Important notes:

- The abstract should be a maximum of **250** words. Abstracts exceeding this limit may not be accepted.
- Only registered delegates may present abstracts.
- Abstracts will only be considered if submitted in English.
- Abstracts are not edited by the organisers and author corrections will NOT be accepted after final submission. Abstracts should therefore be checked carefully for accuracy prior to submission.
- You should indicate one topic from the list that best suits your paper. The topics are used by the Scientific Committee to place abstracts in the most appropriate sessions.
- The submitting author should be the presenting author.
- The abstract shodul be structured using the following headings: **Background/introduction, Aim(s)/objectives, Methods, Results, Discussion/conclusions**
- When a paragraph stops (e.g. within **Objectives**) the sentence should finish with a full stop. The next sub-heading e.g. **Methods** should then begin on a new line.
- The abstract should be as informative as possible and mention statistical methods where appropriate. **ONE** table may be included but no photographs, figures or references, statements such as "results will be discussed" or "data will be presented" will not be accepted. Non standard abbreviations should be described in full when first mentioned followed by the abbreviation in parentheses. The names of authors, names of hospitals, medical schools or clinics should **NOT** to be mentioned in the title or text of the abstract.

Title:

Associations between substance use and sexual risk behaviour among women aged 16-44 years: Evidence from Britain's third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)

Abstract: (Your abstract must use Normal style and must fit into the box. Do not enter author details)

Background/introduction:
Taking account of substance use may be important when developing a sexual risk assessment tool for use with women in community health settings.

Aim(s)/objectives:
To examine whether different measures of substance use have different associations with key sexual risk behaviours among women in the British general population (rather than women attending sexual health clinics who typically report higher risk behaviour).

Methods:
We analysed data from 4,911 female participants aged 16-44 in Natsal-3, a national probability sample survey undertaken 2010-2012, using multivariable regression to examine the associations between substance use variables and reporting: multiple (2+) partners in the last year; non-use of condoms with multiple partners in the last year; non-use of condoms at first sex with most recent partner.

Results:
Reporting multiple partners was associated with current smoking (OR 1.59, 95%CI 1.30-1.93), weekly binge drinking (OR 2.47, 95%CI 1.97-3.10), and drug use ever (OR 1.45, 95%CI 1.20-1.75). Similarly, reporting non-use of condoms with multiple partners was also associated with current smoking (OR 1.39, 95%CI 1.09-1.78), weekly binge drinking (OR 2.47, 95%CI 1.90-3.21) and drug use ever (OR 1.48, 95%CI 1.17-1.88). Non-use of condoms at first sex with most recent partner was only associated with current smoking (OR 1.47 95%CI 1.25-1.73) and weekly binge drinking (OR 1.41 95%CI 1.14-1.73).

Discussion/conclusion:
Differences were found to exist in how substance use variables are associated with the sexual risk behaviours studied. Different substance use questions may therefore be useful in identifying and distinguishing different sexual risk behaviours profiles in community settings.