male, and female swingers using $\chi^2$-tests. Multivariable logistic regression analysis was used to evaluate possible factors (socio-demographics, alcohol, and condomless sex with swing partners) associated with drug use.

**Results** Drug use while swinging was reported by 44% (443/1005); 51% in women, 44% in bisexual men, and 39% in heterosexual men (p=0.007). Among drug-using swingers, XTC (92%;409/443), GHB (76%;338/443), and laughing gas (69%;304/443) were mostly used; 69% (305/443) used ≥4 different drugs (polydrug use). Condomless vaginal sex was reported by 46% in drug-using swingers (vs. 35% in non-drug-using swingers;p<0.001) and condomless anal sex by 30% in drug-using swingers (vs. 21% in non-drug-using swingers;p=0.012). Being a woman (aOR:2.10; 95%CI:1.36–3.09) and condomless vaginal sex (aOR:1.71; 95%CI:1.24–2.35) were independently associated with drug use.

**Conclusion** This study among a large group of swingers shows that drug use and polydrug use during sex are prevalent among both male and female swingers in the Netherlands, indicating that 'chemsex' is not only common among MSM. The association between drug use and sexual risk behaviour suggests that it might be useful to tailor STI prevention strategies, developed for MSM engaging in chemsex, for swingers.

**Disclosure** No significant relationships.

## P068 STD SCREENING AND DIAGNOSIS AMONG 15–24 YEAR OLD DIAGNOSED WITH PRESCRIPTION OPIOID RELATED DISORDER

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**Background** Many injection drug users have elevated STD/HIV risks, such as sexual-trade for drugs, risky condom-less sex, or multiple sex partners. STD diagnosis and screening among opioid users has not been examined.

**Methods** Using 2016 MarketScan commercial claims data, men and women aged 15–24 with opioid prescriptions were identified. We have assessed STD diagnosis and screenings, including chlamydia, gonorrhea, syphilis, and HIV, as well as heroin use using ICD-10 and CPT codes. Women were identified as sexually-active using HEDIS criteria whereas no other criteria used for men.

**Results** We identified 10% (0.4 million) patients aged 15–24 who had opioid use in 2016. Among sexually-active women aged 15–24 years, screening and diagnosis was 48.1% and 2.3% for chlamydia, 56.0% and 4.1% for gonorrhea, 16.6% and 3.8% for syphilis, and 16.0% and 0.3% for HIV among 154,960 women who had opioid use and 51.6% and 2.0% for chlamydia, 55.5% and 4.1% for gonorrhea, 15.1% and 3.8% for syphilis, and 14.7% and 0.4% for HIV among 812,005 women who had no opioid use. Among 332 male and 159 female opioid plus heroin users, screening was 21.2% and 56.6% for chlamydia, 25.9% and 62.3% for gonorrhea, 36.5% and 44.7% for syphilis, and 35.8%, 47.8% for HIV, respectively.

**Conclusion** STD screening among patients with opioids was not significantly different from the enrollees without opioids. STD diagnosis and screening among heroin users are much higher than patients who had not used heroin.

**Disclosure** No significant relationships.

## P069 DO CANNABIS USE AND SOCIAL SUPPORT MEDIATE THE RELATIONSHIP BETWEEN INTERSECTIONAL STIGMA AND BODILY PAIN AND FUNCTIONING?

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**Background** Stigma produces stress for women living with HIV (WLHIV) and is associated with poorer physical quality of life. Cannabis use may help to manage HIV-related symptoms, including stress and pain. Limited research has explored intersectional stigma and associations with bodily pain and physical functioning, or cannabis use as a stigma coping strategy. We examined coping strategies (medical cannabis use, social support) as mediators of the association between intersectional stigma (HIV-related, gender discrimination, racial discrimination) and bodily pain and physical functioning among WLHIV.

**Methods** We conducted a community-based study in 3 Canadian provinces (Ontario, British Columbia, Quebec) with WLHIV. Structural equation modeling (SEM) using maximum likelihood estimation methods was conducted to test the direct effects of intersectional stigma (HIV-related, gender discrimination, racial discrimination) on physical functioning and bodily pain, and indirect effects via social support and medical cannabis use, adjusting for socio-demographics.

**Results** Among 1422 participants (median age: 42.5 years, IQR=35–50), one-quarter (n=362; 25.89%) currently used cannabis (n=272, 43.04%, for medical use), one-fifth (n=272; 19.46%) formerly used, and 54.65% (n=764) never used cannabis. Confirmatory factor analysis suggests the latent construct of intersectional stigma fit the data well ($\chi 2[0]=0$; RMSEA=0; CFI=1). SEM indicated that intersectional stigma has significant direct and indirect effects on physical functioning (B=-0.074, p<005 for direct effect; B=-0.051, p<0.001: indirect effect) and bodily pain (B=0.157, p<0.001 for direct effect; B=0.058, p<0.001 for indirect effect). Medical cannabis use and social support partially mediated this relationship. Fit indices suggest good model fit (CFI=0.981; TLI=0.956; RMSEA=0.032 (90% CI: 0.015–0.049); SRMR=0.020).

**Conclusion** Finding suggest that intersectional stigma contributes to poorer physical functioning and pain. Medical cannabis use and social support, associated with improved physical functioning and reduced pain, partially mediated the associations between intersectional stigma and poorer physical health. Findings can inform strategies to reduce stigma and support WLHIV using cannabis as a stigma coping strategy.

**Disclosure** No significant relationships.