methods** The main trial was conducted (2003–2005) at three public U.S. sexually-transmitted infection (STI) clinics. Patients (n = 38,635) were either shown a safer sex video in the waiting room, or received the standard waiting room experience, based on their visit date. A nested behavioural assessment was administered to a subsample following their index clinic visit (n = 1,609) and at three months follow-up (n = 1,392). We used multivariable modified fusion models to examine social cognitive theory constructs (sexual self-efficacy, self-control self-efficacy, self-efficacy with most recent partner, hedonistic outcome expectations, and partner expected outcomes) and individual characteristics with self-reported condom use at last sex act.

**Results** Of 1,252 participants included in analysis, 39% reported using a condom. Male gender, homosexual orientation and single status were significant predictors of condom use. Both unadjusted and adjusted [for demographic variables and study intervention (RR: 95% CI)] models indicate that sexual self-efficacy (1.50: 1.23–1.84), self-control self-efficacy (1.67: 1.37–2.04), self-efficacy with most recent partner (2.56: 2.01–3.27), more favourable hedonistic outcome expectations (1.83: 1.54–2.17), and more favourable partner expected outcomes (9.74: 3.21–29.57) were significantly (p ≤ 0.001) associated with condom use at last sex act.

**Conclusions** Social cognitive theory constructs were significantly associated with condom use at last sex act, independent of the video intervention. Social cognitive skills, such as self-efficacy and partner expected outcomes, are an important aspect of condom use behaviour.

**P4.095 YOUNG PEOPLE’S KNOWLEDGE, ATTITUDE, AND BEHAVIOUR REGARDING REPRODUCTIVE HEALTH IN THE CONTEXT OF TIRANA, ALBANIA**


A Subashi, Vitrina University, Tirane, Albania

Drug use is a major risk factor in spreading HIV infection. Drug users (DUs) might trade sex for drugs or for money to buy drugs and/or vice versa. Drug use can reduce a person’s commitment to using condoms and practise safer sex. Often, substance users have multiple sexual partners. This increases their risk of becoming infected with HIV or another STI. Therefore, changing drug-related behaviours contributes to eradication of transmission of HIV.

A behaviour change (BC) model, which directly address BCs that merely conducting awareness/training workshops was implemented in Negombo, a tourist destination located in west coast of Sri Lanka where dwellers are vulnerable for drug use and sex trade. BC intervention tools used included low-cost community camps, group, ex-user and one-to-one discussions, brainstorming sessions to demystify myths about drug use and HIV while strengthening target groups. Conducted a rapid situation and response analysis, prior to commencing interventions. Interventions concentrated more on 10 specific spots in Negombo. 350 DUs, their families, peers, 170 regular sex partners (RSP) including commercial sex workers (CSW), and neighbours were targeted through interventions.

As a result, of BC model 80 quitted drug use, 59 reduced use, 29 changed their behaviours, 21 work as peer educators, 37 directed to STD clinics. 59 relapsed. The interventions with RSP resulted in following; 32 supported DUs to quit, 35 were educated on safer sex practices, 13 requested for condoms.

BC model resulted in BCs in DUs, RSP, families and in their localities going beyond awareness and education. DUs and RSP reduced individual risk behaviours, promoted and practised safer sex practices (ex: condom use), motivated to get medical assistance for symptoms and suspected exposure to STDs and if engaged in risky behaviour, to be tested. Changing behaviours related to drug use itself results in HIV risk reduction and prevention.