CONFERENCE ENVIRONMENT POLICY

ASHM Conference & Events Division implements a waste-reduction policy that addresses – Reduce, Reuse, Recycle. This is done before, during and after each conference.

ASHM Conference & Events Division reduces the number of printed materials by using electronic communication means wherever possible, including the website, email, online registration and abstract submission.

ASHM Conference & Events Division monitors final delegate numbers for an accurate forecast of catering requirements in order to avoid waste.

ASHM Conference & Events Division aims to research and prioritise purchasing items and equipment that support the use of recycled materials or can be recycled after use.

ASHM Conference & Events Division will aim to ensure that recycling bins are available onsite at all events.

ASHM Conference & Events Division will endeavour to minimise travel through the use of teleconferences instead of face-to-face meetings and holding meetings only when necessary.

ASHM Conference & Events Division encourages all conference stakeholders to consider the environment by suggesting the following: reduction in printing requirements; recycling conference materials; and reusing conference merchandise.
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On behalf of the Conference Organising Committee I would like to extend a warm welcome to Sydney for the Australasian Sexual Health Conference.

The theme of this year’s conference is ‘Harbouring Desires’. Professor Michael Kidd (Chair of the Australian Government’s Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections) will open the Conference with the Gollow Lecture on Challenges for Sexual Health Medicine. Keynote and international speakers include Professor Graham Hart (UK), Professor Jorgen Jensen (Denmark), Professors Douglas Kirby and Joel Palefsky (USA) and Lynne Hillier (Australia). Topics that will be covered include the nature of human desire, STI prevention strategies (particularly amongst adolescents) and genital mycoplasmas. There are also symposia on Chlamydia, refugee health, sexual assault, the sex industry and sexual dysfunction.

We aim to create a conference at which delegates are both informed and stimulated by the presentations, and where they can also enjoy networking and socialising. The Conference Gala Dinner will be held at Luna Park on Wednesday 20 October, with a funpark theme, promises an evening of good food and entertainment with spectacular views of Sydney Harbour.

The Conference venue is the Sydney Convention and Exhibition Centre, which is on the west side of Darling Harbour, close to the city centre. It offers many open public spaces overlooking the harbour, a plethora of hotels, bars, restaurants, museums, theatres, as well as an IMAX cinema. A short walk over Pyrmont Bridge (or a trip on the monorail) takes you to all the shopping and entertainment opportunities of the CBD. Short trips can take you to world-famous attractions such as Taronga Zoo, Bondi Beach and the Blue Mountains.

We hope you enjoy Sydney and the 2010 Australasian Sexual Health Conference.

A/Professor Richard Hillman
STI Research Centre - The University of Sydney

CONVENOR: A/PROFESSOR RICHARD HILLMAN
STI Research Centre - The University of Sydney

Ms Suzanne Marks
Australasian Chapter of Sexual Health Medicine

Dr Catriona Ooi
Hunter New England Area Health Service

Dr Cathy Pell
Taylor Square Private Clinic

Mr Bradley Whitton
Melbourne Sexual Health Centre

Dr Lynnette Wray
Sydney Sexual Health Centre

Professional Conference Organisers
Pollyanna Strauss, Nicole Robertson
ASHM Conference and Events Division
LMB 5057, Darlinghurst NSW 1300
Phone: +61 2 8204 0770
Fax: +61 2 9212 4670
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from Routledge

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Culture, Health & Sexuality
www.tandf.co.uk/journals/tchs

Sex Education
www.tandf.co.uk/journals/sexeducation

International Journal of Sexual Health
www.tandf.co.uk/journals/wijs

Sexual & Relationship Therapy
25th Anniversary
www.tandf.co.uk/journals/srt

Journal of Sexual Aggression
www.tandf.co.uk/journals/tjsa

African Journal of AIDS Research
www.tandf.co.uk/journals/raar

AIDS Care
www.tandf.co.uk/journals/AIDSCare

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Find out more about Routledge Sexuality & Sexual Health Journals:
www.gender-and-sexuality-arena.com
You are invited to attend a Gilead sponsored Satellite Symposium, which is part of the Australasian HIV/AIDS Conference 2010.

A new era
evidence and choice

guidelines: what are they good for?

Date: Thursday October 21, 2010
Time: 7 am - 8:30 am (breakfast included)
Location: Bayside Gallery B, Sydney Convention and Exhibition Centre, Sydney, NSW

Chair:
Prof. Andrew Carr - St Vincent’s Hospital, Sydney, Australia

Agenda:
What was the Panel thinking? Why certain ART regimens are recommended as preferred
Prof. David Cooper, AO - NCHECR, Sydney, Australia

Finding the right fit: alternatives to the currently preferred first-line regimens
Dr Calvin Cohen - Harvard Vanguard Medical Associates and Community Research Initiative of New England in Boston, Massachusetts, USA

What are we actually doing? Adherence to when to start and what to start with, ART guidelines
Dr Mark Bloch - Holdsworth House, Sydney, Australia

To confirm your attendance at this symposium, please register your details at:
http://secure.ashm.org.au/ei/getdemo.ei?id=59&s=_2ZG0RHC8E
Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections (MACBBVS)

Research Priorities and Evaluation Working Group

Satellite Session

The Research Priority and Evaluation Working Group of MACBBVS:
Discussing the application of research to policy and practice

Friday 22 October, 7.30am – 9.00am

Background

Recently, a working group of MACBBVS was established to address issues related to research and evaluation identified in the suite of national strategies released in 2010. The working group includes researchers from a range of disciplines and interests as well as representatives of community organisations and health services. The working group will be functional for about 12 months (that is, until August 2011).

The working group will be addressing two main issues (1) developing mechanisms to enhance the use of research in policy and practice and (2) setting a process for commenting on research priorities.

Aim and Layout

Moderator: Associate Professor Carla Treloar

Group Discussion Leaders: Members of Working Group

1. Introduce the working group including membership and terms of reference, outline goals and format of session
2. Discussion: How organisations become aware of, access and use research
3. Discussion: What mechanisms would assist organisations in using research more/better
4. Outline the next steps in addressing this issue
PROGRAM AT A GLANCE
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>7.30am - 9.00am</td>
<td>Registration Opens</td>
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<tr>
<td>9.00am - 10.30am</td>
<td>Opening Ceremony and Gollow Lecture Supported by the Australian Government Department of Health and Ageing</td>
<td>Bayside Auditorium A</td>
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<tr>
<td>10.30am - 11.00am</td>
<td>Morning Tea in Exhibition and Poster Area, Bayside Grand Hall</td>
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<tr>
<td>11.00am - 12.30pm</td>
<td>Plenary: The Fruits of Desire</td>
<td>Bayside Auditorium A</td>
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<tr>
<td>12.30pm - 1.30pm</td>
<td>Lunch in Exhibition and Poster Area, Bayside Grand Hall, Poster Themes: Prevention &amp; Epidemiology and Other</td>
<td>Bayside Gallery A</td>
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<td>Satellite Symposium: A new five-year research initiative on the transmission, control and outcomes of sexually transmitted infections</td>
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<td>1.30pm - 3.00pm</td>
<td>Proffered Paper Session: Burning Desires</td>
<td>Bayside Auditorium A</td>
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<td>Proffered Paper Session: Sharing Desire</td>
<td>Bayside Gallery B</td>
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<td>Proffered Paper Session: Desire in the Bush</td>
<td>Bayside Auditorium A</td>
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<td>Afternoon Tea in Exhibition and Poster Area, Bayside Grand Hall</td>
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<tr>
<td>3.30pm - 5.00pm</td>
<td>Symposium: The Business of Desire</td>
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<td>Symposium: Diversity of Desire</td>
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<td>Symposium: Challenges to Desire</td>
<td>Bayside Auditorium A</td>
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<tr>
<td>5.00pm - 6.30pm</td>
<td>Welcome Reception &amp; Poster Viewing Evening, Bayside Grand Hall</td>
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<td>5.30pm - 6.00pm</td>
<td>Beer &amp; Bull: Meet the Experts, Stage Area, Bayside Grand Hall</td>
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<tr>
<td>7.00pm</td>
<td>AChSHM Trainee Dinner, Sponsored by Novartis</td>
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<td>7.00am</td>
<td>Registration</td>
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<td>7.30am - 9.00am</td>
<td>FAMSACA Breakfast Meeting: Case Presentations and Discussion</td>
<td>Bayside Gallery A</td>
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<td>9.00am - 10.30am</td>
<td>Plenary: Young and Desirable Supported by the Department of Health Victoria</td>
<td>Bayside Auditorium A</td>
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<td>10.30am - 11.00am</td>
<td>Morning Tea in Exhibition and Poster Area, Bayside Grand Hall</td>
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<tr>
<td>11.00am - 12.30pm</td>
<td>Symposium: Promoting Desire</td>
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<td>11.00am - 12.30pm</td>
<td>Symposium: Safe Harbours</td>
<td>Bayside Gallery B</td>
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<tr>
<td>11.00am - 12.30pm</td>
<td>Symposium: Unwanted Desires</td>
<td>Bayside Gallery A</td>
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<td>12.30pm - 1.30pm</td>
<td>Lunch in Exhibition and Poster Area, Bayside Grand Hall</td>
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<td>1.30pm - 3.00pm</td>
<td>Proffered Paper Session: Dysplastic Desires</td>
<td>Bayside Auditorium A</td>
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<td>1.30pm - 3.00pm</td>
<td>Proffered Paper Session: Mixed Desires</td>
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<tr>
<td>1.30pm - 3.00pm</td>
<td>Proffered Paper Session: Emerging Desires</td>
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<td>3.30pm - 5.00pm</td>
<td>Symposium: Navigating Desires</td>
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<td>Symposium: Investigating Desires</td>
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<td>3.30pm - 5.00pm</td>
<td>Symposium: Understanding Desires</td>
<td>Bayside Gallery A</td>
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<td>5.15pm - 6.30pm</td>
<td>AChSHM Annual Meeting</td>
<td>Bayside Gallery A</td>
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<td>6.30pm</td>
<td>Free Evening</td>
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**WEDNESDAY 20 OCTOBER**

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<tr>
<td>7.30am</td>
<td>Registration</td>
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<tr>
<td>7.30am - 9.00am</td>
<td>Sexual Health Trainee Case Presentation Breakfast</td>
<td>Bayside Gallery B</td>
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<tr>
<td>8.30am - 10.00am</td>
<td>HIV/AIDS Conference Opening Ceremony and Joint Conference Plenary</td>
<td>Bayside Auditorium A</td>
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<td>10.00am - 11.00am</td>
<td>Morning Tea in Exhibition and Poster Area, Bayside Grand Hall</td>
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<td>10.00am - 11.00am</td>
<td>Ngarra Exhibition, Bayside 103 &amp; 104</td>
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<tr>
<td>10.10am - 10.50am</td>
<td>NCHECR Surveillance Launch, Bayside Gallery A</td>
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<tr>
<td>11.00am - 12.30pm</td>
<td>Joint Symposium: Instant Desire</td>
<td>Bayside Auditorium A</td>
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<tr>
<td>11.00am - 12.30pm</td>
<td>Joint Symposium: Desirable Men</td>
<td>Bayside Gallery B</td>
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<tr>
<td>11.00am - 12.30pm</td>
<td>HIV/AIDS Conference Theme D: Integrating International and National Policies and Programs</td>
<td>Bayside Gallery A</td>
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<tr>
<td>11.00am - 12.30pm</td>
<td>Joint Symposium: Desirable Men</td>
<td>Bayside Gallery B</td>
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<td>12.00pm - 1.30pm</td>
<td>Lunch in Exhibition and Poster Area, Bayside Grand Hall</td>
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<td>12.00pm - 1.30pm</td>
<td>Poster Themes: Clinical and HIV</td>
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<td>12.00pm - 1.30pm</td>
<td>Ngarra Exhibition, Bayside 103 &amp; 104</td>
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<tr>
<td>1.30pm - 3.00pm</td>
<td>Joint Symposium: Aboriginal and Torres Strait Islander Health</td>
<td>Bayside Auditorium A</td>
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<tr>
<td>1.30pm - 3.00pm</td>
<td>Joint Symposium: Political, Cultural and Logistic Realities of Microbicides for Australasia and the Pacific</td>
<td>Bayside Gallery B</td>
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<tr>
<td>1.30pm - 3.00pm</td>
<td>HIV/AIDS Conference Theme B Proffered Paper Session: Adherence, Treatment and Workforce Issues</td>
<td>Bayside Gallery A</td>
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<td>3.00pm - 3.30pm</td>
<td>Afternoon Tea in Exhibition and Poster Area, Bayside Grand Hall</td>
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<td>3.00pm - 3.30pm</td>
<td>Ngarra Exhibition, Bayside 103 &amp; 104</td>
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<tr>
<td>3.30pm - 5.00pm</td>
<td>Sexual Health Conference Closing and Joint Conference Debate</td>
<td>Bayside Auditorium A</td>
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<td>5.15pm - 5.45pm</td>
<td>ASHHNA Annual Meeting, Bayside 102</td>
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<tr>
<td>7.00pm - 11.00pm</td>
<td>Sexual Health Conference Dinner ‘Carnivàle Desires’ at Luna Park</td>
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<tr>
<td>7.00pm - 11.00pm</td>
<td>6.15pm Ferry Departure from Convention Centre Wharf</td>
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NGARARA

Bayside Rooms 103 & 104
20 October 2010
10.00am – 3.30pm

Ngarra exhibition (meaning to tie in the Sydney Language) showcases sexual health initiatives currently being adopted or developed around the country for Aboriginal and Torres Strait Islander populations. We are grateful to and acknowledge the Metropolitan Local Aboriginal Land Council who suggested the name and gave consent for its use for this exhibition.
INVITED SPEAKERS
INTERNATIONAL

Professor Graham Hart
Head of Research Department, Director of the Centre for Sexual Health & HIV Research, University College London, United Kingdom
Supported by the Australian Government, Department of Health and Ageing

Graham graduated with 1st Class Honours in Sociology from the University of Leicester in 1978, and gained his PhD from the University of Kent at Canterbury in 1982. In 1986 he was appointed Lecturer (and later Senior Lecturer) in the Academic Department of Genitourinary Medicine at Middlesex Hospital Medical School (subsequently the UCL Centre for Sexual Health & HIV Research). From 1994 to 2005 he was Associate Director of the MRC Social & Public Health Sciences Unit at the University of Glasgow. He returned to UCL in 2006 to take up the posts of Professor of Sexual Health & HIV Research, Centre Director and, in March 2008, Head of the Research Department of Infection & Population Health. Graham is Chair of the International Scientific Advisory Board for the Wellcome-funded Africa Centre, South Africa, and Deputy Chair of MRC’s Population Health Scientist/Methodology/Biostatistics Fellowship Panel.

Research Interests
• Risk behaviour for HIV infection and other STIs
• Evaluation of complex interventions
• Social and behavioural dimensions of sexual health
• Combination biomedical and behavioural prevention of HIV

Dr Jorgen Jensen
Head, Mycoplasma Laboratory, Statens Serum Institute, Copenhagen, Denmark

Dr Jensen graduated as MD from the University of Copenhagen, Denmark in 1986 and worked as a clinician in different hospitals until he was employed at the Mycoplasma Laboratory, Statens Serum Institut (SSI) in 1987. He is now working as a consultant physician at SSI, heading the STI research and development group.

In 1993 he defended his PhD thesis ‘Direct Detection of Mycoplasma pneumoniae in Clinical Samples. An acute phase Diagnostic Test’ and in 2005 he defended his D.Med.Sci. dissertation ‘Mycoplasma genitalium infections. Diagnosis, clinical aspects, and pathogenesis’. He published the first clinical study linking M. genitalium to male urethritis in 1993 and has been actively investigating this infection including clinical, diagnostic and treatment aspects. Dr Jensen has published more than 90 papers in international peer-reviewed journals as well as two book-chapters on human mycoplasma infections.

Dr Jensen is member of the board of the ISSTDR and national representative in IUSTI Europe.
Dr Douglas Kirby  
**Senior Research Assistant, ETR Associates**  
*Program Division, California, United States of America*

Douglas Kirby, PhD, is a Senior Research Scientist at ETR Associates. For more than 30 years, he has directed large studies of adolescent sexual behaviour, abstinence-only programs, sex and STD/HIV education programs, school-based clinics, school condom-availability programs and youth development programs. He has co-authored research on several curricula, which significantly reduced unprotected sex, by delaying sex, reducing the number of partners, increasing condom use, or increasing contraceptive use. He has conducted international reviews of sex and STI/HIV education programs for WHO, UNESCO, and other international organisations. In these reviews, he has summarised the effects of programs and identified the important characteristics of these programs that actually reduced sexual risk behaviour. In addition, he has examined the changes in behaviour that led to the large reduction of HIV incidence in Uganda in the early 1990s and the intervention efforts that contributed to changes in behaviour.

Professor Joel Palefsky  
**Professor of Medicine, School of Medicine, University of California, San Francisco, United States of America**  
*Supported by CSL Biotherapies*

Dr Palefsky is Professor of Medicine at UCSF School of Medicine. Dr Palefsky completed his undergraduate medical training and training in Internal Medicine at McGill University and completed his fellowship in Infectious Diseases at Stanford University. He is an internationally recognised expert on the molecular biology, treatment, pathogenesis and natural history of anogenital human papillomavirus infections, particularly in the setting of HIV infection. He is the Director of the world's first clinic devoted to prevention of anal cancer, the Anal Neoplasia Clinic at the UCSF Cancer Center. He has pioneered diagnostic and treatment methods for anal intraepithelial neoplasia (AIN) and has been an advocate for screening and treatment of AIN in high-risk populations to prevent anal cancer. He is the chair of the HPV Working Group of the AIDS Malignancy Consortium. He is the author of over 200 publications.
Associate Professor Lynne Hillier,  
Australian Research Centre in Sex, Health and Society, La Trobe University, Victoria, Australia

Dr Hillier is a psychologist by discipline but discovered very early that rigid quantitative methodologies were of limited use in understanding adolescent sexual diversity; lesbian health; intellectual disability and sexuality. Dr Hillier is a social researcher who enjoys using a creative mix of quantitative and qualitative methodologies in her work. Where the quant data gives an association, the qual data helps to understand the whys of those connections.

She has been researching with same-sex attracted young people for over 12 years, including the Writing Themselves In Reports (1998; 2005) two large national studies on the sexual health and well being of this group.

Dr Hillier is interested in the social determinants of health and moving beyond describing deficits and problems with these young people to documenting the creative ways that they work to reframe discourse and their worlds to provide positive healthy ways of thinking about being sexual. She is also interested in safe spaces and how they are created.

Dr Hillier’s work is framed by feminism and she often uses critical discourse analysis, particularly in regard to resistance. Dr Hillier’s recent PhD students have studied lesbian experiences with the health system, sex education in Victorian schools, sex tolerance zones in St Kilda and the experiences of 18-25-year-olds women with an intellectual disability.

Gollow Lecturer  
Professor Michael Kidd,  
Executive Dean of Health, Flinders University, South Australia and Chair of the Australian Government’s Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections, South Australia, Australia

Professor Kidd is an Honorary Professor of the Faculty of Medicine at The University of Sydney and also works as a general practitioner with a special interest in the care of people with HIV and Indigenous health. Professor Kidd was President of the Royal Australian College of General Practitioners from 2002 to 2006. From 1995 to 2009 he was Professor of General Practice at the University of Sydney and, from 1998 to 2009, Head of the Discipline of General Practice. He was also Associate Dean for professional, government and community relations with the Faculty of Medicine at The University of Sydney. Professor Kidd has research and education interests in primary health care and general practice, medical informatics, health policy, medical education, safety and quality in primary care, and the primary care management of HIV, hepatitis C and sexually transmissible infections. He has a Doctorate of Medicine in medical education from Monash University.

Michael is the chair of the Australian Government’s Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections and is a member of the Australian Government’s Medical Training Review Panel. He is a past chair of the Australian Government’s National HIV/AIDS Committee and a past member of the Australian National Council on AIDS, Hepatitis C and Related Diseases. He is also a past member of the Australian Health Information Council which provided advice to Australian Health Ministers on long-term directions and national strategic reform issues for information management and technology in health.

Professor Kidd is the past chair of the Australian Government’s MediConnect Project on electronic prescribing, and a past member of the board of the Australian Government’s HealthConnect program and is a past chair of the Australian General Practice Computing Group which worked with the Australian Government to lead the computerisation of Australian general practice. He has also been an advisor on aspects of health informatics to governments in several other countries including Ireland and New Zealand.
During his triennium (1988-1991) as inaugural President of the Australasian College of Venereologists Dr Morris Gollow and his wife Suzette endowed funds for an honorarium to be given to the invited presenter of the Gollow Lecture, delivered at the annual scientific meeting of the College.

Dr Gollow was born in London in 1925 and trained there, graduating in 1949.

He emigrated to WA in July 1956 and after two years in a remote area moved to Perth. In 1974 he left general practice and joined the Health Department of WA as a venereologist in the Royal Perth Hospital.

One of the organisers of the First National Conference on STDs in Australia, held in Perth in August 1978, he was also President of the WA Venereal Diseases Society from 1980 until his retirement in 1986.

In 1981 he became a Foundation Member of the National Venereology Council of Australia and in 1987 a Founding Fellow of the Australasian College of Venereologists.

He was awarded the Member of the Order of Australia for services to Medicine, particularly in the field of venereology.
Disclaimer
The information in this handbook is correct at the time of printing. The Conference Secretariat reserves the right to change any aspect of the program without notice. The Conference Secretariat reserves the right to alter the Conference Program in the event of unforeseen circumstances. The Conference Secretariat accepts no responsibility for errors, misprints or other issues with abstracts contained in this handbook.

Venue
Sydney Convention and Exhibition Centre
Darling Drive, DARLING HARBOUR
Ph: +61 2 9282 5000
Fax: +61 2 9282 5041
The venue will host the conference sessions, poster presentations, breakfast sessions, conference day catering and the trade exhibition.

Registration Desk
The registration desk will be located on the Ground Level, Main Entrance, Sydney Convention and Exhibition Centre. All enquiries should be directed to the registration desk which will be open at the following times:
Monday 18 October: 7.30am to 5.30pm
Tuesday 19 October: 7.00am to 5.30pm
Wednesday 20 October: 7.00am to 5.30pm
Please note it will also be open during the Australasian HIV/AIDS Conference on Thursday 21 October and Friday 22 October.

Speaker Preparation Room
A speaker preparation room will be located in Bayside 108, Level 1. This room will be open at the following times:
Monday 18 October: 8.00am to 6.00pm
Tuesday 19 October: 7.30am to 6.00pm
Wednesday 20 October: 7.30am to 6.00pm
All speakers must take their presentation to the speaker preparation room a minimum of four hours prior to their presentation or the day before if presenting at a breakfast or morning session.

RACP/AChSHM Points
Registrants may claim one credit/hour of the conference attended to a maximum of 50 credits annually in the Category 2: Group learning activities section. The onus is on the Fellow themselves to determine the total number of credit points they may claim and to claim them. Further information and access to the MyCPD program is available through the RACP website www.racp.edu.au.

RACGP Points
Application has been made to have attendance recognised for Quality Assurance & Continuing Professional Development. If you wish to claim these points please ensure you sign the attendance sheet each day at the registration desk.

HIV Prescriber CME Points
HIV s100 prescribers who are accredited in NSW/ACT/VIC will receive three (3) Prescriber CME points for their attendance at the Sexual Health Conference. If you attend the HIV/AIDS Conference as well you will receive eleven (11) Prescriber CME points in total.

Liability/Insurance
In the event of industrial disruptions or natural disasters the Australasian Sexual Health Conference Secretariat cannot accept responsibility for any financial or other losses incurred by delegates. Nor can the Secretariat take responsibility for injury or damage to property or persons occurring during the conference or associated activities. Insurance is the responsibility of the individual delegate.

Poster Displays
Posters will be displayed, grouped in their disciplines, for the duration of the conference in the Bayside Grand Hall, Ground Floor. Poster presenters have been asked to be present in certain breaks that correspond with their poster theme in order to discuss them further.

Monday Lunch:
Prevention and Epidemiology and Other

Tuesday Lunch:
Laboratory/Diagnostics and Social Research

Wednesday Lunch:
HIV and Clinical

PDFs of the posters are also available online during and post conference. Please visit the conference website to view them. Onsite they can be viewed at the Internet Hubs.
Exhibition
An exhibition will be held in Bayside Grand Hall on the ground floor of the Sydney Convention and Exhibition Centre which also contains the posters and all the catering. The exhibition will be open during the following hours:
- Monday 18 October: 10:30am to 6.30pm
- Tuesday 19 October: 8:30am to 3.30pm
- Wednesday 20 October: 10.00am to 5.00pm

Internet Hub
Internet Hub, proudly supported by the Australasian Chapter of Sexual Health Medicine, will be available during exhibition hours in the Bayside Grand Hall. Six computers will be available for:
- Printing a certificate of attendance
- Viewing the Australasian Chapter of Sexual Health Medicine Mock Exit Assessment Presentation
- Viewing the Australasian Chapter of Sexual Health Medicine Advance Training Curriculum
- Viewing the abstract search database
- Viewing delegate lists
- Completing the Conference Survey through the link sent to you.

Wireless Internet is available for delegates and can be used in the Exhibition Hall only (Bayside Grand Hall). In order to receive the access instructions please visit the Conference Secretariat at the registration desk.

Scholarships
Thank you to the following supporters of the 2010 Conference Scholarships:
- Australian Government, Department of Health and Ageing
- Boehringer Ingelheim
- CSL Biotherapies
- Department of Health, Western Australia
- Gilead
- Queensland Government

Smoking
This conference has a no smoking policy.

Mobile Phones/Beepers
As a courtesy to all delegates and speakers, please switch off, or set to silent, your mobile phones and beepers during all sessions.

Name Badges
For security purposes, all attendees must wear their name badge at all times while in the conference venue. Entrance to the exhibition will be limited to badge holders only. If you misplace your name badge, please advise staff at the registration desk.

Personal Mail
The conference organisers do not accept responsibility for personal mail. Please have all mail sent to your accommodation address.

Delegate List
A delegate list will be viewable and printable at the Internet Hub.

Evaluation Surveys
The evaluation survey is being conducted by an independent researcher, UltraFeedback who will provide individual links to your email account for you to fill out the survey. We appreciate your feedback.

UltraFeedback is the 2010 Australasian Sexual Health Conference research provider and will be gathering your feedback regarding the event. UltraFeedback is an Australian research agency with particular expertise in gathering feedback from those in the health sector including patients, carers, providers, clinicians and all associated health professionals. UltraFeedback can design and administer a survey program to meet your needs as well as undertake focus groups, one-on-one interviews or develop a marketing strategy for a product launch. As a full service market research agency, UltraFeedback has the access and resources you need to solve your business challenges. For further information please contact Felicity Johns on 03 9439 7789 / 0403 141 219 or felicity.johns@ultrafeedback.com.
The following awards will be presented during the closing session of the conference on Wednesday 20 October 2010.

**The Jan Edwards Prize**  
**Sponsored by Novartis**  
Jan Edwards Prize was named in honour of the long-serving Executive Secretary of the previous Australasian College of Sexual Health Physicians. On 15 September 2005 Dr Jan Edwards left after serving 19 years with the College of Sexual Health Physicians and overseeing the affiliation to the Chapter of Sexual Health Medicine with the RACP.

The prize will be awarded for a proffered paper of high standard presented orally by a registered trainee of the Chapter at the annual Australasian Sexual Health Conference or another conference nominated by the Chapter. The prize will only be awarded if there is an oral presentation judged to be of a suitable standard.

The presentation should concern original and unpublished observations made by the trainee. Preference will be given to a presentation which includes an Introduction, Methods, Results and Discussion.

Past winners will be ineligible. The judging panel will be chaired by the President of the Chapter Committee and will be comprised of two Fellows who attended all the presentations by the eligible trainees. In choosing the best paper the judges shall take into account the concept and content of the study and the manner of presentation.

**Value: A$500.00**

**The Sexual Health Society of Victoria Prizes**  
Three prizes of A$250 each will be awarded to the best poster presentations in the categories of:  
1. Clinical/Epidemiological Research  
2. Health Promotion  
3. Social/Behavioural Research  
Prizes will be awarded on content, format and originality.  
**Value: A$250.00 per prize winner**

**The Sexual Health Prize**  
The Sexual Health Prize is awarded by the journal *Sexual Health*. It is awarded to the best written abstract. Abstracts are assessed on a number of features including, structure, clarity, the inclusion of actual data (specifically actual numbers), p values, confidence intervals and odds ratios. They are not assessed on the strength of the science. Abstracts that win generally contain sufficient data to allow the data to be cited without the need to see the presentation or read the full paper. The author will be awarded a full print and online subscription to the journal.  
**Value: A$120.00**

**ASHHNA/ Kendra Sundquist Nurses Prize**  
The Australasian Sexual Health and HIV Nurses Association Inc. is offering a prize for the best oral presentation and the best poster by nurses. Open to all nurses.  
**Value A$500.00**
### Satellite Symposium: A new five-year research initiative on the transmission, control and outcomes of sexually transmitted infections

**Monday 18 October 2010, 12.45pm – 1.15pm**  
Sydney Convention and Exhibition Centre, Bayside Gallery A

The NHMRC has for the first time awarded a Program Grant in the area of sexual health, providing $9.1m funding over five years (2010-14). The grant will be used to support a number of major research initiatives that build on work that has been undertaken by the chief investigators in various areas of sexual health. The session will provide an outline of the major directions of the Program, including a description of projects that are currently underway or in advanced stages of preparation. The Program leaders will invite discussion and comment.

### Beer & Bull Session: Meet the Experts

**Monday 18 October 2010, 5.30pm – 6.00pm**  
Sydney Convention and Exhibition Centre, Bayside Grand Hall

The Beer & Bull session will offer delegates the opportunity to meet international guest speakers, Professor Graham Hart, Dr Jorgen Jensen and Dr Douglas Kirby. The international speakers will be invited to speak briefly about their work and then take questions from the audience. This intimate session will encourage people to interact with the international guests and ask questions about their work and experiences. It will be informally run in a section of the exhibition hall while the Welcome Reception & Poster Viewing Evening occurs.

### Forensic & Medical Sexual Assault Clinicians Australia (FAMSACA) Breakfast Session

**Tuesday 19 October 2010, 7.00am – 9.00am**  
Sydney Convention and Exhibition Centre, Bayside Gallery A

FAMSACA would like to invite all delegates to attend a 1.5 hour breakfast case presentation session, highlighting some of the more interesting aspects of sexual assault cases seen.  
**Ticket cost: A$22**

### Australasian Chapter of Sexual Health Medicine Annual Meeting

**Tuesday 19 October 2010, 5.15pm – 6.30pm**  
(Refreshments served from 5.00pm)  
Sydney Convention & Exhibition Centre, Bayside Gallery A

Refreshments will be served during the Chapter Annual Meeting. The Annual Meeting is only open to Fellows, Trainees and Professional Affiliates of the Australasian Chapter of Sexual Health Medicine.

### Welcome Reception and Poster Viewing Evening

**Monday 18 October 2010, 5.00pm – 6.30pm**  
Sydney Convention and Exhibition Centre, Bayside Grand Hall

All delegates are invited to enjoy a relaxing end to the first day of the conference. This is an opportunity to catch up with old and make new friends, while enjoying drinks and canapés. We encourage you to view the posters and meet the poster presenters during this time. One ticket to the Welcome Reception is included with every registration except day registrations and guests.  
**Ticket cost: A$44.00 for day registrants and guests**
Trainee Case Presentation Breakfast Session
Wednesday 20 October 2010, 7.00am – 9.00am
Sydney Convention and Exhibition Centre, Bayside Gallery B

Registrar case presentations will take place at this early-morning session. The presenters have been asked to present a succinct literature review and their clinical case before taking questions from a panel of Sexual Health physicians and members of the audience. Breakfast will be served from 7.00am with the presentations to begin at 7.30am. This session is included in the registration fees for trainees and students but is an optional extra for all others. Please make the time to attend this session to support the Chapter’s trainees.

Ticket cost: A$22.00 for all registrants except trainees and students
If you would like to purchase tickets to the Trainee Breakfast you may do so up until 12 noon on Tuesday 19 October at the registration desk.

Ngarra Exhibition
Wednesday 20 October 2010, 10.00am – 3.30pm
Sydney Convention and Exhibition Centre, Bayside 103 and 104

Ngarra exhibition (meaning to ‘tie in’ the Sydney Language) showcases sexual health initiatives currently being adopted or developed around the country for Aboriginal and Torres Strait Islander populations. We are grateful to and acknowledge the Metropolitan Local Aboriginal Land Council who suggested the name and gave consent for its use for this exhibition.

Gala Conference Dinner - Carnivàle Desires, have fun under the big top!
Wednesday 20 October 2010, 7.00pm – 11.00pm
Luna Park, Milsons Point, Sydney
6.15pm Ferry Departure from Convention Centre Wharf

Join us at Luna Park and relive the 1930’s Funfair experience. The dinner will start with a cruise across the famous Sydney Harbour from the Sydney Convention & Exhibition Centre. The boat will arrive at the iconic Luna Park where you will be immersed in the historic fun park’s characters and have the opportunity to ride the ferris wheel. A live band is sure to get you up dancing and the night will include a few rounds of table trivia. This is a dinner not to be missed!

Australasian HIV/AIDS & Sexual Health Conference joint registrants: Complimentary
Australasian HIV/AIDS Conference only registrants and day registrants: A$120 Partners/Guests: A$120
If you would like to purchase tickets to the Gala Dinner you may do so up until 12 noon on Monday 18 October at the registration desk. Please note tickets are limited and may be sold out.

Tickets to Associated Events
Tickets and/or name badges will be required for entry to the majority of associated events. All tickets will be given out at registration. The tickets are located in the name badge pocket. A no-refund policy operates for cancellation of function tickets.
LOCATION MAP - SYDNEY
### Company Name

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<td>HIV s100 Prescriber Renewals and ASHM International Gift Fund</td>
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<td>Lilly Australia</td>
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<td>Marie Stopes International and Sexual Health &amp; Family Planning Australia</td>
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<td>Viiv Healthcare</td>
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The following Companies are exhibiting during the Australasian HIV/AIDS Conference and will be available on Wednesday 20 October only.

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<td>HIV Consortium</td>
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<td>NAPWA/AFAO</td>
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<td>National Centre in Social Research</td>
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<td>Sanofi Aventis</td>
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<td>Tibotec, Division of Janssen-Cilag</td>
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### Alere

Alere empowers people to take control of their health by actively integrating diagnostics and health management solutions to provide timely, actionable information in a range of environments from hospital to home. We provide in vitro diagnostics in the fields of cardiovascular, infectious diseases, women’s health, prenatal care, drugs of abuse and oncology. We support healthcare workers and patients by developing simple diagnostic equipment to ensure better quality in both inpatient and outpatient care. We are a global leader in the field of rapid diagnostic tests which are designed to improve the quality of patient care. Specific product lines include tests for the rapid and early diagnosis of myocardial infarction, influenza, acute kidney damage and HIV infection.

### Australasian Chapter of Sexual Health Medicine

The Australasian Chapter of Sexual Health Medicine is the professional body responsible for the education and training of doctors wishing to specialise in sexual health. It contributes to the professional development of other health professionals through its training courses, and the development and dissemination of guidelines and other educational products. It provides expert advice to government and other agencies on sexual health matters and its Fellows contribute to policy development at state and national level.

Contact the Australasian Chapter of Sexual Health Medicine
Education Officer (training related enquiries)
Education Deanery
The Royal Australasian College of Physicians
145 Macquarie Street
SYDNEY NSW 2000
Tel: +61 2 9256 9669  Fax: + 61 2 9256 9698
Email: sexualhealthtraining@racp.edu.au

Executive Officer (all other enquiries)
Australasian Chapter of Sexual Health Medicine
The Royal Australasian College of Physicians
145 Macquarie Street
SYDNEY NSW 2000
Tel: +61 2 9256 9643  Fax: +61 2 9256 9693
Email: sexualhealthmed@racp.edu.au

### Australasian Society for HIV Medicine

The Australasian Society for HIV Medicine (ASHM) is the peak organisation representing health professionals in Australia and New Zealand who work in those areas of health concerned with HIV. ASHM is a key partner in the development of public policies related to continuing medical education, community prescribing and national treatment guidelines for HIV and viral hepatitis. ASHM provides services to members and a range of other individuals and organisations working in HIV, viral hepatitis and sexual health sector.
Boehringer Ingelheim
Boehringer Ingelheim is committed to active involvement and practical answers for people living with HIV. The fight against HIV/AIDS extends to resource-poor settings, where Viramune® (nevirapine) has been donated to treat more than 1,747,000 mother-child pairs in 60 countries through the Viramune Donation Programme. Boehringer Ingelheim is also proud to be a member of the Collaboration for Health in PNG (CHPNG). The CHPNG is the initiative of a group of Australian pharmaceutical companies who are dedicated to making a philanthropic contribution towards improving the health and wellbeing, and political and social stability of Australia's nearest neighbour and is currently working with its partners to provide education and support to health care workers in PNG.
Contact:
PO Box 1969
Macquarie Centre
NORTH RYDE NSW 2113
Tel: +61 2 8875 8833  Fax: +61 2 8875 8712

Bristol-Myers Squibb
556 Princes Highway,
NOBLE PARK VIC 3174
Tel: +61 3 9213 4000 Fax: +61 3 9701 1526
Web: www.bmsa.com.au
Ross Volteas: Product Manager - Virology
Email: ross.volteas@bms.com
Lili Munafo: Disease Area Specialist - Virology
Email: lili.munafo@bms.com

Contiform International
Contiform International is a manufacturer and distributor of medical devices to the healthcare market. We both import and export medical devices with representation in the US and UK markets. Our customer base is made up of women's health clinics, private and public hospital, cosmetic and general surgery. Specialising in Women's Health products, our devices are used in both diagnosis and treatment. The product range includes our patented continence device (Contiform), sterile lubricants (SurgiGLTM), male external catheters (ContiSheathTM), hysterometers, curettes, Rapid diagnostic tests for hCG, UTI, Vaginitis, IUD insertion and removal devices, gynaecological biopsy and obstetric vacuum assisted delivery device, along with liposuction sets, needles and general surgery and clinic consumables from gloves to gowns, wipes to wound care.
CSL Biotherapies

In Australia, CSL Biotherapies manufactures and in-licenses, markets and distributes vaccines with particular focus on vaccines for the prevention and treatment of serious disease. We operate one of the world’s largest influenza vaccine manufacturing facilities and supply seasonal influenza vaccines to Australia and global markets.

In addition, we in-license a range of pharmaceutical products from our partner companies to ensure a comprehensive range of products are available to meet the needs of all Australians.

CSL Biotherapies also manufactures a range of immunohaematology products (diagnostic reagents) that are supplied to Australian laboratories to enhance the safety of blood transfusions for patients in Australia.

Our heritage underpins our strong commitment to research and development, reliability, safety and quality. This philosophy has resulted in the development of many life-saving products and allowed us to play a key role in the collaborative work that has delivered the world’s first vaccine against cervical cancer.

Four Seasons Condoms

With over 20 years experience in condoms and sexual health products, we are excited to launch our range of Naked condoms – they feel like not wearing a condom at all! Designed to be ultra thin but also extra strong, the Naked range is available in three completely different sizes of tighter 49mm, classic 54mm and larger 60mm. Ask for sample of our Naked flavour condom range and water based lubricants, and grab one of our promotional tin packs. Four Seasons is a Quality Endorsed company and 100% Australian owned and operated.

Gilead

Gilead’s mission is to advance patient care by developing therapeutics to treat life-threatening diseases. We apply biopharmaceutical science to create medicines to treat conditions including HIV/AIDS (ATRIPLA® [tenofovir disoproxil fumarate & emtricitabine & efavirenz], Truvada® [emtricitabine & tenofovir disoproxil fumarate], Emtriva® [emtricitabine], Viread® [tenofovir disoproxil fumarate]), chronic hepatitis B (Viread® [tenofovir disoproxil fumarate], Hepsera® [adefovir dipivoxil]), and systemic fungal infections (AmBisome® [liposomal amphotericin B]).

Company name: Gilead Sciences Pty Ltd
Level 1, 128 Jolimont Road
EAST MELBOURNE VICTORIA 3002
Tel: +61 3 9272 4400  Fax: +61 3 9272 4411
GlaxoSmithKline
GlaxoSmithKline (GSK) is one of the leaders in pharmaceutical research and development with a combination of skills and resources that provide a platform for delivering innovation in today’s rapidly changing healthcare environment. GSK is a patient focused organisation with a mission to improve the quality of human life by enabling people to do more, feel better and live longer. We are committed to delivering the best quality pharmaceuticals, vaccines and over the counter products to the people of Australia. In 2009 GSK invested $45.2 million in Australian research and development, and ranked as one of Australia’s top 15 business investors in this area.
Damien McGuire
Level 4, 436 Johnston Street
ABBOTSFORD VIC 3067
Tel: +61 3 9721 4660 Fax: +61 3 8761 2442
Email: damien.p.mcguire@gsk.com
Web: www.gsk.com.au

HIV s100 Prescriber Renewals
HIV s100 prescribers from NSW, Victoria, South Australia and the ACT will be able to complete the new and improved online prescriber renewal process for the current triennium. ASHM staff will be available to help prescribers complete the process and answer any questions.

ASHM International Gift Fund
ASHM members and conference participants are encouraged to visit the special booth where you can meet our regional partners, learn more about ASHM’s regional program and make donations to support this work. PNG carry bags - ‘billums’ - made by a group of HIV positive women and their friends in PNG will be on sale. All proceeds go to supporting these women and their communities.

Lilly Australia
Eli Lilly and Company is a leading innovation-driven company with a growing portfolio of best-in-class and often first-in-class pharmaceutical products. Eli Lilly and Company exists to create answers that matter through innovative medicines, information, and exceptional customer service that enable people to live longer, healthier and more active lives. Our products treat many conditions including cancer, diabetes, cardiovascular disease, erectile dysfunction, mental illness, attention deficit hyperactivity disorder (ADHD), osteoporosis and sepsis. Eli Lilly Australia was established in 1960. Our vision is to create a healthier future for all Australians by finding innovative therapeutic approaches that address unmet medical needs. We will achieve success by delivering improved individual patient outcomes and outstanding financial performance through an unwavering commitment to responsibility, collaboration, agility, our people and our values—respect for people, integrity and excellence.
Marie Stopes International

The Marie Stopes International global partnership, of which Marie Stopes International Australia is a partner, provides vital sexual and reproductive healthcare services to almost 7 million people in 43 countries worldwide.

Marie Stopes International Australia offers a range of services and advice through 12 licensed and accredited centres in the Australian Capital Territory, New South Wales, Queensland, Victoria and Western Australia.

Marie Stopes International Australia also provides life saving support to eight country partner programs in the Asia-Pacific and with Indigenous communities. Surplus funds from our Australian centres are donated to help these programs grow.

For more information, visit www.mariestopes.org.au or call Toll Free 1800 003 707.

Sexual Health & Family Planning Australia

SH&FPA is the national voice of sexual health and family planning organisations (Member Organisations, MOs) around the country and represents these organisations on sexual and reproductive health issues at national and international levels. Projects are shared between member organisations, with a national secretariat currently located in Sydney with Family Planning NSW.

SH&FPA maintains a dynamic international program in South East Asia and the Pacific. The major strategies of the program are focused on enhancing the management and delivery of sexual and reproductive health care and education delivered by or with local organisations in a sustainable setting. AusAID funds most of this work.

State and Territory Sexual Health and Family Planning Organisations

For as long as 80 years SH&FPA Member Organisations in each State and Territory have looked after the sexual and reproductive health needs of a large number of Australians. SH&FPA Member Organisations provide a wide range of sexual and reproductive health services that focus on prevention, early intervention, diagnosis and treatment, and community and professional education.

Member Organisations deliver clinical services, which include:
- Pap smears
- Breast checks
- STD & STI checks and counselling services - HIV, Hepatitis, Chlamydia
- Consultations, counselling and provision of contraceptives
- Pregnancy tests
- Pregnancy counselling
- Treatment and counselling for menopause related problems.

Sexual health and family planning organisations also play a key role in the provision of information and education services about sexuality and sexual health to the public. The extensive community education programs focus on informing the community about:
- Reproduction
- Contraceptive methods
- Relationships and self-esteem

We promote safe sex practices, health and well being and protective behaviours in order to empower people to make informed choices for themselves.
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| 18    | **Medical Industries Australia**  
At Medical Industries Australia we constantly strive to consistently meet our customers' requirements and reliably deliver both quality and value.  
Medical Industries Australia sources and supplies products to Australian Hospitals, the Armed Forces, Clinics, Aged Care Facilities and to the Dental Market; providing both sterile and non-sterile products that are widely used in ensuring safer healthcare for both the patient and medical practitioner.  
As well as a focus on Women’s Health and Aged Care, the comprehensive range includes: Protective Clothing, Incontinence Care, Respiratory Care, Diagnostic Test Kits, Hospital Furniture, Medical and Surgical Consumables. |
| 20    | **MSD Virology**  
MSD/Merck & Co. has been involved in HIV research since the early 1990s.  
Over the ensuing 20 years the company has been instrumental in the early discovery & development of PIs (CRIXIVAN® - indinavir) & NNRTIs (STOCRIN® - efavirenz).  
Over the past 10 years MSD/Merck & Co. has pioneered the discovery & development of the first integrase inhibitor to reach commercial development. ISENTRESS® (raltegravir) is the first in class of the InSTIs.  
Schering Plough, now part of MSD, conducted much of the pioneering development work on the chemokine receptor antagonists (CCR5 inhibitors) for the treatment of HIV & has developed PEGATRON® (peg-interferon alfa-2b + ribavirin) for the treatment of HCV. |
| 4     | **Novartis Pharmaceuticals**  
Novartis is a world leader in the research, development and supply of products to protect and improve health and well-being.  
Our core businesses are in pharmaceuticals, consumer health (including eye-care and animal health), generics and vaccines. In Australia, Novartis employs more than 600 people and invests over AUD $30million annually in local research activities.  
Our name, derived from the Latin ‘nova artes’, means ‘new skills’ and reflects our focus on research and development to bring new treatments to patients and physicians worldwide.  
www.novartis.com.au |
### 13. THE NSW SEXUALLY TRANSMISSIBLE INFECTIONS PROGRAM UNIT (STIPU)

The NSW Sexually Transmissible Infections Program Unit (STIPU) was established by NSW Health to:
- coordinate implementation of the NSW STI Strategy
- provide leadership to the sexual health workforce; and to
- establish dedicated sexual health projects and research to support actions identified in the Strategy.

STIPU focuses on supporting GPs in managing STIs in primary healthcare settings, GP research and STI contact tracing and assisting publicly funded sexual health services in targeting priority populations. STIPU also promotes community awareness of STIs and supports the NSW Sexual Health Infoline.

**Contact:** STI Programs Unit  
Level 3 Nightingale Wing, Sydney Hospital,  
GPO Box 1614, Sydney 2001  
Email: General Practice Project: Carolyn.Murray@sesiahs.health.nsw.gov.au  
Publicly Funded Sexual Health Services Project: Leng.Boonwaat@sesiahs.health.nsw.gov.au  
Social Marketing Project: Liz.Story@sesiahs.health.nsw.gov.au  

### THE BOBBY GOLDSMITH FOUNDATION

Established in 1984, the Bobby Goldsmith Foundation is Australia’s longest-running HIV charity.

Our mission is to help people living with HIV (PLHIV) by providing practical, emotional and financial support so they can maintain their independence and improve their quality of life. It’s the kind of ongoing, unconditional support that usually only friends or family would provide.

The core services BGF provides to its clients are:
- direct financial assistance (mainly for medications, medical care, dental care, course fees and materials);
- a financial counselling service;
- access to a No Interest Loans Scheme (NILS®);
- a range of supported accommodation programs;
- a vocational counselling service (Positive Futures);
- a program of capacity building workshops (Phoenix and PosQuest Workshops) and
- an extensive outreach program to regional and rural NSW.

### POSITIVE LIFE

**who we are...**

Positive Life NSW (previously PLWHA NSW) is a small, professional community organisation managed by people with HIV. Since 1988 we have been working to promote the rights, health and well-being of people with HIV, their partners and families in NSW.

**our aims...**

Our vision is to ensure that people with HIV are given the opportunity to have and maintain the best standards of health and quality of life.

We aim to represent people with HIV in NSW, their partners and communities, and provide health promotion, advocacy and peer support. We also aim to remove prejudice, isolation and discrimination against people with HIV.

**what we do...**
Positive Life NSW works to improve conditions and services for people with HIV. We have strong partnerships with HIV health services, community organisations, government departments and research agencies. We provide information and support for people living with HIV, and the wider community.

Our projects include: advocacy, peer support (After Hours, 729), Positive Speakers’ Bureau, publications (Talkabout, Contacts directory), information and referrals, campaigns and education.

For more information visit www.positive.life.org.au or call 02 9361 6011; Freecall 1800 245 677

ACON
ACON is NSW’s and Australia’s largest community-based gay, lesbian, bisexual and transgender (GLBT) health and HIV/AIDS organisation.

We promote the health and wellbeing of the GLBT community and people affected by HIV, and reduce HIV transmission. We run HIV prevention programs for the groups most at risk of HIV transmission – gay men, sex workers and people who inject drugs. For people with HIV, their families and carers, ACON provides a broad range of health promotion and support services. In the area of policy and advocacy, ACON provides advice on issues related to HIV and human rights.

Our work also covers other health issues for our communities such as:

- Sexual health
- Mental health
- Alcohol and other drug use
- Ageing
- Homophobic violence
- Domestic violence
- Counselling
- Community care
- Housing

The people and communities we serve face the same broad health issues as everyone else. However, mainstream service providers don’t always respond adequately to their needs due to a lack of knowledge, understanding or acceptance, especially in regional and rural NSW.

ViiV Healthcare
A new approach to treating HIV/AIDS.

We are ViiV Healthcare - a global specialist HIV company established by GlaxoSmithKline and Pfizer to deliver advances in treatment and care for people living with HIV.

Our aim is to take a deep and broad interest in HIV/AIDS and then take a new approach to deliver effective and new HIV medicines as well as support communities affected by HIV.
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<tr>
<td>7.30am - 9.00am</td>
<td>Registration Opens</td>
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</table>
| 9.00am - 10.30am | **Opening Ceremony and Gollow Lecture**  
  **Supported by the Australian Government Department of Health and Ageing**  
  Bayside Auditorium A  
  Chairs: Richard Hillman and Anne Robertson |
| 9.05am - 9.10am  | Introduction by Convenor 2010 Sexual Health Conference Committee, Richard Hillman |
| 9.10am - 9.20am  | Welcome to the Land Speaker, Allan Madden, Cultural Education Representative, Metropolitan Local Aboriginal Land Council, NSW, Australia |
| 9.20am - 9.25am  | Official Opening Address                                                |
| 9.25am - 10.30am | **Anne Robertson, President, Australasian Chapter of Sexual Health Medicine**  
  Welcome to the Conference and Introduction of the Gollow Lecturer  
  **Gollow Lecturer: Michael Kidd, Executive Dean of Health, Flinders University, South Australia and Chair of the Australian Government’s Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections, South Australia, Australia**  
  Challenges for Sexual Health Medicine |
| 10.30am - 11.00am| **Morning Tea in Exhibition and Poster Area, Bayside Grand Hall**       |
| 11.00am - 12.30pm| **Plenary: The Fruits of Desire**  
  Bayside Auditorium A  
  Chairs: Richard Hillman and Catriona Ooi |
| 11.00am - 11.45am| **Graham Hart, Head of Research Department, Director, Centre for Sexual Health & HIV Research, University College London, United Kingdom**  
  STI & HIV Prevention for Improved Population Sexual Health: Challenges & Future Directions |
| 11.45am - 12.30pm| **Jorgen Jensen, Head, Mycoplasma Laboratory, Statens Serum Institute, Copenhagen, Denmark**  
  Mycoplasma Genitalium: New Frontiers and Emerging Challenges |
<table>
<thead>
<tr>
<th>Time</th>
<th>Session/Activity</th>
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<tbody>
<tr>
<td>12.30pm -</td>
<td>Lunch in Exhibition and Poster Area, Bayside Grand Hall Poster Themes: Prevention &amp; Epidemiology and Other</td>
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<tr>
<td>1.30pm</td>
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</tbody>
</table>
| 12.35 - 1.15pm | **Satellite Symposium: A new five year research initiative on the transmission, control and outcomes of sexually transmitted infections**  
**Bayside Gallery A**                                                                 |
| 1.30pm - 3.00pm | **Proffered Paper Session: Burning Desires**  
**Bayside Auditorium A**  
Chairs: Marcus Chen and Kym Collins                                                                 |
| 1.30pm - 3.00pm | **Proffered Paper Session: Sharing Desire**  
**Bayside Gallery B**  
Chairs: Juliet Richters and Deborah Bateson                                                                 |
| 1.30pm - 3.00pm | **Proffered Paper Session: Desire in the Bush**  
**Bayside Gallery A**  
Chairs: Linda Garton and Jo-ann Lenton                                                                 |
<p>| 1.30pm - 2.00pm | Guy Rand Kong F - Chlamydia testing and positivity at general practice and sexual health services across Australia- the ACCESS system                                                                 |
| 1.30pm - 1.45pm | Bourne C - Partner notification in the 21st century: How do people really do it?                                                                                                                                  |
| 1.45pm - 2.00pm | Birukila GJ - HIV related sexual knowledge, behaviours and attitudes among African migrants and refugees in Christchurch, New Zealand                                                                                  |
| 2.00pm - 2.15pm | Templeton D - Prevalence and predictors of chlamydia co-infection among gonorrhoea-infected patients attending a metropolitan sexual health clinic                                                                      |
| 2.00pm - 2.15pm | Bilardi J - The job satisfaction of female sex workers working in licensed brothels in Victoria, Australia                                                                                                         |
| 2.15pm - 2.30pm | Twin J - Chlamydia trachomatis genotypes based on clinical samples collected from men who have sex with men in Melbourne and Sydney                                                                                |
| 2.15pm - 2.30pm | Read P - Unprotected fellatio between sex workers and clients: Is it a problem?                                                                                                                                     |
| 2.15pm - 2.30pm | Kwan K - Declining gonorrhoea in the Western Australian Aboriginal populations can it be sustained?                                                                                                                |
| 2.15pm - 2.30pm | Rumbold A - Assessing rates of vulval cancer in Arnhem Land and the association with HPV                                                                                                                            |
| 2.15pm - 2.30pm | Golfer J - A snapshot of chlamydia testing and positivity in eight Aboriginal community controlled health services: Useful information for local quality improvement                                                                 |
| 2.15pm - 2.30pm | Banik B - Rural young men's sexual health is this a missed opportunity in rural health services in Australia?                                                                                                |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>2.30pm -</td>
<td>Bissessor M - Poor sensitivity of culture for detection of neisseria</td>
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<tr>
<td>2.45pm</td>
<td>gonorrhoeae in pharynx and rectum</td>
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<tr>
<td>2.45pm -</td>
<td>* Drummond F - Is azithromycin effective for asymptomatic rectal</td>
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<tr>
<td>3.00pm</td>
<td>chlamydia in men? An audit</td>
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<tr>
<td>3.00pm -</td>
<td>Afternoon Tea in Exhibition and Poster Area, Bayside Grand Hall</td>
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<tr>
<td>3.30pm -</td>
<td>Symposium: The Business of Desire</td>
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<tr>
<td>3.50pm -</td>
<td>The male sex industry: State of affairs</td>
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<tr>
<td>3.50pm -</td>
<td>Kath Albury, ARC Postdoctoral Fellow, Journalism and Media Research</td>
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<tr>
<td>4.10pm</td>
<td>Centre, University of New South Wales, NSW, Australia</td>
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<tr>
<td>3.30pm -</td>
<td>Symposium: Diversity of Desire</td>
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<tr>
<td>3.55pm</td>
<td>Refugee populations and sexual health</td>
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<td>3.50pm -</td>
<td>Catherine Drummond, Dermatologist, Canberra Hospital, Skin and Cancer</td>
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<tr>
<td>4.20pm</td>
<td>Foundation, Darlinghurst, NSW, Australia</td>
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**Monday 18 October 2010**

FULL CONFERENCE PROGRAM
### MONDAY 18 OCTOBER 2010

#### FULL CONFERENCE PROGRAM

<table>
<thead>
<tr>
<th>Time</th>
<th>Speaker</th>
<th>Title</th>
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<tbody>
<tr>
<td>4.10pm -</td>
<td>Basil Donovan, Professor, Sexual Health Head, Sexual Health Program,</td>
<td>Female sex workers in Asia and the Pacific region</td>
</tr>
<tr>
<td>4.30pm</td>
<td>National Centre in HIV Epidemiology and Clinical Research, NSW, Australia</td>
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<tr>
<td>4.20pm -</td>
<td>Sahba Clara Delshad, Senior Health Promotion Officer (CALD), Family</td>
<td>Sexual health promotion among CALD communities</td>
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<tr>
<td>4.45pm</td>
<td>Planning NSW, NSW, Australia</td>
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<tr>
<td>4.10pm -</td>
<td>Jenny Bradford, Obstetrician Gynaecologist, University of Western</td>
<td>Vulval pain and the management of Vaginismus</td>
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<tr>
<td>4.30pm</td>
<td>Sydney, NSW, Australia</td>
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<tr>
<td>4.30pm -</td>
<td>Lisa Maher, Professor, Program Head and NHMRC Senior Research Fellow,</td>
<td>Sex/drug synergies and the street sex work environment</td>
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<tr>
<td>4.45pm</td>
<td>National Centre in HIV Epidemiology and Clinical Research, NSW, Australia</td>
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<tr>
<td>4.30pm -</td>
<td>Richters J - Measuring desire: Labelling and conceptual frameworks for</td>
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<tr>
<td>4.45pm</td>
<td>sexual difficulties, problems and dysfunctions</td>
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<td>4.50pm -</td>
<td>Lisa Maher, Professor, Program Head and NHMRC Senior Research Fellow,</td>
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<tr>
<td>5.00pm</td>
<td>National Centre in HIV Epidemiology and Clinical Research, NSW, Australia</td>
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<tr>
<td>5.00pm -</td>
<td>Welcome Reception &amp; Poster Viewing Evening, Bayside Grand Hall</td>
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<tr>
<td>6.30pm</td>
<td>Beer &amp; Bull: Meet the Experts, Stage Area, Bayside Grand Hall</td>
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<tr>
<td>7.00pm</td>
<td>ACHSHM Trainee Dinner, Sponsored by Novartis</td>
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*Eligible for the Jan Edwards Prize, Sponsored by Novartis*
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<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>7.00am</td>
<td>Registration</td>
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<tr>
<td>7.30am - 9.00am</td>
<td><strong>FAMSACA Breakfast Meeting: Case Presentations and Discussion</strong></td>
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<td>Bayside Gallery A</td>
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<tr>
<td></td>
<td>Maria Nittis/Mandy Ashton: ‘Where did that come from’</td>
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<td></td>
<td>Catherine Sansum: ‘What to believe and what to do when we don’t’</td>
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<td></td>
<td>Alanah Houston: ‘Is twice just bad luck?’</td>
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<td></td>
<td>Cassandra Beaumont: ‘Fed up with follow-up’</td>
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<tr>
<td>9.00am - 10.30am</td>
<td><strong>Plenary: Young and Desirable</strong></td>
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<td>Supported by the Department of Health Victoria</td>
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<td>Bayside Auditorium A</td>
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<td>Chairs: Melissa Kang and Brandon Bear</td>
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<tr>
<td>9.00am - 9.45am</td>
<td>Lynne Hillier, Associate Professor, Australian Research Centre in Sex, Health and Society, La Trobe University, VIC, Australia</td>
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<td>‘When young hearts flutter’ - Practices of desire and care of the self in adolescence</td>
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<tr>
<td>9.45am - 10.30am</td>
<td>Douglas Kirby, Senior Research Assistant, ETR Associates Program Division, California, USA</td>
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<td></td>
<td>The evidence behind why sex education improves sexual health outcomes</td>
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<tr>
<td>10.30am - 11.00am</td>
<td>Morning Tea in Exhibition and Poster Area, Bayside Grand Hall</td>
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<tr>
<td>11.00am -</td>
<td>Bayside Auditorium A</td>
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<tr>
<td>12.30pm</td>
<td>Chairs: Barry Edwards and Lynne Martin</td>
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<tr>
<td>11.00am -</td>
<td>Juliet Richters, Associate Professor in Sexual Health, School of Public Health and</td>
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<tr>
<td>11.20am</td>
<td>Community Medicine, University of New South Wales, NSW, Australia</td>
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<tr>
<td>11.20am -</td>
<td>What do Australians know and understand about chlamydia? The social aspects</td>
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<tr>
<td>11.40am</td>
<td>Julia Purchas, Health Promotion Manager, HIV/AIDS &amp; Related Programs Unit, SESIAHS,</td>
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<td></td>
<td>NSW, Australia and Kellie Checkly, Executive Officer, Shire Wide Youth Services, Miranda,</td>
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<td>NSW Australia</td>
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<td>11.40am -</td>
<td>Evaluation of a Health Promotion approach - Youth peer education</td>
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<td>12.00pm</td>
<td>Sue Laing, Senior Policy and Planning Officer (HIV), Sexual Health &amp; Blood-borne Virus</td>
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<td>Program, Communicable Disease Control Directorate, Department of Health Western Australia,</td>
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<td>Social marketing as a health promotion tool for Chlamydia prevention and testing</td>
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<tr>
<td>12.00pm -</td>
<td>Panel Discussion:</td>
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<tr>
<td>12.30pm</td>
<td>- Melissa Kang, Senior Lecturer, Department of General Practice, The University of</td>
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<td></td>
<td>Sydney at Westmead Hospital, NSW, Australia</td>
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<td>- Victor Tawil, Senior Policy Analyst, Aboriginal Access, AIDS/Infectious Diseases Branch</td>
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<td></td>
<td>, NSW, Australia</td>
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<td>- Philippe Adam, Senior Research Fellow, National Centre in HIV Social Research, NSW,</td>
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<td>Australia and Juliet Richters, Julia Purchas, Kellie Checkly</td>
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<tr>
<td>12.30pm - 1.30pm</td>
<td>Lunch in Exhibition and Poster Area, Bayside Grand Hall</td>
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<tr>
<td>1.30pm - 3.00pm</td>
<td>Proffered Paper Session: Emerging Desires</td>
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<tr>
<td>1.30pm - 1.45pm</td>
<td>Read T - Oropharyngeal Human Papillomavirus virus (HPV) prevalence and risk factors in men having sex with men (MSM)</td>
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<td>Berard D - Just signed factors influencing school-based HPV vaccination in Australia</td>
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<td>Ward J - The use of health services for STIs and BBVs among NSW Aboriginal people aged 16-30</td>
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<td>Sacks-Davis R - Home-based chlamydia testing of young people attending a music festival who will pee and post?</td>
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<tr>
<td>1.45pm - 2.00pm</td>
<td>Bourne C - SIS reminds increase HIV/STI re-testing rate among men who have sex with men at Sydney Sexual Health Centre</td>
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<td>Brown K - Forensic photography the current state of play for sexual assault examiners in Australia</td>
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<td>Breath C - The effectiveness of 1g of azithromycin for mycoplasma genitalium infections: A 5 year review</td>
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<td>Breath C - The effectiveness of 1g of azithromycin for mycoplasma genitalium infections: A 5 year review</td>
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<tr>
<td>2.00pm - 2.15pm</td>
<td>Botes L - Anal Cytology: A poor predictor of severe anal dysplasia in HPV positive men who have sex with men (MSM)</td>
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<td>Guich A - Increasing burden and geographical clustering of HPV-associated anal cancer in Australia</td>
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<td>向下滚动以获取更多内容</td>
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<thead>
<tr>
<th>Time</th>
<th>Session</th>
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</table>
| 3.30pm - 5.00pm | **Symposium: Navigating Desires**  
Bayside Auditorium A  
Chairs: Brandon Bear and Douglas Kirby |
| 3.30pm - 5.00pm | **Symposium: Investigating Desires**  
Bayside Gallery B  
Chair: Richard Hillman |
| 3.30pm - 5.00pm | **Symposium: Understanding Desires**  
Bayside Gallery A  
Chairs: Damian Conway and Nathan Ryder |
| 3.30pm - 3.50pm  | Spring Cooper, Senior Research Officer; and Rachel Skinner, Senior Lecturer, Paediatrics & Child Health, University of Sydney, The Children's Hospital at Westmead, NSW, Australia  
"I know the V stands for vaccination": Adolescents' understandings about the HPV vaccine |
| 3.50pm - 4.10pm  | Jorgen Jensen, Mycoplasma Laboratory, Statens Serum Institute, Copenhagen, Denmark  
Key diagnostic challenges facing our understanding of the roles of Ureaplasmas in male urethritis |
| 3.50pm - 4.10pm  | Michelle McKechnie, PhD Scholar, Sexually Transmitted Infections Research Centre, Sydney University, NSW, Australia  
The role of multiplex PCR in the diagnosis of STIs |
| 3.50pm - 4.10pm  | Lynne Hillier, Associate Professor, Australian Research Centre in Sex, Health and Society, La Trobe University, Victoria, Australia  
"I first realised when...": same sex attracted young people talk about their first realisations of sexual difference |
| 4.10pm - 4.30pm  | Michelle McKechnie, PhD Scholar, Sexually Transmitted Infections Research Centre, Sydney University, NSW, Australia  
Contribution of PCR to diagnosis of syphilis? |
| 4.10pm - 4.30pm  | David Whiley, Queensland Paediatric Infectious Diseases Laboratory, Sir Albert Sakzewski Virus Research Centre, Royal Children's Hospital and Health Service District, QLD, Australia  
Increasing use of gonococcal PCR and the tracking of resistance |
| 4.30pm - 4.45pm  | Steve Lambert, HIV & HCV Education Projects, School of Medicine, The University of Queensland, QLD, Australia  
Public speaking – how to engage your audience |
| 4.45pm - 5.00pm  | Tilley D - STI (Superhighway Transmitted Information): A new approach to professional development |
| 5.15pm - 6.30pm  | **AChSHM Annual Meeting**  
Bayside Gallery A (Refreshments will be served from 5.00pm) |
<p>| 6.30pm        | Free Evening |</p>
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<tr>
<td>7.30am</td>
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<tr>
<td>7.30am -</td>
<td>Sexual Health Trainee Case Presentation Breakfast</td>
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<td>9.00am</td>
<td>Bayside Gallery B</td>
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<td>Chair: Fraser Drummond</td>
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<td>Panel: Frank Bowden, Lewis Marshall and Lynne Wray</td>
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<tr>
<td>7.30am -</td>
<td>Carol Khaw - “Why am I deaf, doc?” - An interesting case of syphilis and HIV co-infection</td>
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<tr>
<td>8.00am -</td>
<td>Rohan Bopage - Recurrent vulval ulcerations following uti: Case of lipschutz ulcers</td>
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<td>8.30am -</td>
<td>Kym Collins - A Trifecta</td>
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<tr>
<td>8.30am -</td>
<td>HIV/AIDS Conference Opening Ceremony and Joint Conference Plenary</td>
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<tr>
<td>10.00am</td>
<td>Bayside Auditorium A</td>
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<td>Chairs: Greg Dore and Sean Emery</td>
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<tr>
<td>8.30am -</td>
<td>Welcome to the Land, Allan Madden, Cultural Education Representative, Metropolitan Local Aboriginal Land Council, NSW, Australia</td>
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<tr>
<td>8.35am</td>
<td>Welcome by ASHM President, Professor Greg Dore, Viral Hepatitis Clinical Research Program, National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney, Infectious Diseases Physician, St Vincent’s Hospital, Sydney, NSW Australia</td>
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<tr>
<td>8.40am</td>
<td>Welcome by Government Representative</td>
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<td>8.45am</td>
<td>Welcome by Kerry Chant, A/Associate Director, AIDS/AIDS Branch, NSW Department of Health, Sydney, NSW, Australia</td>
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<tr>
<td>8.50am</td>
<td>Welcome by Don Baxter, Executive Director, Australian Federation of AIDS Organisations, Sydney, NSW, Australia</td>
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<td>8.55am</td>
<td>Welcome by Robert Mitchell, President, NAPWA, Sydney, NSW, Australia</td>
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<tr>
<td>9.00am</td>
<td>Welcome by the Conference Convenor, Sean Emery, National Centre in HIV Epidemiology &amp; Clinical Research, NSW, Australia</td>
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<tr>
<td>9.05am</td>
<td>Cal Cohen, Research Director of Community Research Initiative of New England and Harvard Vanguard Medical Associates, United States of America</td>
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<td>State of ART therapy, new drugs &amp; new treatment issues</td>
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<tr>
<td>9.30am</td>
<td>Graham Hart, Head of Research Department, Director, Centre for Sexual Health &amp; HIV Research, University College London, United Kingdom</td>
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<td>Can HIV treatment stop the AIDS epidemic?</td>
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<tr>
<td>10.00am -</td>
<td>Morning Tea in Exhibition and Poster Area, Bayside Grand Hall</td>
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<tr>
<td>11.00am</td>
<td>Ngarra Exhibition, Bayside 103 &amp; 104</td>
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<tr>
<td>10.10am -</td>
<td>NCHECR Surveillance Launch, Bayside Gallery A</td>
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<tr>
<td>11.00am -</td>
<td>Joint Symposium: Instant Desire</td>
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<td>11.00am -</td>
<td>Joint Symposium: Desirable Men</td>
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<td>11.00am -</td>
<td>HIV/AIDS Conference Theme D: Integrating International and National Policies and Programs</td>
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<tr>
<td>11.00am -</td>
<td>STI point of care tests: Performance and how they are used in developed and developing countries</td>
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<tr>
<td>11.00am -</td>
<td>STI Modelling and Syphilis Modelling</td>
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<tr>
<td>11.00am -</td>
<td>HIV point of care tests: Performance, how they are used in developed and developing countries, regulatory perspective</td>
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<tr>
<td>11.00am -</td>
<td>Implementation of the National Gay Men's Syphilis Action Plan</td>
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<tr>
<td>11.20am -</td>
<td>Alan Whiteside, Director and Professor, Health Economics and HIV/AIDS Research Division (HEARD), University of KwaZulu-Natal, Durban, South Africa</td>
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<tr>
<td>11.20am -</td>
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<td>11.20am -</td>
<td>Implementation of the National Gay Men's Syphilis Action Plan</td>
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<tr>
<td>11.20am -</td>
<td>Mackay T - Integrating bilateral HIV assistance with national development budgeting and planning frameworks</td>
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<tr>
<td>Time</td>
<td>Panel Presentations and Panel Discussion</td>
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<tr>
<td>11.40am -</td>
<td>Joel Palefsky, Professor of Medicine, School of Medicine, University of California, San Francisco, United States of America</td>
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<tr>
<td>12.00pm -</td>
<td>HPV quadrivalent vaccine in prevention of anal dysplasia</td>
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<td>12.20pm -</td>
<td>Discussion</td>
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<tr>
<td>12.30pm -</td>
<td>Lunch in Exhibition and Poster Area, Bayside Grand Hall</td>
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<tr>
<td>12.30pm -</td>
<td>Poster Themes: Clinical and HIV</td>
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<tr>
<td>1.30pm</td>
<td>Ngarra Exhibition, Bayside 103 &amp; 104</td>
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<td>ASHM AGM, Bayside Gallery A</td>
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**Morning Tea in Exhibition and Poster Area, Bayside Grand Hall**

**Ngarra Exhibition, Bayside 103 & 104**

**ASHM AGM, Bayside Gallery A**
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<th>Time</th>
<th>Joint Symposium: Aboriginal and Torres Strait Islander Health</th>
<th>Joint Symposium: Political, Cultural and Logistic Realities of Microbicides for Australasia and the Pacific</th>
<th>HIV/AIDS Conference Theme B Proffered Paper Session: Adherence, Treatment and Workforce Issues</th>
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<td>1.30pm - 1.40pm</td>
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<td>Chairs: Cathy Pell and Peter Patterson</td>
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<td>Chairs: Jim Pickett and Stuart Turville</td>
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<td>1.30pm - 1.48pm</td>
<td>Simon Graham, Research Manager, Aboriginal and Torres Strait Islander Health Program, National Centre in HIV Epidemiology &amp; Clinical Research, NSW, Australia</td>
<td>John Kaldor, National Centre in HIV Epidemiology and Clinical Research, NSW, Australia</td>
<td>Paxton S - Challenges to women’s lifelong access to ARVs</td>
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<td>Trends of Chlamydia and Gonorrhoea in the Aboriginal and Torres Strait Islander Population, 2001-2009</td>
<td>Recent microbicide clinical trials and trials expected to report in the near future</td>
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<td>1.40pm - 1.50pm</td>
<td>Jan Savage, Senior Policy Officer, Australasian Society for HIV Medicine, VIC, Australia</td>
<td>Christopher McConville, Senior Lecturer In Pharmaceutics, Curtin University, WA, Australia</td>
<td>Ankus J - Collaboration for health in Papua New Guinea (CHPNG) - Australasian Society for HIV Medicine (ASHM) clinical mentoring program</td>
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<td>Review of the evidence for the effectiveness and cultural acceptability of sexual and reproductive health programs for Aboriginal Adolescents in NSW</td>
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<td>James Ward, Program Head, Senior Lecturer, Aboriginal and Torres Strait Islander Health Program, National Centre in HIV Epidemiology &amp; Clinical Research, NSW, Australia</td>
<td>Antiretroviral based microbicides and vaginal rings</td>
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<td>Understanding epidemiology of Chlamydia related to Aboriginal and Torres Strait Islander People: First results from the ACCESS network project</td>
<td>2.06pm - 2.18pm</td>
<td>Tran D - Barriers to antiretroviral treatment in the North Vietnam</td>
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<td>2.00pm - 2.10pm</td>
<td>Rebecca Guy, Senior Lecturer, National Centre HIV Epidemiology &amp; Clinical Research, NSW, Australia</td>
<td>Patricia Fagan, Public Health Physician-Sexual Health, Cairns Public Health Unit, QLD, Australia</td>
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<td>A good news story in Aboriginal and Torres Strait Islander health: Is it possible to eliminate syphilis?</td>
<td>Political cultural and logistic realities of microbicides for Australasia and the Pacific - a perspective from the Torres Strait</td>
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<td>2.10pm - 2.20pm</td>
<td>Richard Chenhall, Lecturer, Medical Anthropology, Centre for Health and Society, Melbourne School of Population Health, University of Melbourne, VIC, Australia</td>
<td>&quot;Our lives&quot;: Socio-cultural influences on the sexual health of Indigenous young people</td>
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<td>2.18pm - 2.30pm</td>
<td>Andrew Valley, Associate Professor, National Centre in HIV Epidemiology and Clinical Research, NSW, Australia</td>
<td>The acceptability of vaginal microbicides in Papua New Guinea: results of a qualitative study among men and women attending an STI clinic in Port Moresby</td>
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<td>2.15pm - 2.30pm</td>
<td>Wheeler E - One year on: Interim findings from the &quot;GP mentoring at the time of HIV diagnosis&quot; project</td>
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<td>2.20pm - 2.30pm</td>
<td>David Wilson, Associate Professor, Head, Surveillance and Evaluation Program for Public Health, National Centre in HIV Epidemiology &amp; Clinical Research, NSW, Australia</td>
<td>Using mathematical modelling to predict HIV incident cases among Aboriginal and Torres Strait Islander people who inject drugs</td>
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<td>2.18pm - 2.42pm</td>
<td>Annemaree O’Keefe, AM, Research Fellow, Lowy Institute for International Policy, NSW, Australia</td>
<td>HIV and Microbicides: hindrance or help in addressing gender inequality in the Pacific</td>
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<td>2.30pm - 2.45pm</td>
<td>Taing K - Moving from viral suppression to whole patient care: An audit of the clinical management of HIV positive patients in a Queensland clinic</td>
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<td>2.30pm - 2.40pm</td>
<td>James Ward, Program Head, Senior Lecturer, Aboriginal and Torres Strait Islander Health Program, National Centre in HIV Epidemiology &amp; Clinical Research, NSW, Australia</td>
<td>Trends in newly diagnosed HIV infection in the Aboriginal and Torres Strait Islander and Non-Indigenous populations, 1992 – 2008</td>
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<td>2.42pm - 3.00pm</td>
<td>Panel Discussion: Jim Pickett, Andrew Valley, John Kaldor, Christopher McConville, Trish Fagan and Annemaree O’Keefe</td>
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<td>3.00pm - 3.30pm</td>
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### Sexual Health Conference Closing and Joint Conference Debate

**Bayside Auditorium A**  
**Chairs:** Andrew Grulich and Anne Robertson  

3.30pm - 4.30pm  
Debate: This house believes that STI control should be a priority of HIV prevention programmes

**For:**
- Catriona Bradshaw, Sexual Health Physician, Melbourne Sexual Health Centre, VIC, Australia
- Graham Hart, Head of Research Department, Director, Centre for Sexual Health & HIV Research, University College London, United Kingdom

**Against:**
- Basil Donovan, Professor Sexual Health, Head, Sexual Health Program, National Centre in HIV Epidemiology and Clinical Research, NSW, Australia
- Jim Pickett, Director, AIDS Foundation of Chicago, United States of America

4.30pm - 4.45pm  
Prize Presentations and Closing Remarks by Anne Robertson, President, Australasian Chapter of Sexual Health Medicine

4.45pm - 4.50pm  
ASHHNA Nurse Prize Presentations by Donna Tilley, President, ASHHNA and Clinical Nurse Consultant, Sydney Sexual Health Centre, NSW, Australia

4.50pm - 5.00pm  
Presentation of next year’s conference by Frank Bowden and Sarah Martin, Committee Convenors of the 2011 Australasian Sexual Health Conference Committee

5.15pm - 5.45pm  
ASHHNA Annual Meeting, Bayside 102

7.00pm - 11.00pm  
Sexual Health Conference Dinner ‘Carnivàle Desires’ at Luna Park

6.15pm Ferry Departure from Convention Centre Wharf
Mycoplasma genitalium was first isolated in 1980 from the urethra of two of 13 men with non-gonococcal urethritis (NGU). Nucleic acid amplification tests are currently the only reliable method for detection. Culture is extremely difficult, insensitive, and slow, and diagnostic serology is not available.

M. genitalium is significantly associated with acute NGU in men. The association has been uniformly shown in more than 30 studies. Where the association with non-chlamydial NGU was evaluated, the association has generally been stronger.

In women, M. genitalium has been associated with cervicitis in most published studies, although statistical significance has not been reached in all. Where female urethritis has been studied separately, M. genitalium has been associated.

In pelvic inflammatory disease (PID), M. genitalium has been detected in the endometrium of 60% of those positive in the cervix, and its presence in endometrial biopsies has been strongly associated with histological endometritis and with recurrent PID. Tubal scarring has been indirectly linked with M. genitalium infection by a significantly higher proportion of women with tubal factor infertility having antibodies against the bacterium compared to women with infertility from other causes. Although antibodies against M. genitalium have been found twice as often in younger women with ectopic pregnancy compared to pregnant controls, the difference did not reach statistical difference.

Treatment of M. genitalium infections with tetracyclines is not effective despite apparent in-vitro susceptibility of most strains. Azithromycin in a 5-day course appears to be an efficient treatment in most settings. Macroline resistance, however, is commonly found where azithromycin 1g single dose is used for treatment of Chlamydia trachomatis, and a significant proportion of patients may carry resistant strains. Moxifloxacin is useful where macrolide resistance is demonstrated, whereas ciprofloxacin is clinically ineffective. However, quinolone and macroline resistant strains have already been isolated, leaving very few treatment options.
Chlamydia re-infections increase the risk of chlamydia sequelae and are associated with HIV seroconversion in men who have sex with men (MSM). Clinical guidelines recommend that for all people diagnosed with chlamydia a repeat test is conducted in 3-months to detect chlamydia re-infections. We assessed the frequency and outcomes of the 3-month test for re-infection among patients attending sexual health services in Australia where recommended re-testing intervals range between 4 and 12 weeks.

We calculated the frequency of the 3-month test for re-infection (re-testing in 30-120 days following a positive chlamydia test) and re-infection (repeat infection within 30-120 days of the initial positive test) in heterosexual females <25 years, heterosexual males <25 years and MSM attending 25 sexual health services across Australia between 2004 and 2008. These services are participating in the Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance (ACCESS) system.

In the five-year period, 17,900 heterosexual females <25 years were tested for chlamydia and 3075 (17%) were positive. Just under half (45%) of these females who tested positive were re-tested anytime in the study period with only 16.5% re-tested within 3-months of the initial positive test and 18.1% of re-tests at 3-months were positive. There were 12,188 heterosexual males <25 years tested for chlamydia and 2265 (19%) tests were positive. About one third (35%) of these men who tested positive were re-tested anytime in the study period with 10.8% re-tested within 3-months of the initial positive test and 23.7% of re-tests at 3-months were positive. There were also 13,303 MSM tested for chlamydia and 1,394 (10%) positive tested. Two thirds (67%) of these MSM who tested positive were re-tested anytime, with 7.3% re-tested within 3-months of the initial positive test and 44% of all re-tests at 3-months were positive.

The high chlamydia re-infection rates at 3-months (18-44%) support recommendations that call for a 3-month test for re-infection following a positive test. The low chlamydia re-testing rates at 3-months (7-17%) highlight the need for innovative strategies to increase re-testing rates following a positive chlamydia test.

Chlamydia notifications in Australia have increased by 52% in females and 55% in males between 2004 and 2008 but trends in diagnoses depend very strongly on the amount of chlamydia testing. Calculation of chlamydia positivity at sentinel clinical sites can allow a more nuanced interpretation of trends after controlling for testing biases. This paper presents the first data on young heterosexuals from sexual health service network of the newly established Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance (ACCESS) system.

ACCESS was established in 2008 to collate demographic and chlamydia testing information from 25 sexual health services. We calculated the proportion tested and chlamydia positivity and assessed trends from 2004-2008 among 16-29 year old heterosexuals (young heterosexuals) using a Chi-square test and predictors using logistic regression.

During the 5-year period, 45,597 young heterosexuals attended these services for the first time. Chlamydia positivity increased significantly among young heterosexual females by 25% from 2004 to 2008, from 10.2% to 12.3% (p<0.01) but no significant increase was observed in young heterosexual males (p=0.74). Independent predictors of chlamydia positivity in young heterosexual females were; being aged 15-19 years (adjusted odds ratio[AOR]=1.36, 95% confidence interval [CI]=1.35-1.84), being Aboriginal and/or Torres Strait Islander (AOR=1.50, 95%CI=1.21-1.86), residing in a regional/remote area (AOR=1.18, 95%CI=1.05-1.34), being a traveller or migrant (AOR=1.25, 95%CI=1.03-1.52) and being Australian-born (AOR=1.23, 95%CI=1.03-1.46). Independent predictors of chlamydia positivity in young heterosexual males were; being aged 20-24 years (AOR=1.44, 95%CI=1.26-1.65), being Aboriginal and/or Torres Strait Islander (AOR=1.50, 95%CI=1.21-1.86), residing in a regional/remote area (AOR=1.18, 95%CI=1.05-1.34), being a traveller or migrant (AOR=1.25, 95%CI=1.03-1.52) and being Australian-born (AOR=1.23, 95%CI=1.03-1.46). Independent predictors of chlamydia positivity in young heterosexual males were; being aged 20-24 years (AOR=1.36, 95%CI=1.20-1.53), being Aboriginal and/or Torres Strait Islander (AOR=1.32, 95%CI=1.03-1.69), and residing in a regional/remote area (AOR=1.32, 95%CI=1.05-1.37).

Our analysis showed the rising trend in chlamydia positivity among young women was lower than the rise in rates seen in population-based notifications. In contrast to population-based notification data, chlamydia positivity in men was not increasing. This highlights the caution necessary in interpreting chlamydia trends without population denominators and testing data.
Chlamydia is the most frequently reported notifiable infection in Australia and diagnoses have nearly doubled from 32,506 in 2005 to 62,693 in 2009 with 82% of diagnoses among 15-29 year olds. Australian clinical guidelines recommend chlamydia testing for all sexually active young people. We analysed chlamydia testing rates and predictors among young people attending general practice clinics across Australia, based on a recently established chlamydia surveillance system.

The Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance (ACCESS), was established in 2008 to collate demographic and chlamydia testing information from 25 general practice clinics. We calculated testing rates in 16-29 year olds at the patient and general practitioner (GP) level. The GP testing rate was weighted by the number of consultations and tests. We also determined predictors of testing at the patient and GP level using multivariate regression. All analyses focused on unique patients.

In 2008-2009, 50892 16-29 year olds attended the clinics and 9.2% were tested for chlamydia (11.1% in females, 6.7% in males). Independent predictors of being tested for chlamydia were being female (Adjusted odds ratio [AOR]:1.56,95% confidence interval [CI]:1.46-1.67), being aged 20-24 years (AOR=1.38,95%CI:1.27-1.49) and 25-29 years old (AOR=1.21,95%CI:1.12-1.31) compared to age 16-19, and seeing a female GP (AOR=1.69,95%CI:1.58-1.81) compared to a male GP. Of the 250 GPs at the participating practices, the weighted average GP testing rate was 2.3% (range per GP: 0%-42%). Independent predictors of GP testing above the median testing rate were being a female GP (AOR=3.83,95%CI:1.98-7.41) and a GP level chlamydia positivity of 3% or more among patients tested (AOR=2.85,95%CI:1.55-5.23) compared to less than 3%.

Our results show that chlamydia testing rates in young adults remain low in participating general practice clinics and there is diversity in the likelihood of testing at the patient and GP level. Improved strategies are needed to encourage more chlamydia testing among young people and these strategies will need to address the variation in testing practices across patients and GPs.
PAPER NUMBER: 604
PREVALENCE AND PREDICTORS OF CHLAMYDIA CO-INFECTION AMONG GONORROEA-INFECTED PATIENTS ATTENDING A METROPOLITAN SEXUAL HEALTH CLINIC

Templeton DJ1,2, Manokaran N1, O’Connor CC1,2
1 RPA Sexual Health, Royal Prince Alfred Hospital, Sydney, Australia
2 National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney, Australia
3 South Western Clinical School, The University of New South Wales, Sydney, Australia
4 Melbourne, Australia
5 Melbourne, Australia
6 Sydney Hospital, Sydney, Australia and Sydney Sexual Health Centre, New South Wales, Australia

Introduction: Anogenital gonorrhoea is commonly diagnosed at the initial sexual health clinic visit by on-site microscopy. Whether to add anti-chlamydial therapy in such situations is unclear.

Methods: The medical records of all patients diagnosed with gonorrhoea between May 2005 and April 2010 were reviewed. Demographic and risk behaviour data were analysed by logistic regression to identify prevalence and predictors of gonorrhoea/chlamydia co-infection.

Results: 212 episodes of gonorrhoea were diagnosed among 189 individuals during the study period. Most (79.2%) gonococcal infections occurred in men who have sex with men (MSM). Of all patients diagnosed with gonorrhoea, 30 (14.2%, 95% CI 9.8%-19.6%) had chlamydia co-infection. Of 165 patients with anogenital gonorrhoea, 27 (16.4%, 95% CI 11.1-22.9%) were co-infected with chlamydia. Genital gonorrhoea was diagnosed by gram stain in 68 of 74 (91.9%) symptomatic patients. There was no difference in symptomatic presentation between those infected with gonorrhoea only and those co-infected with chlamydia at genital (p=0.37) or anal (p=0.91) sites. Compared to those only infected with gonorrhoea, there was no correlation of gonorrhoea/chlamydia co-infection with age (p-trend=0.50), gender (p=0.50), sexual orientation (p=0.95), past history of gonorrhoea (p=0.35) or chlamydia (p=0.79) or being HIV-positive (p=0.72). Nor was there an association with injecting drug use (p=0.79), sex work (p=0.40), being a client of a sex worker (p=0.74) or overseas sexual contact (p=0.51) within the previous 12 months. Subanalyses also failed to identify any significant predictors among men, women, MSM, or among those with anal gonorrhoea alone, genital gonorrhoea alone, or gram-stain-diagnosed anogenital gonorrhoea.

Conclusion: Over one in six sexual health clinic attendees diagnosed with anogenital gonorrhoea had chlamydial co-infection. No predictors of co-infection were identified. Anti-chlamydial therapy should be considered for all patients with gram-stain-diagnosed anogenital gonorrhoea at the initial clinic visit.

PAPER NUMBER: 374
CHLAMYDIA TRACHOMATIS GENOTYPES BASED ON CLINICAL SAMPLES COLLECTED FROM MEN WHO HAVE SEX WITH MEN IN MELBOURNE AND SYDNEY

Twin J1,2, Moore EE1,2, Garland SM2,3, Stevens MP1,2, Fairley CK4, Donovan B5, Rawlinson W6, Tabrizi SN1,2
1 Department of Microbiology and Infectious Diseases, The Royal Women’s Hospital, Melbourne, Australia
2 Murdoch Children’s Research Institute, Melbourne, Australia
3 Department of Obstetrics and Gynaecology, University of Melbourne, Australia
4 Melbourne Sexual Health Centre, Melbourne, Australia
5 National Centre in HIV Epidemiology and Clinical Research, University of New South Wales, and Sydney Sexual Health Centre, Sydney Hospital, Sydney, Australia
6 Virology Division, SEALS Microbiology, Prince of Wales Hospital, Sydney, Australia

Chlamydia trachomatis is a common bacterial sexually transmitted infection (STI) in men who have sex with men (MSM), although little is known about its distribution in Australian MSM communities. From 2004 to 2008, 612 consecutive C. trachomatis positive anal swab and urine samples were collected for genotyping and quantification from MSM attending two sexual health centres (Melbourne and Sydney). The most common serovars detected were D (35.2%), G (32.7%) and J (17.7%), although these distributions varied by year and city. 2.8% of C. trachomatis infections involved more than one serovar and only one LGV isolate (L2b) was detected. The majority of serovar strains showed an identical omp1 genotype (7.5% showing genotypic variability). Serovar G infections were not associated with overseas sexual activity (OR: 0.52, 95% CI: 0.32-0.85); individuals with serovar J were less likely to have had a prior C. trachomatis infection (OR: 0.50, 95% CI: 0.26-0.95); and those with serovar E were more likely to have had a prior infection (OR 2.32, 95% CI: 1.19-4.52). Symptoms were present in 68% of urethral infections and 28% anal infections (p<0.001); there was no correlation between C. trachomatis serovar or copy numbers (1.48x104 cells/anal swab and 3.72x103 cells/ml in urine samples). Presence of symptoms was associated with gonorrhoeal co-infection (OR: 3.52, 95% CI: 2.00-6.17), prior C. trachomatis infection (OR: 1.91, 95% CI: 1.19-3.07) and increasing age (18-25 years = reference, 26-30 years OR: 1.52, 95% CI: 0.92-2.51; 31-35 years OR: 1.89, 95% CI: 1.08-3.30, 36-40 years OR: 1.92, 95% CI: 1.08-3.40; 40+ years OR: 3.11, 95% CI: 1.64-5.91).

This is the largest study of C. trachomatis serovars in MSM; it is the first to report C. trachomatis rectal loads in MSM, and provides an overview on C. trachomatis serovars and genotypic variants that circulate in Australian MSM communities.
Gonorrhoea is prevalent among men who have sex with men (MSM) in Australia and enhances the transmission of HIV between men. Culture is currently being used for the diagnosis of gonorrhoea. This study aimed to determine whether nucleic acid amplification tests (NAATs) increases the sensitivity of screening for gonorrhoea at extra-genital sites compared to culture. MSM attending the Melbourne Sexual Health Centre between January 2010 and March 2009 were screened for gonorrhoea from the pharynx and rectum using modified Thayer Martin medium. After inoculation onto culture media swabs were also tested using opa and porA pseudogene -based real time PCR and quantitated by comparison to quantitated standards. 1011 rectal and 1076 pharyngeal specimens were obtained from 1076 MSM. All specimens underwent testing using culture and PCR. 48 rectal specimens were NAAT positive: 28 were also culture positive (sensitivity 58%, 95%CI: 44%-71%) while 20 were culture negative (p=0.00003). 41 pharyngeal specimens were NAAT positive: 16 were culture positive (sensitivity 39%, 95%CI: 25%-54%) while 25 were culture negative (p=0.000006). A low bacterial load of gonorrhoea was associated with negative culture (p=0.02). This association was significant with rectal infection (p=0.005) and approached significance with pharyngeal infection (p=0.073). The sensitivity of culture for gonorrhoea at the pharynx and rectum is poor and is likely to miss lower bacterial load infections.

Azithromycin is the recommended first-line therapy for asymptomatic rectal chlamydia in Australia. However a recent European study reported significant numbers of treatment failures, with higher failure rates in HIV positive men. In 2009, the Sydney Sexual Health Centre instituted a 6-week re-test policy for all cases of asymptomatic rectal chlamydia to assess the extent of azithromycin treatment failures.

We conducted a retrospective audit of all men who have sex with men (MSM) diagnosed with rectal chlamydia in 2009. We then categorised the infections present at re-testing as probable re-infections (patient reported ongoing sexual activity with an untreated partner) or possible treatment failures (no behavioural information reported to suggest re-infection).

In the 12-month period there were 116 asymptomatic MSM treated for rectal chlamydia with 1 gram azithromycin as a single dose. Twenty-two (19%) of the men were HIV positive. The median age was 34 years (interquartile range 28-39 years) and 78 (67%) returned for a re-test at a median time of 10 weeks (73 days, range 21–372 days with 25 (36%) testing more than 15 weeks after their treatment. Nine men (12%) were still positive – median time for these to re-test was 11 weeks (77 days, range 47-96 days). Of the nine; five were classified as probable re-infection and four as possible treatment failures. None of the men classified as possible treatment failures were HIV positive.

Interpreted conservatively, the azithromycin treatment failure rate could have been as high as 12% in our study. However most of these cases could be explained by re-infection suggesting an actual treatment failure rate of 5%. This finding suggests that azithromycin is still an effective first-line therapy for asymptomatic rectal chlamydia in MSM in Australia, but further studies would be welcome.
PAPER NUMBER: 630
PARTNER NOTIFICATION IN THE 21ST CENTURY – HOW DO PEOPLE REALLY DO IT?

Knight V1, Ryder N2,3, Kenigsberg A1, Hanlon M1, Bourne C1,4, McNulty A1,4

1. Sydney Sexual Health Centre, South East Sydney and Illawarra Area Health, Sydney Australia.
2. Sexual Health and Blood Borne Virus Unit, Department of Health and Families, Darwin Australia.
3. NSW STI Programs Unit, Sydney Australia. 4. School of Public Health and Community Medicine University of NSW, Kensington, Australia.

There is limited information about the specific methods people diagnosed with an sexually transmitted infection (STI) use when notifying their partners. Sydney Sexual Health Centre (SSHC) staff routinely telephone clients diagnosed with a bacterial STI one week following treatment to offer advice and assistance with patient-referral partner notification (PN). This project aimed to investigate the specific methods used by clients when notifying their partners and associated characteristics.

All patients diagnosed with a bacterial STI between 8th March and 31st May 2010, who provided telephone contact details and agreed to be telephoned were contacted 1 week after their diagnosis. The number of contacts the patient nominated at the treatment visit, number actually notified, the method used and any knowledge of action by the contact was recorded. Predictors of using a non-face to face method were determined using logistic regression.

167 index cases were contacted who reported 464 identifiable sexual contacts (median 2 per case) of which 437 (94%) were successfully contacted. The contact methods used were face-to-face 99 (21%), telephone 177 (41%), SMS 66 (15%), email 47 (11%), internet 48 (11%). A non face-to-face method was used for at least one contact by 106 (63%) of the index cases. Only 4 (4%) of the contacts notified face-to-face were given a "contact slip" by the index case. Non face-to-face methods were more likely to be used by index cases reporting a greater number of contacts (adjusted OR 5.3, 95% CI 2.6-10.8). Further analysis of the data will include age, STI and gender of sexual partners.

Telephone and electronic communications are the most common means of patient-referral partner notification at SSHC, and very few people used “contact slips”. As the provision of information to sexual contacts has been shown to reduce reinfection rates, new methods of electronically disseminating this information need to be explored.

PAPER NUMBER: 84
HIV RELATED KNOWLEDGE, ATTITUDES, PRACTICES AND SEXUAL BEHAVIOURS AMONG AFRICAN MIGRANTS AND REFUGEES IN CHRISTCHURCH

Birukila G1

1. Department of Public Health, University of Otago Christchurch, New Zealand.

Background: Africans from Sub-Saharan Africa are the second largest ethnic group affected by HIV/AIDS in New Zealand. Despite their higher HIV prevalence, there is no baseline data on their HIV related knowledge, attitudes, sexual behaviours and practices. This study seeks to fulfil this need.

Methods: A cross sectional survey and focus group discussions of sub-Saharan African migrants and refugees living in Christchurch were carried out. Trained, African community researchers recruited study participants in a variety of community venues and events. An anonymous self-completed questionnaire collected data on demographic characteristics, utilization of sexual health services, HIV testing history, sexual behaviour and attitudes.

Results: A total of 250 participants - 155 men and 95 women were recruited with an average age was 28.3yr and 27.6yr respectively. 66% of men and 80% of women reported ever having an HIV test; 16% of men and 8% a diagnosed sexually transmitted infection. Condoms were not used during the last sexual intercourse for 41.2% of men and 51.3% and 78% of men and 85% of women stated that they were not at risk of getting HIV. In addition, 14% of men and 7% of women reported having more than one sexual partner in the past year. HIV testing was significantly associated with time in New Zealand.

Conclusion: Findings in this study suggest that Africans in Christchurch had low perception of HIV risk, low condom use and reported multiple sexual partners. Health promotion activities need to consider such issues when addressing the issue of HIV risk among Africans.
Introduction: Previous studies have examined sex workers' attitudes to work but not their levels of job satisfaction compared to other occupations.

Aims: The aim of this study was to examine the characteristics and job satisfaction of a sample of female sex workers working in licensed brothels in Victoria and compare them to Australian women.

Methods: A structured survey was undertaken between July and August 2009 with sex workers working in licensed brothels in Victoria. Sex workers attending a sexual health service were approached to complete a questionnaire that included questions about sex work and their most likely alternative job. Survey data was compared with identical questions from the Households, Income and Labour Dynamics in Australia (HILDA) Survey.

Results: Of the 112 sex workers who agreed to participate in the study, 85 (76%) completed the survey. The median number of years women had been working as sex workers was three [range 0.1-18]. The main reasons women started sex work was because “they needed the money” (69%) were attracted to the flexible hours (44%) or had a particular goal in mind (43%). The two biggest concerns women had about sex work were their safety (65%) and the risk of sexually transmitted infections (STIs) (65%). When compared to the median job satisfaction scores of Australian women working in sex workers’ most likely alternative jobs, 43% of sex workers reported a higher median satisfaction score for sex work in relation to total pay, 50% in relation to hours worked and 47% in relation to flexibility, 26% in relation to job security, 19% in relation to the work itself and 25% in relation to overall job satisfaction.

Conclusions: Women primarily do sex work for financial gain although a significant minority prefer it to other work they would be likely to do.

Sex workers are a priority population in the Australian and NSW Sexual Health Strategies. However, over the last decade, rates of STIs in this group have been low, and condom use for vaginal sex has been high. Anecdotally sex workers were increasingly reporting unprotected fellatio with clients and this had coincided with a local increase in notifications of gonorrhoea in women. The aim of this retrospective study was to investigate condom use for fellatio at work.

From May 2009 to April 2010, 1023 female sex workers reporting fellatio were seen at the Sydney Sexual Health Centre. All sex workers have pharyngeal gonorrhoea cultures collected as part of sexual health screening. We extracted demographic, risk behaviour and STI diagnoses from our clinic database. 533 sex workers (52%) were new to the clinic. Only 225 (22%) spoke English as a first language, 316 (31%) spoke Thai, 250 (24%) spoke Mandarin/Cantonese, 156 (15%) spoke Korean and 76 (8%) spoke other languages. The median age was 29 years.

New sex workers reported consistently using condoms for fellatio at work less often (66%) than sex workers attending on subsequent occasions (84%, p<0.001). Mandarin/Cantonese speakers were significantly less likely to use condoms consistently (62%) than Thai (86%) or English-speaking sex workers (77%, p=0.04). 12 sex workers were diagnosed with pharyngeal gonorrhoea, and half were Mandarin/Cantonese speakers.

Interventions to promote condoms for fellatio by sex workers are needed. Further research into the determinants of this behaviour is due.
Monday 18 October
1.30pm - 3.00pm: Proffered Paper Session: Sharing Desire

PAPER NUMBER: 574
USING SOCIAL NETWORK ANALYSIS TO LOCATE RISKY SEXUAL PRACTICES IN THE GAY COMMUNITY.

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The gay community is an ever-evolving constellation of venues, events, websites and locales that enable and are defined by social relations among gay men. As such, they are extremely complex and demonstrate a high degree of inter-relatedness which challenges simplistic notions that men who engage in sexual risk can be reached through a small number of easily identified venues. Conversely, that inter-relatedness offers the opportunity to reach those same men by forming an understanding of their patterns of engagement with the gay community and tailoring interventions suited to those modes of engagement.

In a world first, we applied two-mode, or affiliation, social network methods to map a gay community. Using a mixture of online and offline survey methods we interviewed gay men about the venues, events, websites and locales (hereafter sites) they used; their frequency of use of each site; any whether they engaged with each of the sites of any of these reasons: medical; political; social; recreational; romantic; sexual; support; and volunteer/work. We also collected socio-demographic data from the men along with a brief behavioural profile.

Complete data were obtained from 920 men who identified 459 specific sites. Men named an average of 8.4 sites (range 0-39) and sites were named an average of 34.4 times by an average of 17.1 men. Men reported between 0 and 11+ casual partners for unprotected anal sex in the previous year. Not surprisingly, the number of sites access for sexual purposes was strongly associated with the reported number of casual partners for unprotected sex. However, there were also associations between the number of those partners and patterns of medical, romantic and political engagement with the gay community.

Social network analysis offers unique insights into the structure of gay communities and the complex nature of men's engagement with those communities. This offers new opportunities for intervention.

PAPER NUMBER: 547
THE WOMEN ON WOMEN’S (WSW) HEALTH STUDY. BEHAVIOURAL FACTORS ASSOCIATED WITH BACTERIAL VAGINOSIS (BV) IN WOMEN WHO HAVE SEX WITH WOMEN (WSW)

Fethers KA1,2, Fairley CK1,2, Garland SM1,4, Walker S1, Hocking JS1, Chen MY1,2, Fehler G2, Bradshaw CS1,2,5

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5 Department of Epidemiology and Preventive Medicine, Monash University, Melbourne

WSW have higher rates of BV than exclusively heterosexual women; however the reasons for this, the cause of BV and whether it is sexually transmitted are unknown. We are conducting a national BV prevalence and incidence study in 500 WSW to determine the behavioural and microbiological factors associated with prevalent and incident BV.

WSW are recruited using internet, festival and media-based promotion. Postal study-kits containing information and consent forms, questionnaires, swabs and slides are sent to participants. Information regarding demographics and a broad-range of sexual practices are collected by on-line questionnaire through the study website (www.wowhealth.org.au). Gram-stained self-collected vaginal smears are returned by post and scored by the Nugent method. Women who are postmenopausal, pregnant or with a past history of BV are not eligible.

150 participants were enrolled between March-May 2010; 98 have completed the cross-sectional study and 70 have entered the cohort-study. Interim-unadjusted cross-sectional analysis shows a median age of participants of 31 years (range 19-49) and a BV prevalence of 29% (95% CI 20-38). Women with > 10 lifetime female sexual partners (FSPs) and 5-9 FSPs had increased odds of prevalent-BV compared to women with <5 FSPs, OR=5.1 (95% CI 1.5-17.6) and OR=2.3 (95%CI 0.7-7.3), respectively, p for trend=0.01. Smoking was significantly associated with prevalent-BV (OR 2.7 (95%CI 1.1-6.8), p=0.04), but numbers of male partners and age were not associated with prevalent-BV. Of the 22 female-female couples in the cross-sectional study, 19 (86%) were concordant for BV presence/absence.

Interim analysis indicates prevalent BV is strongly associated with increasing numbers of FSPs, but not male partners, and vaginal flora is highly concordant within female couples. Comprehensive cross-sectional and preliminary cohort data will be available for presentation. This study will advance our understanding of the aetiology and transmissibility of BV between women.
Introduction: A cluster of cases of rare vulvar cancer has been identified in young Aboriginal women living in the Arnhem Land region of the Northern Territory. The objective of this study was to assess the population prevalence of oncogenic HPV in the affected region to determine whether a higher HPV prevalence is responsible for the very high disease incidence.

Methods: A prospective cross-sectional survey of HPV infection was undertaken amongst 562 Aboriginal women living in remote communities in the Arnhem Land region. Women were consented for vulvo-vaginal, peri-anal and endocervical HPV genotyping collected by separate vulvo-vaginal and perianal sweep swabs and a PreservCyt endocervical sample collected during Pap screening. HPV DNA testing was undertaken using PCR with broad spectrum L1 consensus PGMY09/11 primers with genotyping of positive samples by Roche Linear Array.

Results: The overall rate of high-risk HPV positivity was 40% in the vulvo-vaginal-perianal (VVP) samples and 26% in cervical samples. Multiple high-risk HPV types were detected in 16.9% of VVP samples, and 6.5% of cervical samples. HPV 16 was the most common genotype on both sites (16.9% in VVP samples, 6.5% in cervical samples).

Conclusion: The overall cervical high-risk HPV positivity rate found in this study is similar to the rate found in the Women's HPV prevalence Indigenous Non-Indigenous Urban Rural Study, the largest Australian survey of HPV genotype prevalence in women. These findings suggest that excess prevalence of high-risk HPV may not be the key causal factor in this geographic cluster of vulvar cancer. Future research exploring other factors including genetic susceptibility to this disease is planned.
An online survey was conducted among men (N=247) aged 16 to 25 years who are living, studying and working in rural Australia. Majority (81%, n=200) were sexually active, 50% (n=123) had penetrative sex before the age of 16. Only 31% used condom every time they had penetrative sex in the last 12 months. Participants dislike of condoms (39%) or uses of another contraceptive (53%) by their partners were the main reasons for not using condoms. Although knowledge of STIs was reasonably good, a small proportion of participants were aware of the legal age for sexual activities (23%), age to give consent for medical treatment (33%) and age to have own Medicare Card (33%). Many participants (71%) were aware they had the same right to confidentiality and privacy as adults.

Although general practitioners (77%) and community health nurses (51%) were considered the most trusted source of advice on sexual health matters, only 39% consulted a GP and 12% consulted a community health nurse for advice on sexual health. GPs were the preferred health provider (n=123, 78%) in the last 12 months; however only 28% (n=63) of participants had discussed sex and STIs and 22% (n=51) were tested for STIs. Of those who had an STI test, 49% (n=25) were tested by their usual GP, 25% (n=13) by another GP. Participants’ reasons for getting tested for STIs were due to unprotected sex (41%), partners /friends advice (27%), burning sensation during urination (18%), discharge and lump (10%). Tests as a result of GPs’ advice (6%) were surprising low.

We conclude that the proportion of young men receiving sexual health services is low, although they are at risk of STIs. GPs and community health nurses should take the initiative to test for STIs opportunistically while serving young men, particularly in rural Australia.

The highest gonorrhoea notification rates in Western Australia (WA) have historically occurred among Aboriginal people living in remote areas. The aim of this paper is to describe trends in gonorrhoea notifications and testing in WA from 2000 to 2009.

Demographic data were extracted from the WA Notifiable Infectious Diseases Database and behavioural risk factor data were extracted from the enhanced gonorrhoea surveillance database. Data from major pathology laboratories on the number of gonorrhoea tests conducted in the remote area were available from 2004.

The gonorrhoea rate increased by 20% from 2000 (69.2/100,000 population) to 2007 (82.9/100,000 population). In this time period, the average Aboriginal:non-Aboriginal rate ratio was 79:1 and the average remote area:metropolitan area rate ratio was 26:1.

The gonorrhoea rate decreased by 22% from 2008 (77.5/100,000 population) to 2009 (60.5/100,000 population) and was 22% lower than the previous five-year average rate of 77.8/100,000 population. In this time period, the Aboriginal:non-Aboriginal rate ratio decreased by 36% to 50.2:1 and the remote area:metropolitan area rate ratio decreased by 16% to 21.7:1. The gender and age distributions of gonorrhoea remained stable, with the majority of notifications occurring in males (58%) and people aged 15 to 24 years (52%).

The rate of gonorrhoea testing conducted in the remote area decreased by 2% from 2008 (10,160/100,000 population) to 2009 (9,976/100,000 population) but was 3% higher than the previous 5-year average rate (9,646/100,000 population). As the rate of gonorrhoea testing in the remote area has remained stable, the decrease in gonorrhoea appears to be real.

There has been a decrease in the rate of gonorrhoea notifications among Aboriginal people in remote areas of WA which is likely to be real. Prevention and control strategies must be maintained to sustain this decrease and achieve further decreases.
For over a decade high rates of sexually transmitted infections (STIs) have been reported from remote Aboriginal communities in Central Australia (CA). Untreated or inadequately treated gonorrhoea and chlamydia can lead to pelvic inflammatory disease (PID) that is associated with adverse reproductive outcomes. Anecdotal evidence has suggested that signs and symptoms (S&S) of PID are unrecognised by health care providers and misdiagnosis as a urinary tract infection (UTI) is common. Despite this there has been limited investigation of PID in this population. Here we report a review of the management of lower abdominal pain (LAP) and PID diagnosis in five remote Aboriginal communities in CA.

We reviewed the medical records of 686 women of reproductive age to identify clinical presentations with S&S consistent with PID and/or UTI during 2007-08. Clinical management was assessed against local guidelines and any information on STI history was extracted.

Based on the available records, 160 (23%) women had S&S of PID and/or UTI. LAP was recorded in 70% (n=114) of presentations and S&S of PID alone in 43% (n=148). Despite this PID was diagnosed in only 11% (n=39). Our findings indicate some confusion in interpreting S&S and making a diagnosis of UTI, STI and/or PID, and that the majority of presentations with S&S consistent with PID are not being assessed, diagnosed or treated in accordance with PID management guidelines.

When a PID diagnosis is missed, the reproductive health of the woman is at risk. This study has identified clear recommendations for health service policy and clinical practice and also identified research gaps that can improve the understanding of the sexual health of Aboriginal women in remote Australia.

**Trichomonas vaginalis** infection is rare in Australia’s major cities but very common in some remote Aboriginal communities. There are currently few data from other regional and remote areas of Australia, and none describing the associations of infection in a large, geographically diverse sample of women. We describe associations of infection among women presenting to sexual health outreach clinics of Greater West Area Health Service (GWAHS) in rural and remote NSW.

All women undergoing sexual health screening at any of the 13 outreach sexual health clinics are routinely tested for **Trichomonas vaginalis** using an in house PCR. Demographic and behavioural data was extracted from the data base or medical records. Remoteness was determined by the client’s postcode of residency using the Australian Accessibility/Remoteness Index.

From March to December 2009 266 individual women attended and 193 (73%) were tested. The prevalence of **Trichomonas vaginalis** was 11% (95% confidence interval 7.2-16%).

**Trichomonas vaginalis** infection was significantly associated with increasing remoteness (p trend <0.001). There was a non-significant increase among Aboriginal women, younger women and women who had never had a past Papaniculaou smear. As Aboriginal women were more likely to live in remote areas than non-Aboriginal women (p = <0.001), we conducted an analysis stratified by Aboriginality, and found a trend to toward increasing prevalence among women living remotely in both groups, suggesting remoteness to be an independent predictor of infection. Following the collection of additional data we plan to use logistic regression to determine the effect of remoteness, controlling for Aboriginality, symptoms, age and injecting drug use.

Our data suggests the increased prevalence of **Trichomonas vaginalis** infection in remote Aboriginal communities has more to do with remoteness than Aboriginality. Strategies aimed at reducing the prevalence of this infection should increase access to sexual health care for all people living in remote areas.
The paper will review available evidence on the state-of-affairs relating to the male sex industry. In particular, we highlight two important and interrelated developments: trends in safe sex interactions and ‘barebacking’ (the phenomenon of deliberate unsafe sex); and the impact communications technologies, such as the internet and mobile telephone, on the male sex industry. In particular, we are interested in how these developments have impacted on the socio-legal status of the male sex industry and the health and safety of sex workers and clients. Public health and socio-legal implications will be discussed. The review will present Australian as well as data from both developed and developing countries on the male sex industry over the past decade.
Background: Substantial evidence supports the role of environmental and contextual factors in influencing risk and protective behaviours among injecting drug users and sex workers, particularly those who are street-based. Indeed, street-based injecting and street-based sex work are not mutually exclusive and the environments in which they are located are often socially and spatially contiguous. This paper identifies synergies between injecting and sexual risk in street-based environments and explores implications for interventions designed to reduce harm and create safer environments.

Methods: Ethnographic fieldwork and in-depth interviews in three Sydney neighbourhoods characterised by street-based sex and drug markets were conducted between 1998 and 2008. Observations recorded as field notes and audio-recorded in-depth interviews were conducted with participants involved in sex work and injecting drug use. A grounded theory approach was used to code and compare content and identify key themes.

Results: Results suggest that synergisms between street sex and drug markets increase the harms associated with sex work by shaping income generating practices in ways that promote unsafe sex and unsafe drug use. Findings also illustrate how spatial features of street sex and drug markets, and the location of harm reduction services, interact to shape risk and protective practices. Aggressive policing creates environments characterised by uncertainty and risk and may result in secondary harms by displacing sex workers who use drugs to isolated public spaces. Injecting drug use acts as a driver of informalisation and the under-development of occupational norms, compounding the marginalisation of sex workers who inject and impeding collaboration and community development.

Conclusions: Findings indicate a need for interventions, supported by legal and policy reforms, that attempt to reduce the environmental risks of street-based sex work.
REFUGEE POPULATIONS AND SEXUAL HEALTH

Benson J

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STRUCTURAL AND CULTURAL ISSUES ASSOCIATED WITH HIV RISK AND PROTECTION AMONG PEOPLE FROM CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) BACKGROUNDS

Korner H

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Recent surveys have demonstrated that female sexual dysfunction is common, with rates of between 40% and 70% of women reporting some episodes of sexual dysfunction. The commonest sexual dysfunction for women is lack of interest in sex, or Hypoactive Sexual desire Disorder (HSDD). The impact of HSDD on women’s wellbeing may be significant, and will be explored further.

The management of these problems has traditionally focused on an individual biopsychosocial approach for each woman as the nature of the problem varies from one individual to another. It is important to consider contextual factors, including the quality of the relationship, past sexuality, and other mental and physical health comorbidities. Careful exploration with women of ways of improving their sense of sensuality and sexuality are an important component of the clinical session.

However, there is an increasing place for medical management of this condition. Health practitioners working in this area will need to exclude any underlying medical conditions with a good clinical history, examination as indicated, and the use of appropriate tests. If there is no underlying pathology, the use of hormonal and other medications may be indicated. These and other possible future options will be considered.

In summary, the management of female sexual dysfunction requires an individual approach from a holistic viewpoint. However, the increasing medicalisation of HSDD means there is a concomitant increase in the need for health practitioners to be aware of current and future treatment options.

Pain is a common presenting symptom of vulval disorders. It may variously be described as discomfort, burning, stinging, stabbing, and the word chosen may give a clue to the cause. Pain may be a manifestation of infectious diseases, referred pain from musculoskeletal or pelvic structures, or a neuropathy.

This presentation will deal with pain caused by dermatological conditions of the vulva.

Pain due to fissures or excoriations may be a secondary manifestation of many common vulval inflammatory conditions such as eczema, psoriasis, lichen sclerosus and chronic candidiasis.

Vulval pain may be a primary symptom arising from vulval dermatoses which present as erosions, ulcers and rarely, blisters. These conditions include lichen planus, desquamative inflammatory vaginitis, aphthous ulcers, drug eruptions, Behcet’s disease, Crohn’s disease and immunobullous disorders such as pemphigus and mucous membrane pemphigoid.

Clinical features, investigations and approach to management will be discussed.
Are sexual difficulties such as lack of interest in sex or difficulty with arousal or orgasm just part of normal life, or are they medical conditions that warrant treatment?

We draw on data from a national representative-sample survey, the Australian Longitudinal Study of Health and Relationships, on the prevalence, incidence and recurrence of sexual difficulties over a year ascertained by answers to single-item questions about aspects of sexual experience and performance. Over 4000 men and women aged 20–64 years in heterosexual relationships form the cohort examined.

Upon recruitment, 34% of men and 66% of women reported experiencing one or more sexual difficulties for at least a month in the previous year, such as trouble maintaining an erection or taking too long to reach orgasm. Of people who reported a difficulty, about 62% regarded it as only a minor problem or not a problem at all; only 26% had sought help. At 12-month follow-up, 21% of men and 36% of women reported developing a new sexual difficulty, with the highest incident difficulties being a lack of sexual interest (men 11% and women 26%) and for women taking too long to reach orgasm (11%) and for men reaching orgasm too quickly (7%). In addition, 51% of men and 68% of women with ≥1 sexual difficulties at recruitment reported having ≥1 of these recur or persist a year later.

Clearly many people are not distressed by things that might be regarded by others as impediments to pleasurable sex, and even people who do find them a problem do not necessarily expect medical care or counselling to help them. These findings are considered in the light of the process of illness-making that ensures pharmaceutical companies have willing prescribers and a market among consumers when a new drug is released.
‘WHEN YOUNG HEARTS FLUTTER’: PRACTICES OF DESIRE AND CARE OF THE SELF IN ADOLESCENCE

Hillier L.
Australian Research Centre in Sex, Health and Society, La Trobe University, VIC, Australia

THE EVIDENCE BEHIND WHY SEX EDUCATION IMPROVES SEXUAL HEALTH OUTCOMES

Kirby D
ETR Associates Program Division, California, USA
Surveys show that people are better informed about HIV than about other sexually transmissible infections, chlamydia included. Many are not aware that chlamydia can affect one's fertility, or that men can catch it. This presentation draws on data from national and state-wide surveys of adults, secondary school students, prisoners, gay men and lesbians. It then looks at in-depth studies of understandings of sexual transmission of infections and explores some non-rational notions of contagion and ‘cleanliness’ that are widely held despite scientific education and the availability of information about chlamydia in health campaigns and the popular media.

The presenters will give an overview of peer education in a youth health setting and discuss the Summer Survival program run by Shire Wide Youth Services for the past 15 years in the Sutherland Shire, Sydney. The presentation will include a description of the approaches used in sexual health and drug and alcohol peer education and the outcomes of the program, including how it has been replicated in other parts of South Eastern Sydney.

The presentation will also provide a summary of the findings and analysis of the Summer Survival sexual health surveys. The survey has been used as an engagement tool with young people by peer educators for the past ten years. The survey results provide in-depth information on individual’s demographics, sexual activity and behaviour, where young people source sexual health education and information as well as drug and alcohol use, particularly in relation to sexual behaviour.
SOCIAL MARKETING AS A HEALTH PROMOTION TOOL FOR CHLAMYDIA PREVENTION AND TESTING

Laing S.

Sexual Health & Blood-borne Virus Program, Communicable Disease Control Directorate, Department of Health Western Australia, WA, Australia
PAPER NUMBER: 889
CONTRACEPTIVE CONUNDRUMS

Read, C
Consultant in Family Planning, Reproductive & Sexual Health

This session will cover the ‘Top 10 Questions’ about curly issues in contraception. It will be case study focused and will highlight practical clinical knowledge combined with evidence based research and expert opinion. Topics to be discussed include contraception for the very young – legal aspects, perimenopause – what to use and when is it safe to stop contraception, issues with venous thromboembolism and hormonal methods, working with people from different cultural backgrounds, migraines and the pill, emergency contraception – when is it appropriate, drug interactions, the woman with a disability, contraception in epilepsy and what method can be used in a woman who has had cancer.

PAPER NUMBER: 100
CONTACT TRACING: WAYS TO DO IT

Mc Nulty A
Sydney Sexual Health Centre, Australia

Everyone agrees someone should be responsible for contact tracing. Who should do it – the patient, the diagnosing clinician or public health officials? Do we know what impact contact tracing has on STI control. In this overview the most effective methods of contact tracing will be examined. The use of communication technologies such as SMS for contact tracing will be discussed. The challenges we encounter with contact tracing and some potential solutions will be presented.
Abortion availability and legality varies quite widely from state to state across Australia. Early surgical abortion is available in most urban areas; early medical abortion is now available from a number of private abortion services, also all in urban areas. Early abortion is much less accessible to women living in rural and remote areas across the country. Late abortion, usually medical abortion using misoprostol, increasingly together with mifepristone (RU486), is available in many large public hospitals; late abortion is performed by surgical methods in a few Australian hospitals and clinics. Improving the availability of mifepristone to practitioners has the potential to improve the access of Australian women, especially rural women, to safe early abortion services. Current practice in surgical and medical abortion in Australia will be discussed.

Australians are remaining healthier and sexually active for longer with increasing numbers of older people seeking new partners. Internet dating sites are a flourishing venue for meeting new partners due to the powerful combination of accessibility, affordability, anonymity and acceptability. Whilst most internet-based sexual health research has focused on high risk groups such as men who have sex with men, the privacy afforded by the ability to screen prospective partners online also appears to be particularly welcome for older heterosexual people. A 2009 FPNSW survey of 1788 women using the internet dating service, RSVP, found that women aged 40 years and above had met as many new sexual partners via the internet as younger women in the previous year.

Most National STI strategies have not specifically included older people and health professionals may be less likely to engage this group in sexual health discussions due to an assumption of low risk and personal discomfort. Renegotiating safe sex in older age can therefore be a challenge and we have seen a rise in STIs in older as well as younger people in this country. The FPNSW online dating survey of found that the women aged 40 years and above were more likely to agree to sex without a condom with a new partner than the younger group and recently single women appear to be at particular risk of STIs due to a higher prevalence of risk-taking behaviours.

Education and service delivery need to be directed to our ageing population and the presentation will include strategies for engaging this frequently neglected group of older women and men in safe sex discussions, the negotiation of condoms and STI screening during primary care consultations.
11.00am - 12.30pm: Symposium: Unwanted Desires

**SEXUAL ASSAULT – IS IT OUR PROBLEM?**

Williams A
Victorian Institute of Forensic Medicine, VIC, Australia

**FORENSIC SPECIMENS - HOW TO TAKE THEM**

Franco M¹, Nittis M²

¹ Sexual Assault Laboratory, Department of Analytical Laboratories, NSW, Australia
² Forensic Medical Unit, Westmead Hospital, NSW, Australia
Introduction: Sexual assault (SA) is commonly reported in cross-sectional studies of men who have sex with men (MSM) worldwide, but there are few community-based data and no published SA incidence data among MSM.

Methods: Participants in the Health in Men (HIM) cohort study reported lifetime history of SA at baseline and annual experience of SA at each annual face-to-face interview.

Results: At study entry 319 of 1427 participants (22.5%, 95% CI 20.4-24.8%) reported past SA. Independent demographic predictors of past SA significantly varied by employment status (being on pension or benefits vs full-time employment, OR 5.28, p<0.001) and ethnicity (Asian v Anglo: OR=0.37, p=0.015; European v Anglo: OR 1.45, p=0.042, Aboriginal v non-Aboriginal OR 3.79, p=0.024). Those reporting past SA had more lifetime male sexual partners (p-trend <0.001). During 5965.7 person years of follow-up 55 incident SA were reported (incidence 0.92 per 100PY, 95% CI 0.71-1.20). The incidence of SA was significantly higher among those who reported a past history of SA at baseline than those who did not (1.08 vs 0.41 per 100PY, HR 2.61, p=0.009). Independent demographic predictors of incident assault varied by religious affiliation (p=0.038) and lower weekly income (p-trend=0.006). In the previous 6 months, those suffering incident SA had more male sexual partners (p=0.056), more unprotected receptive anal sex with casual partners (p-trend 0.004), but were no more likely to seroconvert to HIV (p=0.313). There was no association with sex work, smoking, alcohol or other recreational drug use.

Conclusion: These are the first prospective data to examine sexual violence among MSM. Similar to other studies, a number of demographic and behavioural correlates suggest socioeconomic disadvantage and potentially heightened STI/HIV risk in victims of SA. There is a need for routine and regular enquiry regarding SA experience of all MSM attending clinical services.
HPV-associated oropharyngeal cancers are becoming more common.

Aims: To determine the prevalence of, and risk factors for oropharyngeal HPV infection in MSM, and to compare the sensitivity of throat swab, oral rinse and absorbed rinse specimens.

Methods: Cross-sectional study of 500 MSM (half with HIV infection) attending Melbourne Sexual Health Centre in 2010. Men completed a behavioural questionnaire, provided a self-administered throat swab and a gargled saline sample. Half the saline was absorbed in a tampon, to be suitable for postage. Preliminary type-common HPV testing by polymerase chain reaction has been performed on oral rinse specimens from nearly half the men by mid-June. Full results, including HPV typing by linear array and adjusted risks will be presented in October.

Results: The first 161 men, median age 34 (interquartile range IQR 26 - 47), reported receptive oral sex with a median of five partners (IQR 2 - 15) in the past year and median time since last receptive oral sex was five days. Of 229 men with HPV results available, 105 (46%) have HIV infection. HPV was detected in at least one oral rinse sample from 35 men (15.3%, 95% confidence interval: 11.2 - 20.6%), with a prevalence of 10.5% in HIV uninfected men and 21.0% in HIV infected men (P < 0.05).

Conclusions: Preliminary results indicate the prevalence of any type of oropharyngeal HPV is about ten percent in HIV-negative MSM in Melbourne and this doubles with HIV infection.
High-grade Squamous Intraepithelial Lesions (HSIL) are the probable precursor lesions of anal cancer. Anal cytology and High Resolution Anoscopy (HRA) have been proposed as methods of identifying men with HSIL. However, concerns have been raised regarding their sensitivity and specificity.

We conducted a prospective study to investigate the value of anal cytological screening among MSM attending a Sydney HIV outpatient clinic.

Self-collected anal samples were obtained using moistened Dacron swabs. Men yielding a cytological result of Atypical Squamous Cells of Undetermined Significance (ASCUS), Atypical Squamous Cells – possible High-grade (ASC-H) or HSIL were offered further investigation by HRA. Due to capacity limitations, a systematically selected sample of men with Low-grade Squamous Intraepithelial Lesions (LSIL) was also offered HRA.

A total of 291 men participated in the study. The median age was 50 years (range 25-75). Of the 285 men with technically satisfactory anal cytological specimens, 73 (6%) were reported as cytologically negative, 121 (42.5%) LSIL, 48 (16.8%) ASCUS, 29 (10.2%) ASC-H, 14 (4.9%) HSIL.

Of the 92 men who had an HRA, 12 (13%) had cytological evidence of LSIL, 39 (42.4%) ASCUS, 27 (29.3%) ASC-H and 13 (14.2%) HSIL. 11 (12%) were clinically normal at HRA (no biopsies taken), one (1.1%) had normal mucosa, 13 (14.2%) wart virus effect, 13 (14.2%) had LSIL, 51 (62.9%) had histologically confirmed HSIL and 3 (3.3%) other inflammatory changes. No-one was diagnosed with anal cancer.

Histologically proven HSIL was found in 60% of those with cytological evidence of LSIL, 58.1% with ASCUS, 70.4% with ASC-H and 61.5% with HSIL. Self-collected anal cytology significantly underestimated the severity of dysplasia. We need to understand this disconnect in order to develop better screening tools for anal dysplasia. Anal cytological screening cannot be relied upon to exclude HSIL.

Prophylactic vaccination is efficacious against HPV16/18-related anal cancer precursors. We report on anal cancer incidence and survival in Australia, with a focus on the squamous cell type, over 90% of which is attributable to HPV16/18.

Data were obtained from the Australian National Cancer Statistics Clearing House including counts and incidence of squamous cell carcinomas of the anus, anal canal and rectum (anal SCC) from 1982 - 2005, and five year relative survival. Data from The Australian Survey of Health and Relationships were used to define postcodes in which a high proportion of men identified as homosexual.

From 2000 – 2005 there were an average of 270 cases of invasive anal cancer per year with annual age-adjusted incidence of 1.35 (95% CI 1.28-1.41)/100,000. SCC was the most common histology (74%). SCC incidence was higher in females (1.10 vs 0.88/100,000), but adenocarcinoma incidence was lower (0.25 vs 0.37/100,000). Over time, there was a significant increase in incidence, more pronounced in males (3.4% pa 95%CI: 2.5–4.3) than females (1.9% pa 95%CI: 1.2–2.6). Incidence of anal cancer in men was almost 10-fold higher (RR 9.6, 95% CI 6.6 – 14.1) in eight postcodes where more than 10% of men identified as homosexual, compared to postcodes where less than 4% of men did so. Five year relative survival improved from 59% in 1982–1988 to 68% in 1997–2004, and was higher in females (73% vs 61%).

There has been a marked increase in incidence of HPV-associated anal carcinoma, particularly in males, over the past 25 years in Australia. A high degree of geographical clustering in postcodes with high homosexual identity was identified. Projections in anal cancer burden will need to consider changes in behavioral risk factors, the impact of the current female HPV vaccination program and the contribution of gay men. Anal cancer services for men should be developed in the gay suburbs of Australian cities.
The quadrivalent human papillomavirus (HPV) vaccine has demonstrated high efficacy in clinical trials but no reports to date have described the vaccine's effect at a national level. From mid-2007 Australia was the first country to fund a universal vaccination program for all females between 12 and 26 years and coverage rates of ~80% have been achieved.

We established a national surveillance network to determine trends in clinical presentations for genital warts. Eight sexual health services located around Australia provided data on all new patients (n= 112 083) between 2004 and 2009. Data were collected on new diagnoses of genital warts (n=9867), demographics, sexual behaviour, and HPV vaccination status.

From the start of the vaccination program in mid-2007 there has been a marked decline in the proportion of younger women (of an age that qualified them for free vaccination) diagnosed with genital warts: the decline to the end of 2009 was greater among Australian resident women (59%; p-trend<0.001) than among traveling/migrant women (25%, p-trend=0.38). Heterosexual men experienced a lesser but significant decline (28%; p-trend <0.001). There was no decline in warts among older women (not eligible for free vaccine) or among men who have sex with men. By 2009, 65% of resident women of eligible age, 15% of traveling/migrant women of the same age, and 11% of older women reported having had a quadrivalent or an unknown HPV vaccine.

High coverage by the vaccination program has had a large population-level impact on the incidence of genital warts in young Australian women. A more modest impact for heterosexual men has presumably resulted from herd immunity.

To measure the level of Human Papillomavirus (HPV) vaccine uptake in young Victorian rural women, assess their knowledge of HPV and explore their attitudes toward HPV vaccination.

A web-based questionnaire was completed by 256 young Victorian women aged 18-26 who resided in rural Victoria. The questionnaire consisted of 56 questions assessing HPV knowledge, vaccine uptake and attitudes about the HPV vaccine.

This study found 73% of rural women aged 18 to 26 years had received the HPV vaccine. Knowledge of HPV, vaccine beliefs, less frequent condom use and higher perceived sexual activity were positively associated with having been vaccinated against HPV, however, in the multivariate model the only significant predictor of having received the HPV vaccine was a higher HPV vaccine belief score. Knowledge surrounding HPV was higher than in previous studies with 85% of respondents indicating they had heard of HPV. This knowledge however was patchy and many respondents confused aspects of the infection. Of concern was the finding that 40% of women believed only women were susceptible to HPV infection. There was good understanding of the relationship between HPV and cervical cancer with 80.3% of participants aware that HPV could cause cervical cancer and 94% of women understood the need for continued Pap smears post-vaccination.

This study found high level of acceptance in young rural women for the HPV vaccine and for vaccines in general. It also found that since the introduction of the HPV vaccine, with the accompanying media campaign, women's knowledge of HPV and its link to cervical cancer have increased substantially, although there remains significant misunderstanding and confusion. Continued efforts in providing easy to understand information are required if the vaccination program is to achieve its goal of reducing morbidity and mortality due to cervical cancer.
We investigated the distribution of HPV types in a sample of anal cancer specimens collected from patients attending three Sydney hospitals.

Cases of anal cancers were identified from the pathology databases of people attending three Sydney hospitals during the period 1990-2009. Formal saline preserved paraffin block specimens were retrieved from storage and tested for of HPV by PCR.

A total of 157 infections were detected in the 114 patients. At least one HPV type was detected in 111 (97%) of specimens. 86 (75%) of samples showed a single HPV infection, with a maximum of six HPV genotypes found in a single sample. HPV16 was found alone in 69 (62%) of cases, HPV18 was found alone in no cases. HPV16 was detected either alone or in combination with other types in 84 (76%) of samples and HPV18 was found in combination with other types in 4 (4%) of samples. HPV6 was found alone in 7 cases (6%), HPV11 was found alone in 3 cases (3%). HPV6 was found in combination with other types in a further 3 cases (3%) and HPV11 was found in combination with other types in 3 more cases (3%). HPV52 and HPV54 were the second and third most common types.

HPV16 was the most common infection type found, both alone and in combination with other types. These findings are similar to other published rates of HPV in anal cancer specimens, with the majority containing HPV16. This study differed in that type 18 was less common and types 52 and 54 more common. 22.5% of cancers did not have any of the HPV types covered by bivalent prophylactic HPV vaccine and 16% by the quadrivalent vaccine. These findings may have implications for future vaccine deployment and development.
SMS REMINDERS INCREASE HIV/STI RE-TESTING RATES AMONG MEN WHO HAVE SEX WITH MEN AT SYDNEY SEXUAL HEALTH CENTRE

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In mid 2008, Sydney Sexual Health Centre implemented a SMS reminder system to improve re-testing rates for HIV and sexually transmissible infections (STIs) in men who have sex with men (MSM). Clinicians were encouraged to offer 3-6 monthly SMS reminders for HIV/STI screening to MSM.

We compared re-testing rates (two or more HIV/STI tests in 6 months) among MSM who received the SMS reminder between mid 2008 and 31 May 2010 (SMS group) to those who didn’t receive the SMS reminder during a similar time period (control group), using a chi-square test and multivariate analysis which controlled for any imbalances in factors that could affect re-testing in the study groups.

There were 1947 HIV/STI tests conducted in HIV-negative MSM in the study time period; 1054 in the SMS group and 893 in the control group. In the SMS group, HIV/STI re-testing rates were significantly higher (61%) than the control group (21%) p<0.001. There were two significant differences in patient characteristics between study groups that could affect re-testing rates: In the SMS group, 35% of patients reported three or more sexual partners in the last three months, compared to 44% in the control group (p<0.001) and in the SMS group 21% of patients reported ano-genital symptoms compared to 36% in the control group (p<0.001). After adjusting for these differences in the multivariate analysis we found HIV/STI re-testing was 5.3 times more likely (95%CI:4.3-6.5) in the SMS group compared to the control group.

SMS reminders at a large sexual health clinic more than doubled HIV/STI re-testing rates. SMS offers a cost-efficient system and has great potential value in increasing HIV/STI re-testing in clinical settings.

FORENSIC PHOTOGRAPHY – THE CURRENT STATE OF PLAY FOR SEXUAL ASSAULT EXAMINERS IN AUSTRALIA

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In Australia there is a perception amongst clinical staff that the taking of forensic photographs is harmful to the victim of an alleged sexual assault. Previous research has outlined the benefits of using colposcopy and anoscopy during sexual assault examinations, as well as the usefulness of photographing other injuries such as bruises, bite marks and a wide range of penetrating wounds.

OBJECTIVE: This research was undertaken to explore the harms and benefits associated with both genital and non-genital photography for victims of sexual assault as perceived by forensic medical and nurse examiners in Australia.

METHOD: In 2010 an on-line survey was conducted within the membership of the Forensic and Medical Sexual Assault Clinicians Australia Inc. (FAMSACA) to review current practice in Australia and 38 clinicians responded.

RESULTS: The results will be presented in more detail at the conference.

Key points:

• Respondents were more likely to be taking non-genital than genital photographs with the overwhelming majority having a separate consent form for photography.
• Less than 20% reported that clients found genital photographs completely unacceptable but only 5% found non-genital photographs unacceptable.
• The most inhibitory factor (50%) was the clinician’s own inexperience with taking clinical photographs, followed more or less equally by anxiety about the patient’s potential distress, opposition from other staff and health service policy (25-30%).

CONCLUSION: The benefits may include access to peer review, second opinions and quality assurance audit processes, in particular for the relatively isolated practitioners in rural and remote areas. Education of new forensic examiners also rated highly. Practitioners expressed concerns about the protection of the victims’ privacy in the event that photographs were requested by the courts, however only 10% of those who currently took photographs had ever been asked to produce these during a trial.
PAPER NUMBER: 179
THE EFFECTIVENESS OF 1G OF AZITHROMYCIN FOR MYCOPLASMA GENITALIUM INFECTIONS: A FIVE YEAR REVIEW
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Introduction
Azithromycin is significantly more effective for Mycoplasma genitalium (Mg) than doxycycline. A case-control study of urethritis at Melbourne Sexual Health Centre (MSHC) in 2004-2005 indicated that 1g-azithromycin may not be sufficiently effective for Mg with cure rates of 72% (95%CI 55-85%); macrolide-resistance was detected in all cases failing azithromycin. However the numbers of Mg-cases were small and further studies were warranted.

Routine Mg testing commenced at MSHC in 2005 for urethritis and in 2007 for cervicitis. Two audits were conducted to monitor the efficacy of 1g-azithromycin for Mg from March 2005-November 2007 and December 2007-December 2009. We present data on the effectiveness of 1g-azithromycin for Mg-infections from 2005 to 2009.

Methods
Males with urethritis were tested for Mg by first void urine (FVU) and females with cervicitis were tested by cervical/high vaginal swab or FVU. Samples were tested at the Royal Women's Hospital by PCR assay targeting the 16S rRNA gene of Mg. Mg-infected patients were asked to attend for a test-of-cure (TOC) ≥2 weeks post-treatment. Cases treated with 1g-azithromycin pre-TOC were included in the audit. Persistent infections were treated with moxifloxacin. Cure rates following 1g-azithromycin in the two audit periods were compared by the Chi Square test.

Results
Between March 2005 and November 2007, 120 Mg-infected patients (101 males/18 females) were treated with 1g-azithromycin pre-TOC, azithromycin cure rates were 84% (95%CI 77-90%). From December 2007 to December 2009, 111 Mg-infected patients (86 males/25 females) were treated with 1g-azithromycin pre-TOC, azithromycin cure rates were 69% (95%CI 60-77%). 1g-azithromycin was significantly less effective for Mg in 2007-9 compared to 2005-7, p=0.008. Moxifloxacin cured all but one case of persistent Mg infection.

Conclusion 1g-azithromycin may be becoming less effective for Mg at MSHC with current treatment failure rates approaching 30%. Testing is underway to determine the proportion of cases due to azithromycin-resistance. These findings have important implications for clinical practice.

More frequent screening of higher risk men who have sex with men (MSM) for syphilis could reduce the transmission and prevalence of syphilis. This study assessed the impact of a computer alert to clinicians on the rate of syphilis testing among high risk MSM.

In October 2008, a computer alert was introduced at the Melbourne Sexual Health Centre. This alert appeared for MSM who reported more than 10 partners in the prior 12 months (high risk men), reminding clinicians to test such men more frequently for syphilis. Syphilis testing rates among MSM were determined for the 12 months before and the 12 months after the introduction of the alert.

The proportion of MSM identified as being high risk who were tested for syphilis was 77.2% (1559/2017) and 88.7% (1282/1445) for the before and after periods respectively (p<0.001). The proportion of MSM identified as being lower risk who were tested for syphilis was 65.1% (1228/1885) and 68.1% (1667/2448) respectively (p=0.04).

The use of a computer alert was associated with increased syphilis testing of higher risk MSM attending a clinical service. Roll out of the alert to other clinics where MSM are seen could help to increase screening of MSM at increased risk of syphilis.
The use of self-collected specimens to test for sexually transmissible infections (STIs) has reduced the opportunity for physical examination. Physical examination has been found to be of limited value in asymptomatic heterosexual women and men, but prior studies have excluded higher risk populations. We performed a retrospective cross-sectional study to determine the diagnostic yield of physical examination among all clients attending our sexual health service.

The Sydney Sexual Health Centre database was used to identify asymptomatic clients attending for the first time between January and June, 2009. Demographic and behavioural data was extracted from the database for all clients. Medical records were then manually reviewed to determine the number and nature of diagnoses made by physical examination and whether this varied by sex and sex of sexual partners.

Of the 590 clients included, 450 (76%) received anogenital examinations. Ten (2.2%, 95% confidence interval [CI] 1.1-4.1%) STIs were found, including 4 cases of cervicitis, 4 of anogenital warts and 2 of molluscum. Nineteen (4.2%) other non-STI conditions were detected, mostly in heterosexual women and men who have sex with men (MSM).

This retrospective audit of the diagnostic yield from physical examination of asymptomatic clients showed a very low yield of significant STIs in all client groups. Physical examination of asymptomatic clients was of limited value, even among higher risk individuals such as MSM. Sexual health clinics could direct resources currently used to examine clients towards increasing the STI testing rate by allowing asymptomatic clients to self-collect specimens.

Syphilis is a growing public health problem in Australia, disproportionately affecting men who have men (MSM). Rapid and accurate detection of syphilis is vital to ensure patients and their contacts receive timely treatment. We evaluated a real-time PCR assay for the diagnosis of *Treponema pallidum* with swabs of suspected early syphilis lesions in longitudinally assessed patients.

Of 288 specimens from MSM with suspected primary or secondary syphilis, 74 (25.7%) were positive. The overall sensitivity and specificity of PCR for the detection of *Treponema pallidum* in lesions of early syphilis was 77.0% (95%CI: 65.8-86.0) and 97.7% (95%CI: 94.6-99.2), respectively, when compared with standard syphilis serology. The sensitivity was 88.5% (95%CI: 76.1-95.6) for lesions of primary syphilis compared to 50% (95%CI: 28.2-71.8) for lesions of secondary syphilis. The lowest sensitivity was in specimens collected from generalised rashes (35.3%, 95%CI:14.2-61.7). The PCR was able to detect five early primary infections (10% of the primary infections) where the serology was initially negative but three patents seroconverted between 7 days and 35 days after the initial negative test. If these patients are included in the analysis, the sensitivity and specificity of PCR for primary syphilis improves substantially.

*Treponema pallidum* PCR is a potentially powerful tool for the timely diagnosis of early syphilis, particularly for primary lesions where a serological response can be delayed.
Introduction: Australia was one of the first countries to implement a nation-wide program providing Human Papilloma Virus (HPV) vaccination to girls at school. To date, there are no published studies describing or explaining decision-making processes and behaviour post-implementation of HPV vaccination of adolescents. We aimed to investigate the experiences, beliefs, and decision-making of adolescents, parents, teachers, and vaccination nurses involved in a school-based HPV vaccination program.

Methods: A purposive sample of 9 schools was selected to reflect a range of vaccination coverage (high versus lower uptake), and school types (Catholic, Independent or Government). Semi-structured focus groups and interviews with participants (n= 185) were conducted until saturation was reached. Transcripts were analysed inductively and emergent themes were subject to constant comparison.

Results: An explanatory model of decision-making and behaviour was constructed from the data. Five decision-making groups emerged across a continuum of vaccination behaviour: active decision-making—vaccinated, passive decision-making—vaccinated, passive decision-making—not vaccinated, active decision-making—not vaccinated, and active decision-making—anti-vaccination. A range of factors influenced participants in each of the decision-making—behaviour groups. Adolescents were often part of the decision-making process; mostly this resulted in decision agreement. Where adolescents were not involved, non-agreement sometimes occurred.

Conclusions: Our research suggests that there are several processes of decision-making and behaviour in adolescent HPV vaccination. We have presented a variety of paths that girls and their parents experience to arrive at a decision and behavioural outcome about HPV vaccination. Attitudes, past experiences and worldviews contributed to this process as did information accessed and fear.

Despite young Aboriginal and Torres Strait Islander (TSI) people being recognised as a priority population very little is known about health service usage by this population. In order to address this gap in information, we developed a survey instrument to collect information on health service usage by young Aboriginal people in NSW, as well as knowledge and risk behaviours in relation to STIs and BBVs.

Information was collected from young Aboriginal people aged 16-30 at two Aboriginal events in NSW, in 2007 and 2008. Individual consent was sought and data were collected using a self-administered questionnaire using a hand held computer device (PDA). 293 Indigenous people completed the survey, median age 20 years, with 58% female. 64% reported they were not in a regular relationship and 90% described themselves as heterosexual. 14% of respondents had completed high education and residence in a metropolitan location was reported by 66%. Over half of respondents (58%) reported that they had ever had an STI test (including HIV). Ever testing for an STI was significantly more common among people aged 21-30 compared to 16-20year olds (77% vs. 42% p <0.001), among women (64% vs. 53% p= 0.07), and among people residing in major cities compared with regional and rural areas (66% vs. 51% p=0.01).

34% of respondents reported having had an STI test within the last year. Among respondents who said that they had been tested for an STI in the past 12months, over half (54%) reported that their most recent test took place at an Aboriginal Community Controlled Health Service, and 30% sought testing at a general practice. Furthermore over half of (54%) respondents believed that ACCHSs were the best place to obtain advice relating to STIs.

These results highlight the central role that ACCHSs play in providing STI and BBV health services to young people in NSW.
PAPER NUMBER: 185
HOME-BASED CHLAMYDIA TESTING OF YOUNG PEOPLE ATTENDING A MUSIC FESTIVAL - WHO WILL PEE AND POST?

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Background
Chlamydia is the most common notifiable disease in Australia. It predominately affects young people but only a small proportion of Australian young people are tested annually. Home-based chlamydia testing has been piloted in several countries to increase testing rates, but uptake has been low. We aimed to identify predictors of uptake of home-based chlamydia testing to inform future testing programs.

Methods
We offered home-based chlamydia testing kits to participants in a sexual behaviour cross-sectional survey conducted at a music festival in Melbourne, Australia. Those who consented received a testing kit and were asked to return their urine or vaginal swab sample via post.

Results
Nine hundred and two sexually active music festival attendees aged 16-29 completed the survey; 313 (35%) opted to receive chlamydia testing kits, and 67 of 313 (21%) returned a specimen for testing. One participant was infected with chlamydia (1% prevalence). Independent predictors of consenting to receive a testing kit included older age, knowing that chlamydia can make women infertile, reporting more than three lifetime sexual partners and inconsistent condom use. Independent predictors of returning a sample to the laboratory included knowing that chlamydia can be asymptomatic, not having had an STI test in the past six months and not living with parents.

Conclusions
A low proportion of participants returned their chlamydia test, suggesting that this model is not ideal for reaching young people. Home-based chlamydia testing is most attractive to those who report engaging in sexual risk behaviours and are aware of the often asymptomatic nature and potential sequelae of chlamydia infection.

PAPER NUMBER: 484
GOING WHERE THE PEOPLE ARE: REACHING YOUNG PEOPLE AND MSM FOR SEXUAL HEALTH PROMOTION VIA SOCIAL NETWORKING SITES

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The FaceSpace Project involved the creation of fictional characters who interacted on SNS. Four characters were developed in collaborative workshops involving actors and participants from the target population. Characters used a combination of videos, photos and dialogue to deliver a narrative about their social activities on SNS with embedded health messages.

The characters targeting young people (16-29 years) were "live" from November 2009 until April 2010. A mixed methods approach, incorporating computer-based laboratory analysis of usage, site usage data, online surveys, and on- and off-line focus groups, was used for evaluation. Five Facebook pages, including the overall study page, attracted 900 fans, engaging a range of users who were: predominately female (59%), living in Australia (93%), aged 18-24 years (43%) and 25-34 years (32%). Pages received a total of 7421 unique views and 629 interactions. One quarter of fans followed two or more pages and 175 valid surveys were collected at baseline and 91 at follow up.

The evaluation highlighted the difficulties in implementing such a project including, embedding health promotion messages in entertainment, reaching target populations, maintaining online presence, interaction and interest over time. Challenges in developing this pilot study include ethical dilemmas of online interventions, limited control over site design and delivery and developing appropriate evaluation frameworks.

This project offers a new model for delivering health promotion interventions using SNS. We will present our lessons learnt on how to develop and implement a collaborative, adaptive and interactive online intervention in a new and challenging environment.

Background
Young people and men who have sex with men (MSM) are both considered priority populations for sexual health promotion. Social networking sites (SNS) offer a novel environment for health promotion due to their popularity, interactivity and potential to engage and create communities. However few health promotion interventions have been trialled in these spaces.

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This project offers a new model for delivering health promotion interventions using SNS. We will present our lessons learnt on how to develop and implement a collaborative, adaptive and interactive online intervention in a new and challenging environment.
Chlamydia is a sexually transmitted infection that can cause serious upper genital tract infections, however, in Australia there are limited population data for chlamydia. Understanding the incidence of chlamydia will be important in the design of a chlamydia screening program in Australia.

Women aged 16 to 25 years were recruited from sexual health clinics (SHC) and general practice clinics (GP) in south-eastern Australia and consented to participate in longitudinal study over a 12-month period. Participants were requested to send back questionnaires and self-collected vaginal swabs through the post which were tested for chlamydia.

Overall, 1116 women were recruited from 29 clinics; with a 79% retention rate. The prevalence of chlamydia at recruitment was 4.9% (95%CI: 2.9-7.0). Increased numbers of sexual partners was strongly associated with chlamydia (Adjusted odds ratio [AOR]=6.4; 95%CI:3.6-11.3), as was being recruited from a SHC (AOR=7.9; 95%CI: 4.1-11.8). Antibiotic use in the previous 2 months was protective against chlamydia (AOR=0.4; 95%CI: 0.2-1.0). Chlamydia incidence was 4.7 per 100 women years (95%CI:3.6-6.2) and associated with increased numbers of new sexual partners (Hazard ratio [HR]= 3.0; 95%CI:1.5-6.0), younger age (3.7; HR=95%CI:1.9-7.0) and less education (HR=2.8; 95%CI:1.7-4.8). Chlamydia incidence was similar between patients recruited from GP compared with SHC ([4.6 per 100 women years (95%CI:12.6-8.6) versus 4.6 per 100 women years (95%CI:2.7-8.0) (p=0.73)]. Chlamydia re-infection was high (28.1 per 100 women years (95%CI:13.9-75.7) and was not associated with clinic type (p>0.05). The median chlamydia organism load was 1.4 x 10^5/5μL and the most common serovar identified was serovar E (51.9%).

Chlamydia is a common STI in young Australian women, and an incidence of 4.9 per 10 women years for chlamydia suggests annual testing is appropriate for a chlamydia screening program. The high re-infection rate indicates the importance of partner notification and re-testing 3 months after treatment.
Many young people from Culturally and Linguistically Diverse (CALD) backgrounds arrive in Australia with limited or no knowledge about sexual and reproductive health. Upon settlement, there are further barriers to access learning, which poses significant public health problems among our CALD communities.

We have culturally tailored our sexual health education to deliver workshops for young people from CALD backgrounds targeting schools, TAFES, Universities and community workshops in the homes or neighborhood centers. The leading issues found from these workshops include low level sexual and reproductive health knowledge, low level of STI knowledge, low level condom use and most concerning was the rapid increase in unplanned teenage pregnancy among African refugees.

The most effective approach in providing sexual health education to young refugees was to adopt a collaborative approach with various community service providers. However, there was a great need for external agencies to be culturally trained in sexual health education prior to collaborating with the young people. Using a school setting was found to be an effective way to reach the target audience and have successful delivery. To allow this to be sustainable, we have created a School Based Youth Health Nurse (SBYHN) toolkit to train SBYHN’s and other health teachers to deliver sexual health information in a way that is culturally competent. The use of bi-lingual workers was also fundamental with assisting with translation, gaining trust and creating a safe environment to discuss culturally inappropriate and taboo topics such as sex.

Challenges in delivering such education included limited research and evidence and the lack of confidence and cultural training by service providers and community organizations.
Australia has implemented a nation-wide program providing HPV vaccination to girls at school. There are few published studies that explore vaccination from an adolescent perspective.

We will present data from a qualitative study conducted in 9 Sydney schools (Catholic, Independent and Government) with a range of vaccination coverage (high and lower uptake). Semi-structured focus groups with girls (n=130) aged 11-17 years were conducted until saturation was reached. Observations were conducted in three schools on vaccination days.

We found the following issues of importance to adolescent vaccination 1) lack of understanding about HPV and HPV vaccination; 2) adolescent involvement in decision-making about HPV vaccination; and 3) fear of HPV vaccination. Strikingly low levels of understanding about HPV vaccination among adolescents have implications for their future sexual behaviour and cervical screening. Adolescents' understanding and involvement in consent should be further promoted for ethical, health, and procedural reasons. The impact of fear of experienced by adolescents vaccinated in this setting is significant and can be addressed. Various strategies for achieving this will be presented. Formative data from our current study, which aims to develop an intervention to promote understanding and confidence and reduce fear among adolescents being vaccinated, will also be presented. In this study, adolescents themselves are contributing to the design of the intervention for use in schools.
Ureaplasmas, previously called T-strain mycoplasmas, have been linked with non-gonococcal urethritis (NGU) from their first isolation in the 1950’s. However, the association of ureaplasmas with NGU has been controversial. The results of human and animal inoculation studies, together with controlled antibiotic and serologic investigations support a causal role for ureaplasmas in NGU, but their importance is much lower than that of Chlamydia trachomatis and Mycoplasma genitalium.

In studies based on culture, ureaplasmas have been isolated significantly more often, or in higher quantities, from men with NGU than from controls only in about half of the published studies. Initially, all urea-hydrolyzing human Mycoplasma species were designated as *U. urealyticum*, but it is now realised that two distinct species should be considered. These species have been designated *U. urealyticum* (formerly biovar 2) and *U. parvum* (formerly biovar 1). Keeping the old species name for biovar 2 has, unfortunately, lead to considerable confusion when the older literature is interpreted. On the other hand, the division has lead to new research evaluating the possible differential disease associations. These studies have become possible due to the development of specific PCR assays to detect, quantify, and easily differentiate the two species. A small number of studies have suggested that *U. urealyticum* is more closely associated with NGU than *U. parvum*, although other studies disagree. In studies where an association with NGU has been shown, the odds ratios have been low, leading to a poor predictive value of a positive *U. urealyticum* test. Furthermore, in only a few studies has the association been controlled for infection with *C. trachomatis* or *M. genitalium*.

Thus, it is obvious that further work is needed to establish what proportion of NGU can be attributed the ureaplasmas, which species is more pathogenic, and at what quantity. Predisposing factors, such as a lack of mucosal immunity in individuals who develop disease is likely to play a significant role and should also be taken into account.

Multiplex PCR (mPCR) is a variant of PCR in which two or more target sequences can be amplified by including more than one pair of primers in the same reaction. It allows the simultaneous detection, identification and typing of multiple micro-organisms in clinical specimens.

The high level of sensitivity of mPCR, allows the use of less invasive specimen types, including first voided urine specimens or self-collected vaginal swabs that are unsuitable for less sensitive methods such as culture and antigen tests.

The mPCR is a user friendly testing platform suitable for use in both sexual health clinics and community settings. This technology makes it possible to investigate the presence of a wide range of potential pathogens in women who decline a physical examination, thus increasing their usefulness in screening programmes. Further investigations using this technology may allow greater understanding of the roles of other organisms in the development of conditions such as acute PID, in which the pathogens are frequently not, identified using current testing methods.
Close to 2500 cases of syphilis are notified in Australia, and 12 million worldwide each year. The days of rapid diagnosis of syphilis by examination of lesion fluid by dark-ground microscopy in a clinic side-room are long past. Now, serological tests are the mainstay of syphilis diagnosis, which is fairly satisfactory for diagnosis of early (but not too early) syphilis but their limitations for diagnosis of complicated, atypical, recurrent, latent, late or congenital syphilis are well-documented. In the last 5 years PCR testing for *Treponema pallidum* DNA has become increasingly available.

PCR is most commonly used for diagnosis of genital ulcers but has also been used successfully in a variety of specimens, including CSF, bronchoalveolar lavage, placental tissue, paraffin-embedded skin tissue blood, vitreous humor, bone, ear lobe scrapings and plasma. Targets used include the polymerase 1 gene, polA, and the 47 kDa membrane lipoprotein gene. The sensitivity varies between different specimens and stages of disease but the specificity is high (with optimal test performance). PCR often allows confirmation of the diagnosis of syphilis when serology is indeterminate or even negative.

PCR can be also used to detect macrolide resistance (by PCR and sequencing of the macrolide target gene, 23S rDNA) and for strain typing, which has shown differences in geographic distribution and, potentially, in neurovirulence of different subtypes. In future, application of molecular diagnosis and strain typing of *T. pallidum* will improve management and understanding of the pathogenesis and epidemiology of syphilis.

**PAPER NUMBER: 900**

**CONTRIBUTION OF PCR TO DIAGNOSIS OF SYPHILIS?**

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**INCREASING USE OF GONO-COCCAL PCR AND THE TRACKING OF RESISTANCE**

**Whiley D**

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The online world has been marketed to us as ‘easier, instant, and everywhere’. Whilst this is true for our experiences as users of banks, airlines and retailers, the developers who created our online experience laboured long and hard to achieve this illusion of simplicity.

The development of any learning material needs an investment of time, money and expertise. Rumble, in The Costs and Economics of Open and Distance Learning (Kogan Page, London, Stirling-USA, 1997) states that it takes an average of 18 hours to develop one hour of content for students. Anyone who has ever edited their holiday photos into a simple quick slideshow for family and friends knows that developing electronic materials is far from easy, or instant!

This presentation will explore the experience of The College of Nursing’s collaborative with ASHM in the development of two completely online subjects. The challenges of adapting material for online viewing along with engaging the student will be discussed. It will also examine some of the resources available for educators, writers, developers and students.

This presentation will cover:
1. Asking some basic questions. Why was the study done? What type of study is it? Was the design appropriate?

2. Types of studies. 
Drug trials, epidemiological studies, studies to evaluate tests, qualitative studies and reviews

3. The strengths and pitfalls of randomised controlled trials?

What was the research question? Were the methods appropriate for the study?
Was the study original?

5. Papers dealing with diagnostic tests.
New tests should be validated against an established gold standard. Diagnostic tests are seldom 100% accurate. A test is valid if it detects most people with the target disorder (high sensitivity) and excludes most people without the disorder (high specificity), and if a positive test usually indicates that the disorder is present (high positive predictive value)

6. Qualitative research. Qualitative methods aim to make sense of, or interpret phenomena in terms of the meanings people bring to them. It may define preliminary questions, which can then be addressed in quantitative studies. Analysis should be done using explicit, systematic, and reproducible methods

7. How to evaluate reviews and meta-analyses.
Effective engagement of an audience while public speaking has a lot to do with understanding who your audience is; ‘where they are at’; and how they are going to learn something new .... and a lot less to do with nerves and the potential to stuff up the prepared speech.

This short summary presentation will detail five key skills and topics that may assist an individual to effectively engage with their audience:

1. Preparation
2. Knowing your audience
3. Voice control
4. Expression
5. Understanding how a person learns something new

The bulk of this short presentation will concentrate on the 5th element and explore how and understanding of learning theory best equips a presenter to effectively engage with their audience.

The Australian Government Department of Health and Ageing (DoHA) launched the National Sexually Transmissible Infections Prevention Program (NSPP) in May 2009 to help combat the rising rates of sexually transmissible infections in Australia. The main component of the NSPP was a social marketing campaign. In order to assist general practitioners (GPs) at the time of campaign activity a number of support materials were produced. This research aims to evaluate the impact of the support materials, particularly in relation to Chlamydia.

The study involved a postal survey of 509 GPs who were selected from a national database of over 23,000 practitioners held by the DoHA. There was a single round of recruitment and no follow-up. Relative risk goodness-of-fit and ordered logistic regression analysis were used to analyse the results.

63 GPs returned completed questionnaires (12.4%); their demographic characteristics were comparable to the Australian GP population. Almost half were aware of the campaign (47%). The most effective method of promoting the campaign was a letter from the Chief Medical Officer (CMO). Most of those who received the CMO letter found the enclosed poster useful (60%). Very few respondents used the health professionals’ website associated with the campaign (3%). An interest in sexual health (p=0.03) and more years since graduation (p=0.01) were both linked to a favourable impression of the support materials.

Future social marketing campaigns must use additional strategies to improve GP awareness of support materials. A letter from the CMO appears the most useful strategy here and can be combined with delivery of other supporting materials. Approval of the campaign by those with an interest in sexual health provides some validation of the support materials. Continued work with GPs further from their medical studies may be warranted to ensure they are kept up to date about Chlamydia.
Continuing professional development is a vital component of professional practice across all health disciplines. A relatively small speciality such as sexual health requires some practitioners to work in locations with limited access to professional development.

We established a pilot teleconference using the NSW Health WebEx real time desktop visual sharing of presentations for our regular 1 hour sexual health registrar teaching sessions and 1 hour journal club. Six 2 hour sessions were hosted by Sydney Sexual Health Centre between February and May 2010.

Multidisciplinary staff from publically funded sexual health centres from across NSW participated, including doctors, nurses, counsellors and health promotion officers. Each session was broadcast to between 3-10 sexual health sites, with multiple listeners at each site. In addition to the in-person attendees at the host site, an audience of between 10-30 health professionals attended each session via WebEx teleconference with the majority having no previous access to this form of professional development.

An evaluation survey was sent to all participants at the end of the pilot. 25 responses in total were received: 11 from the host centre and 14 who attended via teleconference. The relevance to continuing education was rated as good or very good by 77%. From regional/remote locations 77% attended the whole 2 hours and 66% from greater Sydney. The majority, 88% from all centres indicated they are likely or very likely to attend in the future. Positive themes included support for professional development. However concerns about the effect of teleconferencing on group interaction will need to be addressed.

Funding for hosting the sessions was provided by the NSW sexually transmitted infections programs unit, and ranged from $250-400.

This pilot project was well received and contributes to improved professional development for those working remotely. Based on the positive evaluation we intend to continue the program.
Syphilis and HIV co-infection occurs commonly. The clinical presentation of syphilis in HIV infected patients may be different from HIV negative patients in that co-infection with HIV may result in unusual clinical presentations of syphilis such as an increased frequency and acceleration of the development of neurological sequelae. This includes increased frequency of acute syphilitic meningitis, increased cranial nerve abnormalities and increased meningovascular syphilis.

We report an interesting case of syphilis and HIV co-infection.

The patient was a 37 year old man who has sex with men living in Melbourne. One and a half years prior to being seen at our clinic in Adelaide, he developed “flu” like illness, lymphadenopathy, severe headaches and mouth ulcers. At that time, a diagnosis of viral illness was made. His symptoms resolved but soon after, he developed progressive left sided hearing loss resulting in a total hearing loss 6 months later. Right sided hearing loss associated with a right facial palsy occurred subsequently. The right facial palsy resolved but the right sided hearing loss progressed. Several ENT specialists saw him and a diagnosis of autoimmune disease was made.

The patient moved to Adelaide and was diagnosed with HIV infection by a GP. During initial evaluation at Clinic 275, patchy scalp alopecia and hepatosplenomegaly were noted. Laboratory findings showed a RPR of 1:128 with a reactive TPPA screen for syphilis, a CD4 count 189 cells/mm3 (9%) and HIV RNA of 1004 copies/ml. Following positive CSF findings, he was admitted for treatment of otosyphilis/neurosyphilis and was an inpatient for 2 weeks. Following discharge, he was commenced on antiretroviral therapy for his HIV co-infection. The patient has remained profoundly deaf bilaterally.

This case demonstrates 8th cranial nerve abnormalities in a patient with HIV/syphilis co-infection and reinforces the importance of considering these diagnoses in any young patient especially men who have sex with men, presenting with cranial nerve abnormalities.

This is a case of a young woman with recurrent, disabling, vulval ulceration following upper respiratory tract infections. We believe this is a presentation of Lipschutz ulcers, an under-recognised condition.

The patient is 26yr old woman with a history of recurrent upper respiratory tract infections since childhood. She has no other significant medical history and no regular medications. Over the last 12 months, she has had 6 episodes of acute tonsillitis followed by vulval ulceration. Her symptoms commence with sore throat and fever, followed by painful vulval ulceration within few days. The ulcers last 1 to 2 weeks and heal with scarring.

She has been reviewed by many doctors and was previously diagnosed as having genital herpes, despite multiple negative HSV PCR swabs. She was reviewed at our service in early 2010 with another episode of vulval ulceration following a sore throat. Her tonsils were enlarged, but no exudate was visible. On genital examination there was marked oedema of the vulva, with multiple tender ulcers on the labia. A HSV PCR swab of the ulcers was negative as expected. Microscopy and culture of the vulval ulcers revealed normal skin flora. STI screening was negative for Chlamydia, gonorrhoea, HIV and syphilis serology. Histology of a vulval punch biopsy reported only non specific inflammation.

She has no features of Behcet disease. In the past she had recurrent mouth ulcers, but not for the last few years. There are no features of generalised vasculitis and pathergy test was negative. She was initially managed with potent topical corticosteroid spay and local anaesthetic gel applied to the ulcers, but these measures had minimal effect and she required systemic corticosteroids. Tonsillectomy was recommended as a preventive measure.

We believe this is a case of Lipschutz ulcers with some challenging management issues. This condition is largely under-reported and under-recognised and will be further discussed during the presentation.
The health sector response to STI control is informed by a mix of evidence, anecdote and the art of clinical practice. The interface between the individual client and the communities they inhabit, add to the complexity.

This case documents the path of an intelligent, well informed MSM who had unrestricted access to free healthcare and psychological support. He was well connected with the MSM community and was aware of the public health messages around MSM and safer sexual practices. He had easy access to free condoms.

Despite this, the outcome was less than satisfactory and the clinicians were left wondering "What more could we have done?" How do theories of behavioral change help us look at this case?

What is the effect of repeated sexual health screens and PEP in response to high risk sexual practices? Does the return of a normal sexual health screen after risk, or success after NPEP, give people a sense of invincibility?
8.30am - 10.00am: HIV/AIDS Conference Opening Ceremony and Joint Conference Plenary

STATE OF ART THERAPY, NEW DRUGS & NEW TREATMENT ISSUES

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CAN HIV TREATMENT STOP THE AIDS EPIDEMIC?

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Point of care (POC) tests have enormous potential to impact the detection, treatment and prevention of STIs in both developed, and especially developing countries. In particular, the appropriate use of POC tests can enable timely interventions for patients in areas that do not have access to laboratory facilities, and prevent loss to follow-up (and interventions where appropriate) for patients in all areas.

However, uncertainty about test performance and clinical feasibility are major impediments to the effective use of POC tests for a wide range of infectious diseases, including most STIs.

It is obvious that the performance of POC tests should be evaluated in comparison to agreed “gold standard” diagnostic tests, but this is complicated by the lack of access to suitable specimens/panels and testing sites, and the absence of agreed protocols for performance evaluation. As a result, performance data for most commercially available tests is limited to small numbers of “convenient” clinical samples, without consideration of field performance and acceptability to clinicians. The lack of consistent, validated specimen panels also prevents meaningful comparison between published or claimed performance for tests from different manufacturers.

This presentation will discuss issues that impact on the performance, lab- and field-evaluation, and end use of POC tests for STIs such as Chlamydia, gonorrhoea, and trichomonas, but with particular reference to our ongoing work to identify (or develop) suitable POC tests to support improved control of syphilis infection, especially in the settings of high endemicity and neonatal syphilis.
Increasing rates of syphilis amongst gay men in several Australian jurisdictions lead to the development of a National Gay Men's Syphilis Action Plan in 2009. The Plan was guided by mathematical modelling of the expected impact of some public health interventions (behaviour change, chemoprophylaxis, mass treatment, targeted screening and treatment, partner notification and follow up), complimentary social research about the acceptability of these interventions, a technical workshop and summaries of current Australian and international public health responses to syphilis. The Plan aims for a sustained reduction in infectious syphilis by 2013 with the recommendations for testing [routine quarterly syphilis testing with HIV + immune monitoring (90% coverage), >20 partners/6mth at least 6mth testing (90% coverage)]; partner notification [(75% regular and 10% casual partners) enhance patient-, clinician-, centrally-led approaches]; health promotion [increased STI testing and partner notification messages to gay men as above, retain focus on sustaining condom use]; and monitoring and evaluation [surveillance and studies to collect appropriate data].

Implementation of the plan has included revision of MSM STI/HIV testing guidelines; communication to GPs, S100 providers and HIV services about the Plan; triaging MSM into public sexual health services; investigating GPs reminder systems for testing; GP practise nurse training; investigating & overcoming regulatory barriers to STI testing including who can order tests and how; exploring alternative testing locations and methods including rapid, point of care syphilis tests; incorporating and supporting contact tracing in routine clinical care with revised national and state guidelines; community communications about the Plan and recommendations including condom reinforcement; enhanced public health notification procedures and coordinating existing and new systems for evaluation.
Like cervical cancer, anal cancer is strongly associated with HPV infection. Men who have sex with men (MSM) have the highest incidence of anal cancer in the population, particularly those who are HIV-seropositive. Among the latter, the incidence has not declined since the introduction of antiretroviral therapy and may instead be increasing as they live longer. Anal cancer is preceded by high-grade anal intraepithelial neoplasia (AIN 2+). Currently there is no routine AIN screening and treatment program to prevent anal cancer, similar to the CIN screening program to prevent cervical cancer.

In the Merck 020 trial, 598 MSM aged 16-26 years were randomized to receive quadrivalent HPV (HPV 6/11/16/18) vaccine or placebo at enrollment, month 2, and month 6. Efficacy analyses were performed in a per-protocol population (seronegative at day 1 and DNA-negative from day 1 through month 7 to the relevant vaccine HPV type). Median follow-up was 2.5 years (post-dose 3). Vaccine efficacy against HPV 6/11/16/18-related AIN in MSM was 77.5% (95% CI: 39.6, 93.3) (5 vaccine cases versus 24 placebo cases). Efficacy against AIN 1 was 73% (95% CI: 16.3, 93.4), and efficacy against anal warts was 100% (95% CI: 8.2, 100). Efficacy against AIN 2+ was 74.9% (95% CI: 8.8, 95.4).

These results demonstrate that the quadrivalent HPV vaccine is efficacious in preventing AIN including AIN 2+ related to HPV 6/11/16/18 in MSM naïve to vaccine HPV types at enrollment. HPV vaccination may be an important tool for anal cancer prevention among at-risk individuals.
Australia provides bilateral assistance to the HIV response in Indonesia; it has also funded several other initiatives including GFATM, UN system and international NGOs. Australia has committed itself to more effective delivery of aid through signing the Paris Declaration and the Jakarta Commitment regarding aid effectiveness and delivery. These commit aid agencies to deliver more aid via national and government systems and ensure aid is integrated into national development frameworks. The commitment of both the Indonesian and Australian governments to the Millennium Development Goals (MDGs) is a demonstration of the need to ensure a high level of national ownership and guidance of key development programming.

**Key question:** To what extent has the bilateral assistance program for HIV contributed to progress in meeting national economic and development goals?

Response: Strengthening a response to HIV in any country aims to reduce numbers of people being infected with HIV; in this way international assistance arguably contributes to reducing morbidity and mortality, protecting overall productivity of a workforce, and stronger health and social welfare systems. From a contrary perspective, international financial and technical assistance is sometimes criticized as relieving national institutions of their responsibility for managing and funding their own programs and allowing them to divert scarce resources to other less valuable programs; an additional criticism is that the availability of international assistance delays local commitment to building sustainable financial and institutional responses to HIV.

In Indonesia, Australia recognizes these issues and has adapted the bilateral program to respond in varying ways. These include providing initial support for urgent responses when national authorities could not pay for or deliver the programs and services required; and maintaining support during periods when the national situation is stabilizing but ensuring that assistance is complementary to, and supportive of, national and local program planning and financing. This has only been achievable since the Indonesian government has given higher priority to addressing the MDGs as part of its positioning as a key player in global affairs. The assistance provided by Australia has also engaged with strengthening the relationship between government and civil society.

In the case of Indonesia, it is arguable that Australia’s assistance to support the response to HIV has contributed to the national development agenda.
Few studies have investigated the association of socio-economic deprivation, local construct of masculinities and HIV-risk practices among young people in Indonesia. This study aims to fill the gap and explore the social, cultural and economic contexts of HIV-risk practices among young male injecting drug users in a slum area, commonly named lorong, in the city of Makassar, South Sulawesi, Indonesia. HIV-risk practices are defined as risky injecting practices including the sharing of needles and other injecting equipment and unsafe sexual practices such as having multiple sexual partners and low level of condoms use. Employing qualitative approach, in-depth interviews were conducted with 21 young men (aged between 15-24 years) who were recruited in several hanging out spots in the lorong as well as participant observation aimed to document the lived experience of young male drug injectors in this locality. The interviews and participant observation revealed the crucial role of socio-economic deprivation in the lorong (particularly rampant unemployment among young men) and rewa (a local construct of masculinity) in stimulating young men in this locale to be engaged in risky drug use and drug injecting practice as well as unsafe sexual practices that render them vulnerable to HIV infection. Furthermore, the risk of HIV among young male drug injectors in this locality should not be viewed in isolation but should be seen in its intersection with other risks experienced by these young men. I argue that to be more effective, the individualization of risk that characterize the existing harm reduction programs in Makassar need to be complemented with broader community based programs that address socio-economic deprivation in the lorong. Additionally, harm reduction programs for male drug injectors in the lorong should be cognizant to the cultural and structural constraints hindering them to apply safer drug injecting and safer sexual practices.

Global Health Initiatives (GHI) have become the dominant force in multilateral HIV/AIDS programs and have driven an agenda, or espoused a rhetoric, of coordination and locating HIV/AIDS assistance into development frameworks. The current and emerging crisis of faltering funding support and treatment availability for HIV programs in resource limited countries requires that we ask whether such agendas have been adhered to and effective.

The Global Fund for AIDS, Tuberculosis and Malaria (GFATM) has been called “the most successful innovation in foreign assistance in the past decade”; PepFar and other GHI have been credited with bringing HIV treatment to literally millions of people who would otherwise not have been able to access these and died. Yet, it is now the case that countries with the highest HIV epidemics are queuing for funds to maintain, much less expand, their national programs, and people who are both on HIV treatment and those waiting for it are queuing up for drugs to stay alive.

How has the international HIV response come to this predicament a mere 8 years since the GFATM was launched and wealthy western countries pledged the necessary fund to support effective programs? Why is this occurring at the same time as the benefits of investing in international HIV support are becoming more evident?

This paper reviews recent research findings on both aid effectiveness and the impacts of GHI on national HIV/AIDS programs. It will consider what sustainability means in international development policy and what needs to change to ensure that funds for HIV programs are committed and effective and that treatment access continue to expand.
The HIV epidemic in Australia historically has been primarily among gay men. While this continues to be the case, there are indications of an increase in diagnoses among other populations, which present new and different challenges for policy, health promotion and service providers.

In 2008, diagnoses in people born in sub-Saharan Africa constituted 9.5% of total HIV diagnoses in Australia, up almost 3% from the previous year. Australian HIV surveillance data also indicates a higher per capita rate of HIV than in other population groups since country of birth has been collected for new diagnoses. HIV agencies have also been seeing an increase in the number of Africans living with HIV accessing their services.

This presentation will give an overview of recent data and the key issues related to HIV care, support, awareness and prevention with people born in sub-Saharan Africa. It will also provide an update on how the Australian Federation of AIDS Organisations is supporting the development of an African community response to HIV.
PAPER NUMBER: 769
TRENDS OF CHLAMYDIA AND GONORRHOEA IN THE ABORIGINAL AND TORRES STRAIT ISLANDER POPULATION, 2001-2009

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Aim: To present a trend analysis of chlamydia and gonorrhoea notifications in the Indigenous population between 2001-2009.

Methods: We analysed trends of gonorrhoea and chlamydia in the period 2001-2009 by: notifications, age standardised rates, age, gender, geographical location and Indigenous status in jurisdictions where accurate and complete data (greater than 50%) were available.

Results: Between 2001 and 2008, chlamydia and gonorrhoea notifications increased for both the Indigenous and non-Indigenous populations, 67% and 300% for chlamydia and 29% and 13% for gonorrhoea respectively. In 2008, the rate in Indigenous Australians was substantially greater than for the non-Indigenous population, 4 times greater for chlamydia and 39 times greater for gonorrhoea. The female to male ratio of gonorrhoea in the Indigenous population suggests mainly heterosexual transmission with 1.1 for females and 1 for males. However in the non-Indigenous population the rate of females is 1 to 0.29 males, which suggests predominantly homosexual transmission. In Australia, 81% of chlamydia diagnoses and 67% of gonorrhoea diagnoses are found in those 29 years or less. This is consistent for chlamydia notifications in the Indigenous and non-Indigenous populations, but a greater proportion (78%) of gonorrhoea diagnoses were made in those aged 29 years or less. However, the highest rate of gonorrhoea notification in the Indigenous population was in young women aged 15 – 19 years whereas for the non-Indigenous population it was in men aged 20-29 years. The Indigenous population resident in remote and very remote locations had higher rates of chlamydia and gonorrhoea infection than those in urban areas.

Conclusion: Rates of chlamydia and gonorrhoea have increased for both the Indigenous and non-Indigenous populations. Our analysis suggests chlamydia and gonorrhoea are more likely to affect young Indigenous men and women and those resident in remote areas.

To provide advice on the most effective programs to address sexual and reproductive health issues among Aboriginal adolescents in NSW.

PAPER NUMBER: 820
REVIEW OF THE EVIDENCE FOR THE EFFECTIVENESS AND CULTURAL ACCEPTABILITY OF SEXUAL AND REPRODUCTIVE HEALTH PROGRAMS FOR ABORIGINAL ADOLESCENTS IN NSW

Savage J
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This review considered the peer-reviewed scientific literature and citations, grey literature internationally and nationally. Documents were evaluated the level of evidence they provided: the level of methodological rigour, and sources and levels of bias – and thus validity and generalisability.

There is a lack of adequately evaluated international and national interventions in adolescent sexual and reproductive health and there is no high level evidence about Aboriginal adolescents in this area. Much of the literature sourced was descriptive comprising reports and case studies. No evidence was found about the socio-cultural aspects and meaning of adolescence and reproductive health in Aboriginal communities.

Review of the international literature identified program approaches and program characteristics associated with positive outcomes in sexual and reproductive health which may be applicable to Aboriginal adolescents. These include:

- School-based sex education
- Community based education, development and contraceptive services
- Development programs.
- commencing sex education before the onset of sexual activity (somewhat less strong)

Analyses of the successful programs identified characteristics to be adopted in program development. These address program principles and qualities, content and delivery. The approach to program development and consultation in Aboriginal communities is discussed.

Recommendations were presented to NSW Health. They emphasise the importance of working with the Education Department to develop, modify, implement and evaluate pilot or ongoing school based SR&H programs and with the health and community sectors, relevant youth and community government agencies to develop, modify, implement and evaluate pilot or ongoing community and youth development programs and continuing to build evidence.

The recommendations informed the framework which was developed by NSW Health for the NSW Aboriginal Sexual and Reproductive Health Program.
Aboriginal and Torres Strait Islander people are identified as a priority population for STI control. Passive surveillance has demonstrated that in 2009 chlamydia notification rates were 6 fold greater in Aboriginal and Torres Strait people than non-Indigenous people. However passive surveillance is influenced by testing patterns and Indigenous status is incomplete in many jurisdictions. We report on Aboriginal and Torres Strait Islander peoples data from a new national chlamydia enhanced sentinel surveillance system titled ACCESS, that aims to assist in the interpretation of passive surveillance trends.

Established in 2008, ACCESS is comprised of six separate sentinel surveillance networks across Australia: sexual health services (SHS), family planning clinics (FPC), antenatal clinics (ANC), Aboriginal Community Controlled Health Services (ACCHS), general practitioners (GP), and diagnostic laboratories (LAB). In total, 92 sentinel sites are participating and are geographically spread across Australia. We analysed chlamydia testing rates and positivity in Aboriginal and Torres Strait Islander people attending the sites in 2009.

In the 12 month of 2009, a total of 11,682 Aboriginal and Torres Strait Islander people attended ACCESS sites; 506 at one ANC, 1439 at 25 SHSs, 2185 at 27 GPs and 7552 at eight ACCHS. Overall 62% of for Aboriginal and Torres Strait Islander patients were female. Chlamydia testing rates for Aboriginal and Torres Strait Islander people varied between service provider networks; 3.95% at GPs, 17.7% at ACCHS, 62.8% at SHSs and 88.3% at one ANC. The corresponding chlamydia positivity rates at the network sites were 7.3% at GPs, 6.5% at ACCHS, 14.8% at SHSs and 12.3% for ANCs.

ACCESS has provided us with substantial information on chlamydia positivity and testing rates for Aboriginal and Torres Strait Islander people attending a range of different primary health care settings. Over time it is anticipated that ACCESS will provide substantial new information regarding rates of chlamydia infection especially in jurisdictions where passive surveillance data is incomplete for Indigenous status.

To describe the recent epidemiology of infectious syphilis among Aboriginal and Torres Strait Islander communities and consider whether it may be possible to eliminate syphilis from this population.

The National Notifiable Diseases Surveillance System (NNDSS) has collected infectious syphilis data from 1996 onwards. The group most affected by infectious syphilis in Aboriginal and Torres Strait people are female. Chlamydia testing rates for Aboriginal and Torres Strait Islander communities remains 6 times higher than for non-Indigenous Australians and around 23 times higher in remote areas. The group most affected by infectious syphilis in Aboriginal communities is females aged 15–19 years residing in remote communities. The public health imperative of eliminating syphilis is strengthened by the high pregnancy rates in this age group.

Elimination of syphilis from Aboriginal and Torres Strait Islander communities is not an unrealistic goal. Syphilis meets three main criteria for elimination: (a) availability of effective treatment, (b) availability of reliable means to diagnose infection, and (c) the life-cycle of the organism is confined within the human host. Further, the absolute number of notified cases is less than 200 nationally and these cases are geographically concentrated. A precedent has been set with the elimination of Donovanosis - why can’t we do it with syphilis?
Indigenous people have been the target of many interventions to address poor sexual health. Despite being a priority group for health research, Indigenous youth continue to bear a significant burden of sexual ill health. International studies demonstrate the social and cultural particularity of young people's sexual health, and argue that a lack of contextual understanding has weakened the efficacy of interventions. Very little is known about how Indigenous young people negotiate relationships, define risk, and conceptualise their sexuality and sexual decision making within their expectations of life. Even less is known about the positive aspects of sexual relationships that young people experience and how their views are influenced by the culture and society in which they live. The "Our lives" project sets out to investigate sexual behaviour and sexual decision making in the context of the everyday life experience and aspirations of Indigenous young people under 25 in the NT, WA and SA.

A key aspect of this research is the development of innovative qualitative methodologies to engage Indigenous youth in the research process. Body and risk mapping have played a central role in the preliminary phases of this project, alongside the development of Studio 34, a forum for promoting youth sexual health through the creation of media, music and arts by young people for young people. As there is strong community, government and non-government involvement, the resources developed can be shared across many sectors improving the likelihood of sustainable short and long-term benefits.

HIV risk factors and notifications are well understood for Australia's Indigenous population, and within this context injecting drug use (IDU) is an increasingly concerning risk factor for HIV transmission. Over the last 10 years the rate of HIV acquired through IDU has increased among Indigenous people, and is currently seven times the rate of non Indigenous peoples. This is of concern because epidemics around the world have escalated rapidly when widespread infection occurs in heterosexual populations and among injecting drug users.

We reviewed HIV epidemiological data, IDU demographic data and Needle Syringe Programs (NSP) access among Indigenous people, and incorporated these data into a mathematical transmission model in order to: (i) estimate the number of HIV infections that would have occurred in the absence of needle and syringe programs (NSPs); and (ii) forecast the expected number of HIV cases over the next 10 years according to current circumstances or if there is a change in injecting behaviour or access to NSPs.

The model shows us that an estimated 39 (0-140) HIV infections have been averted among Indigenous people due to NSPs over the last 10 years. If Indigenous people did not have access to NSP then it could be expected that rather than 3-4 IDU-related HIV transmissions per year, this population would experience up to an average of 231 incident cases per year. Similarly, if NSP coverage was to decrease by just 25% then annual incidence rates could increase by an expected 50-60%. If sharing of injecting equipment was to increase by 25% then projected incidence by 2019 would increase by ~31%; conversely, a 25% decrease in sharing of injecting equipment would result in a likely decrease in incidence by ~28% among Indigenous IDU.

This data highlights the importance of improving NSP access and coverage as well as targeted prevention messages for HIV and other BBV for this population.
Indigenous peoples are exposed to a number of risk factors for HIV acquisition including high rates of STIs and injecting drug use (IDU), and poorer access to health services compared to the non-Indigenous population. National HIV surveillance data was analysed to compare the pattern of HIV infection in Australia, by Indigenous status.

Information on Indigenous status at HIV diagnosis was sought prospectively for cases newly diagnosed from January 1995 and retrospectively for cases diagnosed in 1992 – 1994. Exceptions to this were Victoria and ACT which commenced in 1998 and 2005 respectively.

Of 14,185 cases of HIV infection newly diagnosed in Australia in 1992 – 2008, 320 were identified as Indigenous, 13,001 as non-Indigenous, and a further 864 not reported for Indigenous status. Fewer than 10 cases of HIV have been diagnosed among Torres Strait Islander people in the period 1992-2008. The median age at HIV diagnosis was 32.1 for Indigenous cases vs. 36.4 and among Indigenous cases women accounted for 27% vs. 12% of non-Indigenous cases. The rate of HIV diagnosis in the Indigenous population declined from 5.8 in 1992 – 1998 to 4.1 in 2004 – 2008, whereas the rate increased in the non-Indigenous population from 3.8 to 4.3 in the same periods. HIV transmission among Indigenous men who have sex with men (MSM) was relatively stable at 51% in 1992 – 2008. The percentage of HIV diagnoses among non-Indigenous MSM declined from 74% in 1992 – 1998 to 68% in 2004 – 2008. Indigenous cases attributed to heterosexual contact declined from 34% in 1992 – 1998 to 23% in 2004 – 2008 and increased from 14% in to 23% among non-Indigenous cases in the same periods. Among Indigenous cases, HIV infection attributed to IDU increased from 4% in 1992 – 1998 to 22% in 2004 – 2008, whereas cases among non-Indigenous remained stable at 3% in 1992 - 2008.

Long term trends indicate a similar population rate of newly diagnosed HIV infection by Indigenous status. The substantially higher percentage of Indigenous cases with a history of IDU, among younger people, women and heterosexual cases has implications for STI/BBV policy in Australia.
HIV acquisition remains a critical issue in the developing world with an estimated 7000 new infections daily worldwide. More than 60% of these infections are in women under the age of 25. Therefore, there is an urgent need to develop prevention methods that are safe, efficacious and acceptable, while allowing the at risk individuals to protect themselves from infection. In the absence of an effective vaccine a microbical product would provide such an option. Currently antiretrovirals are being used to treat HIV infected patients in order to lower the viral load. However, recently they have been considered as potential microbicidal candidates.

Tenofovir, an NRTI, is one of the leading antiretrovirals being evaluated as a possible microbicide candidate. A recent phase III clinical trial in South Africa found that a 1% Tenofovir gel was 39% effective in reducing a woman’s risk of becoming infected with HIV during sex. Dapivirine is an NNRTI with high potency against HIV-1 (IC50 value of 0.9) that is also being evaluated as a potential microbicide candidate. A randomized, double-blind, phase 1 trial of a 0.05% Dapivirine gel, conducted in 36 healthy HIV-negative women and found the gel to be safe and well tolerated.

Intravaginal rings (IVRs) have been used to deliver drugs to the vagina and systemic circulation for a number of years. The three primary products available are Femring®, Estring®, and Nuvaring®. These products are used for either hormone replacement or contraception and are generally well accepted by women. The possibility of IVRs deliver one or more drugs (microbicide) over an extended period of time (e.g. months) is potentially useful in preventing HIV transmission. IVRs are torus shaped devices manufactured from elastomeric or thermoplastic materials. IVRs can be manufactured as either matrix or reservoir-type devices. Therefore IVRs offer the potential to provide continuous release of two or more antiretrovirals to the vagina over a period of 1 to 2 months, thus reducing compliance issues which are associated with microbicide gels.
Young people living in the Torres Strait are strikingly vulnerable to an HIV/AIDS outbreak. This vulnerability is evidenced by data indicating inadequate knowledge of sexually transmitted infections (STI) and HIV (especially HIV transmission), frequent risk behaviours and a low level of a sense of personal threat from either STI or HIV. These factors are compounded by deficient implementation of sex education in schools, poor access to condoms and to confidential sexual health services, persistently high prevalence/s of the common bacterial STI, and by the region's proximity to Papua New Guinea where a generalised HIV epidemic is now well established. In the main, the Torres Strait population and culture is religious and conservative and discussion of harm minimisation HIV prevention strategies, is confronting. This presentation will begin to explore local responses to the possibility of individually mediated prevention strategies, in the face of the potential for an established HIV epidemic.

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**PAPER NUMBER: 186**
**CHALLENGES TO WOMEN’S LIFELONG ACCESS TO ARVs**

Paxton S
Advisor

To examine the challenges to accessing HIV services for women in six Asian countries.

Twelve HIV-positive women from Cambodia, China, India, Indonesia, Thailand, Vietnam, were trained in qualitative and quantitative research methods.

Women designed a questionnaire and focus group discussion (FGD) guide and pilot tested the tools.

Over 1,300 questionnaires were administered and 38 FGDs conducted.

Data was analysed using SPSS; FGDs were analysed thematically.

In all countries except China, a majority of women received post-test counselling.

Most women travel to their nearest HIV clinic at least once per month.

Women with positive children travel more often and further than other women.

Young women and women in urban areas had significantly easier access to antiretroviral medication (ARVs).

Most women said they had needed HIV services in the past six months but were not able to get access to them.

An ongoing and major challenge to women’s access to ARVs is money for transport (79%).

One in two women faced discrimination within the public health system in the previous two years; older women, migrants and refugees were significantly more likely to face discrimination than others, including sex workers and drug users.

If ARV access is to be sustainable, clinicians need to prescribe more than one month’s ARVs per visit once the client is stable. Two months at a time reduces transport costs by half, making it easier for women to raise cost of travelling to and from the clinic.

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**PAPER NUMBER: 291**
**COLLABORATION FOR HEALTH IN PAPUA NEW GUINEA (PNG) – AUSTRALASIAN SOCIETY FOR HIV MEDICINE (ASHM) CLINICAL MENTORING PROGRAM**

Ankus JM, Reis E

1 Australasian Society for HIV Medicine, Sydney, NSW, Australia

HIV prevalence rate in PNG is expected to rise from 1.61% in 2007, to 5.07% in 2012 (NDOH and NACS, 2007). The 2007 Estimate report on the HIV epidemic in Papua New Guinea identifies that faith based organisations accounted for 50% of ART sites but currently only cater for 8% of all patients on ARV, while only 38% of HIV positive people who need treatment are receiving it (UNAIDS/WHO, 2008).

Increasing numbers of people testing HIV positive in PNG especially in rural areas and the need for HIV treatment access is placing strain on existing health care services. Health care workers need to be up skilled in HIV treatment care and support to meet the demands of the growing epidemic.

**Description**

The Collaboration for Health in PNG is a philanthropic initiative of six Australian based pharmaceutical companies (Boehringer-Ingelheim, Gilead, GlaxoSmithKline, Merck Sharp and Dohme, Pfizer and Tibotec) formed in 2002. In 2007 they funded the ASHM Clinical Mentoring Program 2008-2009. The program focuses on working with the PNG National Catholic Health Service in providing regular mentoring visits and training to staff at seven selected HIV treatment sites across PNG.

**Lessons Learned**

The Program was independently reviewed in late 2009. Findings show that the program is well regarded amongst clinical sites and stakeholders, has had a significant impact on health sites and has assisted in better clinical management of HIV positive people.

Conclusions from the review and program coordination indicate the importance of:

- Continuity and regularity of mentoring visits
- Confidence and cultural sensitivity of mentors
- Monitoring and evaluation strengthening
- Collaboration with the PNG National HIV Program

**Next Steps**

The Clinical Mentoring program has received further funding for another two years. This Program will focus on consolidating achievements and expanding services to a further two sites. The Program will also provide, for the first time, mentoring and training to public health services in PNG.
Since 2005, the Vietnamese government has been implementing highly active antiretroviral therapy for individuals infected with HIV. ARV drugs have been provided via three systems administered by PEPFAR, World Bank, and the National Drug Program for free access through 206 outpatient clinics nationwide. However, only about 30% of HIV patients received treatment in 2009, far behind the goal of the National HIV Strategy to provide ARV to 70% AIDS patients by 2010. This qualitative study explores barriers to ARV treatment in Vietnam that may shed light on such low coverage.

The study was undertaken in 5 provinces (Hanoi, Hai Duong, Quang Ninh, Bac Kan, and Bac Giang), representing different geographical regions in northern Vietnam (urban, rural, and mountainous). Data was gathered from 5 clinics in 9 focus groups with HIV patients who are on ARV treatment, 13 in-depth interviews with doctors, and 15 in-depth interviews with non-ARV HIV patients.

Findings indicate that patients identified the fear of being known to have HIV positive as the biggest obstacle to the use of ARV clinics. Furthermore, limited knowledge in ARV, unstable living and working place, poverty, travel difficulties, and the lack of social support from family and community hinder patient efforts to access to the treatment. Providers reported that inconsistent patient management system among different ARV clinics, coupled with a shortage of qualified specialists, lack of facility and equipment, too complicated ARV distribution mechanism, and long waiting time before getting approval for free drugs comprise significant structural barriers to high coverage of ARV treatment in Vietnam. They also noted that social stigma attached to HIV/AIDS, inadequate media health education, poor patient supportive policy, weak coordination between relevant government authorities, and lack of linkage among different projects that provide HIV-related services are the core issues of poor ARV uptake.

To improve access to treatment, outpatient clinics need to be reorganized, operating in a consistent system, and provided with sufficient human resource, facilities and equipment. The Government should adopt the Supportive Program for HIV patients through a Health Insurance Scheme, and promote health education for HIV patients, particularly in remote areas.

In New South Wales (NSW) and Western Australia (WA), a significant number of new HIV cases are diagnosed by general practitioners (GPs) who have limited or no experience in providing a new HIV diagnosis. This group also do not easily or proactively access support and information before delivering the new diagnosis.

The ASHM Mentoring at the Time of Diagnosis Project aims to support the GP through making a new diagnosis. Three HIV reference laboratories across NSW and WA act as a referral point, offering mentoring service to low HIV case-load GPs, when notifying a positive HIV result. Support is then provided by experienced clinical advisors through a phone mentoring service supplemented with resources, before the patient is aware of the result. The project also aims to encourage GPs to consider a shared care relationship, to continue to care for the patient’s general health and wellbeing, alongside tertiary specialist services.

Since commencement of the project in late 2009, 40 GPs have been mentored. The GPs were primarily located in metropolitan centres with 24 diagnosing HIV for the first time. The mentoring service almost always accessed the GP before the diagnosis was delivered to the patient. The most common reasons for GPs declining the mentoring service are that they have existing experience in giving an HIV diagnosis or that they have access to an experienced colleague for support.

Contact tracing and testing of contacts was the information most often requested by the newly diagnosing GPs. Other common requests included information about referral to tertiary providers and the GPs’ role in the ongoing management of the patient. Encouragingly, 20 mentored GPs were interested in engaging in a shared care relationship.

Preliminary data indicate that inexperienced GPs are being reached and supported by the clinical advisors, before the delivery of an HIV diagnosis.

A detailed independent evaluation of the project is being undertaken to review the impact of mentoring on the GPs’ clinical practice and patient outcomes. The intention is to expand the project to include the remaining NSW reference laboratories.
With the development of highly active antiretroviral therapy (HAART), suppression of HIV and long term survival of HIV positive patients is expected in Australia today. The clinical challenge facing HIV clinicians today is to move from a model of care focusing on viral suppression to a chronic disease model in which co morbid conditions and risk factors are comprehensively assessed and managed to reduce rates of serious non AIDS related morbidity and mortality. The first step is assessment of the current standard of clinical care of HIV patients in Australia today.

HIV positive patients attending Clinic 87 at Nambour, QLD in 2009 were retrospectively studied. Parameters assessed in the audit included; a) HIV-specific parameters b) screening for co morbid infections including viral hepatitis, sexually transmitted infections and latent tuberculosis c) screening for non infectious co morbid conditions including; cardiovascular risk factors, renal disease, osteoporosis, psychiatric diagnoses and substance abuse, and d) health system delivery factors.

Of 180 HIV positive patients included in the audit, 88% patients were currently receiving HAART but 32% had a detectable HIV viral load in the 12 month audit period. Compliance was recorded as high, but side effects of HAART were only documented in 54% patients. Failure to attend clinic appointments was frequent (29% patients) and follow-up of failure to attend was not comprehensive.

This audit documented the rates of identified areas where improvements are required in the assessment and management of co morbid conditions. There were high rates of smoking (52%), hypertension (16%), and dyslipidaemia (17%). These risk factors were not assessed in all patients, and where detected were not modified in a significant proportion of patients. Significant rates of proteinuria (56%), and elevated blood glucose (15%) were recorded.

HIV positive patients require complex HIV-specific care, but also have high rates of co morbid conditions that are not comprehensively managed under the current clinical paradigm. There is an urgent need to develop clinical algorithms and care pathways to systematise detection and management of these conditions, and for audit and benchmarking between clinics to ensure high standards of HIV clinical care throughout Australia.
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In 2005 the requirement for level 2 (procedural) indemnity was removed by the major local medical indemnity provider in SA (MDASA). This was subject to the GP completing an accredited training, including clinical and practical components. SHine SA developed and implemented this course as we were the only primary care providers of IUD insertion in the Adelaide metropolitan region. The purpose of this research is to do a long term evaluation on the course we developed to review and revise so the course continues to practically encourage GPs to return IUD insertion to normal scope of general practice.

This paper reports on a long term evaluation of this course which has followed up on all the GPs who attended the initial theoretical part of the course before July 2009. The research will find the number completing their practical training and the number who did go on to insert in their primary care setting. In addition more qualitative data on the reasons for the subsequent continuation or discontinuation will be explored including both clinical confidence issues and practical barriers such as cost of setting up, Medicare rebate and availability of emergency equipment.

The methodology will be a questionnaire forwarded to all the participants of the course run by SHine SA since July 1st 2005 when the change was signalled by the medical defence organisation. The increasing popularity of the IUD as treatment and contraception has made the training of GPs to insert IUDs in primary care settings a major issue for women's access to IUDs. By evaluating the effectiveness of this training and revising our training in the light of the evaluation we hope to be able to deliver more effective training.

Sexual practices have been associated with the acquisition of a variety of infections. It is increasingly recognised that certain cancers are also linked to sexual activity. Human Papilloma Virus has been associated with the development of High-grade Squamous Intraepithelial Lesions (HSIL), the precursors of anal cancer.

Early sexual debut and multiple sexual partners have been described as risk factors for the development of HSIL. We set out to explore the possible contribution of certain esoteric sexual practices to the development of HSIL.

We conducted a study among HIV-positive men who have sex with men in an outpatient clinic in Sydney between October 2008 and January 2010. Comprehensive sexual histories and self-collected anal samples were collected for subsequent cytological analysis.

291 HIV-infected men participated in the study. Their median age was 50 years (range 25 - 75 years); the median age at first receptive anal sex was 19 years (range 6 – 50 years). Of the 60.1% (n=175) reporting having douchéd at least once, 73 (42.0%) douchèd at least once per week. Of the 64 (22.3%) reporting ever having been fisted, 4 (6.9%) were fisted weekly; 204 (70.1%) reported ever having used anal sex toys receptively, of whom 6 (3.5%) reported this practice at least weekly. In the 91 (31.3%) giving a history of ever inserting recreational drugs anally (shelving), 1.3% reported shelving at least once per week.

There was no significant difference in degree of anal cytological abnormalities between men ever having douchéd (p=0.972, CI180-190), ever being fisted (p=0.757, CI1.74-1.93), ever using receptive anal sex toys (p = 0.476, CI 1.79 to 1.89), ever shelving recreational drugs (p=0.61, CI1.79-1.94) and ‘never’ engaging in any of these esoteric sexual practices.

Esoteric sexual practices were poor predictors for the detection of abnormal anal squamous intraepithelial lesions.
POSTER NUMBER: 3
PAPER NUMBER: 449
PREGNANCIES IN WOMEN UNDER THE AGE OF 25 IN OUTER WESTERN SYDNEY.

Bower H1, Fleming KL1, Newman P2, Read CM3

Family Planning NSW:
1The Warehouse Youth Health Centre, Penrith, NSW, Australia,
2Data and Evaluation Unit, Ashfield, NSW, Australia, 3Consultant to Family Planning NSW.

Introduction
Teenage pregnancy is a global issue with Australia having one of the higher teenage pregnancy rates in the developed world. In 2008 clinicians at the Warehouse Family Planning youth clinic anecdotally reported a rise in unplanned pregnancies at the clinic. This study aimed to quantify the number of pregnancies presenting to the Warehouse and their outcomes.

Methods
A retrospective file audit was undertaken of pregnancies in women aged 14 to 24 presenting to the Warehouse between February 2008 and February 2009 inclusive.

Results
There were 82 pregnancies in the review period; 56 (68%) in women aged under 20 and 37 (45%) in women aged 16-18 years.

Contraceptive usage was available for 63 women: 36 (57%) reported using a contraceptive and 27 (43%) no contraceptive. Condoms were used by 19/36 women (53%), but over 50% reported irregular use or breakage. The combined oral contraceptive (COC) pill was used by 12 women (33%); half were irregular takers. Condoms plus the COC pill were used by 5 women (14%). The emergency contraceptive pill was used by 5 women.

Outcomes were reported for 54 pregnancies: 32/54 pregnancies (59%) were terminated; 15 (28%) continued, 5 (9%) miscarried and there were 2 (4%) ectopic pregnancies.

Conclusions
This audit of pregnant young women attending a family planning service indicated high rates of no or imperfect contraceptive use, and little use of combined contraceptive methods. This information will be used to develop health promotion strategies to encourage more positive contraceptive behaviour. A focus on regular and correct contraceptive use will aim to assist women who are pregnant to modify future contraceptive behaviour to avoid further unintended pregnancies.

POSTER NUMBER: 4
PAPER NUMBER: 134
HIV TESTING OF HOMOSEXUAL MEN: CLINICIANS AS PART OF THE TESTING EQUATION

Petlo T1, Fairley CK1,2, Whitton B3, Chen MY1,2

1Melbourne School of Population Health, University of Melbourne, Australia 2Melbourne Sexual Health Centre, Alfred Hospital Australia

Introduction
High HIV testing coverage of men who have sex with men (MSM) attending clinical services has been advocated to improve early HIV detection. The proportion of MSM tested has been used as a measure of service quality. The aim of this study was to determine HIV testing rates and predictors of testing among MSM attending a sexual health service, including the impact of the treating clinician.

HIV testing rates among MSM attending the Melbourne Sexual Health Centre between 2003 and 2009 for the first time were calculated for individual treating clinicians. Factors independently associated with HIV testing were determined by logistic regression. Medical records were audited to ascertain the reasons why HIV tests were not performed.

Overall, 78% of 4425 men were tested for HIV. Men reported a median of 6 male partners in the prior year with 51% reporting unprotected anal sex. Seventy six percent of men reported a previous HIV test, performed a median of 12 months prior to their visit.

HIV testing rates were higher for nurses (median 89%; range 77-95%) than doctors (median 73%; range 45-88%) with significant differences between doctors but not nurses (p<0.001).

Men were less likely to be tested if they presented with symptoms of an STI (AOR 2.7, p<0.001) and if they saw a doctor versus a nurse (AOR 1.9, p<0.001) independent of recent sexual risk and duration since their last HIV test. Reasons for not testing included patient decline (28%) and recent testing (15%); however, no reason was documented in 39%.

While overall HIV testing rates were high, substantial differences in testing rates between clinicians were evident. Strategies geared at optimizing HIV testing need to take into account the frequency with which clinicians offer testing.
Lymphogranuloma venereum (LGV) has re-emerged among men who have sex with men (MSM) internationally. Previous cases among MSM in Australia have been reported. We aimed to characterise a series of LGV cases seen at the Melbourne Sexual Health Centre.

We reviewed all cases of LGV seen at the Melbourne Sexual Health Centre between 2005 and 2010. During this period MSM who were diagnosed with rectal chlamydia using strand displacement assay were routinely questioned about symptoms of proctitis using a symptom check list. Those with symptoms of proctitis had specimens forwarded for Chlamydia trachomatis omp1 genotyping. Genotyping of chlamydia-positive first void urine and penile ulcers in MSM was undertaken on selected MSM based on clinical presentation.

During the study period, of 292 chlamydia positive ano-rectal specimens that were genotyped, 21 (7.2%) tested positive for LGV. Of the 8 chlamydia positive urine or penile specimens genotyped, 4 were positive for LGV. There was also one case of an inguinal bubo that tested LGV positive from aspirated pus. In all cases L2 or L2b type was isolated.

Of the 25 cases of LGV, 18 (72%) were in HIV positive men. Of the 21 men who had ano-rectal LGV, all had ano-rectal symptoms, namely: ano-rectal pain (71%), anal discharge (62%) and/or rectal bleeding (52%).

All but one of the LGV infected men received at least a 3-week course of doxycycline 100mg twice daily. Two men with ano-rectal LGV remained LGV positive on follow up when tested 3 months later. Both these patients were noted to have had unprotected sex following initial treatment, hence, it is unclear whether this was due to treatment failure or reinfection.

LGV continues to be seen among MSM in Melbourne presenting with proctitis. Genotyping of anal chlamydia infections has been useful in distinguishing LGV from the more common non-LGV chlamydial infections, therefore ensuring appropriate antibiotic therapy and follow up are instigated.

The sexual health team at South Metro Public Health Unit identified a trend of female patients with laboratory confirmed Chlamydia, who had also presented to metropolitan Emergency Departments (ED) in the previous month with associated symptoms but had not received Sexually Transmitted Infection (STI) testing at that time. Eleven patients were observed over a two month period.

As a result an education program – ‘The 2 Pot Piss’ was introduced to encourage ED staff to consider Chlamydia as a differential diagnosis, particularly for women less than 40 years of age with abdominal pain, and/or gynaecological or urinary symptoms.

The 2 Pot Piss programme requires a patient to provide a First Void Urine together with a Mid Stream Urine sample. Positive results are treated as per gold standard. Follow up of all ED positive STI testing is undertaken by the sexual health team at South Metro Public Health Unit to ensure appropriate contact tracing and treatment is completed.
To determine the proportion of clinically important diagnoses in a low-risk, asymptomatic population who use a computer-assisted self-interview (CASI) to assess risk profiles, and to calculate the proportion and confidence intervals of clinically important diagnoses.

Medical records were retrospectively analysed between July 2008 and June 2009 for risk characteristics and diagnoses.

In 1060 patients, there were 26 clinically important diagnoses; 22 cases of genital warts, 3 of herpes and 1 unintended pregnancy. There were 54 cases of chlamydia.

The STIs detected in a low-risk, asymptomatic population completing CASI were genital warts, herpes and chlamydia. As chlamydia is effectively diagnosed and managed from self-collected samples, patient review is not always required. This study provides evidence for an express testing service for chlamydia to streamline the screening of low risk, asymptomatic patients as identified by CASI without the need to for a traditional face to face consultation.

Chlamydia, express testing, computer-assisted self-interviews (CASI)

Australia provided free quadrivalent human papillomavirus (HPV) vaccine to 12-18 year old girls in a school-based program from April 2007 and to women <27 years through general practices from July 2007. Coverage rates for three doses of the vaccine are about 70% in both groups.

The proportion of new clients with genital warts at Melbourne Sexual Health Centre (MSHC) from January 2004 to December 2009.

44,256 new clients attended MSHC between 2004-2009 and genital warts were diagnosed in 4,518 (10.2%; 95% confidence intervals (CI): 9.9-10.5). The proportion of warts in women <28 years fell from an average of 12.7% before 2008 to 4.4% in the last quarter of 2009. The proportion of new clients with genital warts was significantly lower in 2008-9 than 2004-7 for women <28 years (RR=0.45 (95% CI, 0.39-0.52)), heterosexual men (RR=0.82 (95% CI 0.75-0.90)) and men who have sex with men (MSM) (RR= 0.80 (95% CI, 0.65-0.98) but not women ≥28 (RR=1.1 (95% CI, 0.87-1.3)). The falls in warts in women <28 and heterosexual men occurred despite significantly higher mean numbers of sexual partners per year in 2008-9 compared to 2004-7 (P<0.001 for both women <28, and heterosexual men). In contrast, the fall in warts in MSM was associated with a lower mean number of male partners in 2008-9 (11.5 partners per year) compared to 2004-7 (17.3 male partners per year, P<0.001).

Our data suggest that the initial rapid and marked reduction in the incidence of genital warts among women <28 years of age, originally seen in 2008, is continuing in 2009. The reduction in genital wart diagnoses observed in MSM may be due to a lower risk profile of MSM in 2008-9.
Access to sexual health services is limited in parts of rural Victoria where embarrassment, confidentiality and stigma, present significant barriers. For young people, access is further limited by cost and travel. In June 2009, Melbourne Sexual Health Centre (MSHC) commenced TESTme, a 12 month sexual health service pilot to provide access to sexual health services for young people, Aboriginal people and men who have sex with men. The project was funded by the Victorian Department of Health.

The TESTme website was developed and either telephone or webcam sexual health consultations were provided by a MSHC sexual health nurse. Potential clients made contact with TESTme via a 1800 freecall number. If STI testing was recommended, a testing pack was posted which included self collected swab/s, instructions, an evaluation questionnaire and a reply paid envelope. Clients with positive results were phoned and free treatment was posted to them.

The TESTme pilot service screened 24 at risk clients and found a Chlamydia prevalence of 16.6%. Approximately $15,000 was spent on advertising however; no client contact resulted from this. Most referrals (64%) were from school and community health nurses. In response to community feedback and the project steering committee changes to the initial TESTme model occurred. The TESTme website was re-developed and access changed to include phone or website. Webcam consultations were removed due to negative feedback from young people; all TESTme clients chose telephone consultations.

Accessing at risk individuals living in rural Victoria was difficult. School nurses and community health nurses were the best way to reach these individuals rather than mainstream advertising.

The pilot is now complete and TESTme has been integrated as an important extension to MSHC service delivery. It continues to provide STI testing to rural Victorians who are at significant STI risk.

A 38 year-old man who regularly attends a primary health care clinic complained of increasing lethargy and recurrent respiratory tract infections. He was previously known to have multiple casual male sexual partners (involving unprotected receptive and insertive anal intercourse) but no prior diagnosis of a sexually transmitted infection. (He was most recently screened for HIV, Hepatitis B, Syphilis, Gonorrhea and Chlamydia in March 2010.) Examination revealed that the patient was slightly pale but no other abnormality. Basic blood investigations were performed revealing a mild anaemia with a haemoglobin of 103 g/L (130 – 180 g/L), MCV of 97 fl (80 – 98 fl) and normal hepatic and renal function. Additional testing was performed to determine the cause of anaemia. A blood film demonstrated macrocytosis, spherocytes, bite cells and occasional nucleated red blood cells consistent with oxidative haemolysis. Other parameters were consistent including high lactate dehydrogenase, high reticulocyte count, low haptoglobin positive Heinz bodies and negative direct Coomb’s test.

On further questioning the patient admitted to inhalational amyl nitrite (‘poppers’) use. Other causes of oxidative haemolysis were excluded including excessive fava bean consumption, normal glucose-6-phosphate dehydrogenase (G6PD) testing, normal serum electrophoresis and normal methaemoglobin level. Upon cessation of this recreational drug his haematological parameters returned to normal.

Haemolytic anaemia caused by amyl nitrite has been infrequently reported in the literature. Significant haematological manifestations may develop in patients with no underlying haemoglobin or enzyme abnormality. It is important to be aware of this rare but potentially serious adverse effect of recreational drug use with this agent.
NO TIME TO WASTE!
TIMELY TREATMENT OF CHLAMYDIA TRACHOMATIS - AN AUDIT


B2 Sexual Health Clinic, Fremantle Hospital & Health Service, Fremantle Western Australia.

The B2 Sexual Health Clinic regularly screens for chlamydia trachomatis (C/T), providing treatment and follow-up for clients with a positive result. A retrospective audit was undertaken to evaluate time to treatment of C/T infections occurring 1/1/2009 to 31/12/2009 inclusive. Reminders for follow-up were also included in the audit. Clinic database and client case files were utilised for data review.

161 episodes of positive C/T were identified with 40 cases included in the audit. Exclusions were made for data entry error, diagnosis or treatment elsewhere, and presumptive treatment on day of testing.

When a positive result is identified, the laboratory directly notifies the Clinic via telephone.

97.5% cases were treated within 14 days of testing. All cases (100%) were treated within 14 days of B2 clinic being notified of a positive result. Average time between specimen collection and treatment was 4.6 days (range 1 – 15), with a median of 4 days.

In all cases (100%) an attempt was made to contact the client on the same day that B2 received the positive result, with 80% being notified on that day. 95% clients were notified of their test result within seven days of specimen collection. Average number of contact attempts was 1.5 (range 1 – 6); the median was one attempt. Average time between test and client notification was 2.5 days (range 1 – 9), with a median of two days.

Reminders, mainly by telephone, were made to 77.5% clients when follow-up testing was due. An additional 17.5% had follow-up appointments without documented reminders and 5% clients did not receive follow-up reminders. While 75% had documented reference to follow-up appointments, 25% had no evidence of a post-treatment appointment.

This audit, with reference to literature, indicates that the B2 Clinic functions competitively alongside other sexual health clinics both nationally and internationally.

POSTER NUMBER: 12
PAPER NUMBER: 528
DOWNLOAD TO DIAGNOSIS: TESTING FOR CHLAMYDIA ONLINE

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An online chlamydia screening program was launched in February 2010 by the Western Australian Department of Health (WA Health). The program aims to improve access to chlamydia testing and is coordinated by Fremantle Hospital’s B2 Sexual Health Clinic. The program can be accessed via WA Health’s youth sexual health (http://www.getthefacts.health.wa.gov.au) and chlamydia (http://www.couldihaveit.com.au) websites.

Participants must be 16 years or older, have a mobile telephone, access to a computer with printer and the ability to visit a PathWest specimen collection site. Symptomatic participants are advised to see a doctor immediately. Concerns can be discussed with a nurse through a telephone helpline. Participants complete a brief online self-assessment before entering their details onto a printable pathology request form. They then present, with the pathology form, to a PathWest collection site where they receive instruction on specimen collection. Males provide a first catch urine specimen, females provide a self-obtained low vaginal swab (SOLVS). Specimens are tested for both chlamydia and gonorrhoea. Testing is funded by WA Health, so the participant incurs no financial costs.

Results are faxed to the B2 Clinic where a nurse follows up all positive results by notifying the participant via their mobile and providing counselling, referral for treatment and contact tracing. Participants who wish to be informed of their negative result can do so via a toll-free telephone number. All participants who have contact with the B2 clinic regarding results receive a risk assessment, safer sex education and are directed to an electronic satisfaction survey. Feedback to date has been encouraging.

Relevant data pertaining to participant demographics, test results and outcomes are captured on a database. Media advertising for the program is scheduled for late July 2010.

This presentation will discuss project challenges, milestones and preliminary data.
Background
In 2008, the Sydney South West Area Health Service (SSWAHS) Sexual Health Service, introduced specific strategies to encourage sex workers to attend its sexual health clinical service in Liverpool, Sydney.

Method
Data was collected one year prior to implementation of the strategies – 2007, and one year after -2009, for evaluation. From this data, female sex worker registrations, attendances and new sex workers accessing the service was analysed, together with sexually transmissible infection and associated diagnoses. The results, in association with the strategies will be presented for discussion.

Findings
In 2009 statistically significant increases were demonstrated in the number of female sex worker registrations. There were 178 female sex worker registrations at the Liverpool sexual health clinic out of a total 810 female registrations, in comparison to 2007, where there were 126 female sex worker registrations out of a total 1219 female registrations p<0.0001.

Similarly, 2009, showed increase of statistical significance in female sex worker attendances. There were 557 female sex worker attendances out of a total 1891 female attendances, as compared with 2007, there being 505 female sex worker attendances out of a total 2806 female attendances p<0.0001.

Again, in 2009 a statistical significant increase was seen in the number of new female sex workers presenting to the Liverpool sexual health clinic. Seeing 73 new sex workers out of a total 410 new female clients, as compared with 2007, seeing 45 new sex workers out of a total 464 new female clients p<0.0023.

Conclusion
The strategies implemented have impacted in a positive way – increasing the number of sex workers registered, attendances and new sex workers accessing the service. The key strategy of working collaboratively with the Health Promotion Team – may be considered the reason for the success. Thus, continuation of this approach is warranted, with a recommendation to expand and develop further strategies.

Nucleic acid amplification tests (NAAT) have enabled highly sensitive chlamydia screening using non-invasive urine samples. Current recommendations are for men to hold their urine for at least 1-2 hours before urine testing. Although studies have shown no difference in sensitivity when comparing time periods greater and less than two hours, the minimum acceptable time remains unclear. Due to the extremely high sensitivity of NAATs it is plausible that test sensitivity would be acceptable with shorter times since urination. As chlamydia testing is often performed opportunistically on asymptomatic individuals, the deferral of testing due to recent urination may result in less screening being performed.

Men returning to SSHC for treatment of asymptomatic urethral infection between July 2009 and June 2010 were asked to participate. Men were excluded who had either received antibiotics in the last 8 weeks or urinated within the last hour. Two first-void urine samples were collected at 20 minute intervals. Samples were tested using the Roche COBAS Amplicor PCR test. A short questionnaire was used to elicit symptoms. The positivity of paired samples was assessed to determine their relative sensitivities.

A total of 22 men have been enrolled. All 22 samples were positive 20 minutes after voiding (100%, 95% confidence interval 85-100%).

Our findings are consistent with a previous study in symptomatic men that showed no reduction in sensitivity using samples at 20 minutes after the previous void. However, our study only included men who were asymptomatic, as these men have the lowest organism load, and hence likely to have the greatest reduction in sensitivity with recent voiding. We will continue to recruit men to achieve the required sample size to demonstrate equivalent sensitivity. Removal of this barrier may boost the uptake of chlamydia screening programs among men. Voiding intervals as short as 20 minutes do not affect NAAT sensitivity.
In December 2008, the Northern Territory (NT) parliament passed legislation mandating all adults in the NT to report to police any sexual activity in a child below 16 years of age. Following review in August 2009 the legislation was changed to mandatory reporting of all sexual activity under 14, and in the age group of 14-15 reporting if the age difference between partners was two years or more. This legislation raised fears in clinicians about a possible drop in service access in under 16-year-olds, an age group that has a significant prevalence of STIs. Therefore we audited pre and post-legislation-change service access of under 16 attendees to Clinic 34 (urban public sexual health service) in Darwin. We also reviewed numbers of Medicare rebated chlamydia tests performed in the NT to assess a possible change of service access by young people.

The retrospective audit study was performed using data from Clinic 34 for the calendar years 2005 to 2009 to audit the clinic service access. Over the studied time service access by the over-16 age-group has increased from 6013, 6233, 6382, 7658 to 9179 presentations respectively. However there has been no service access increase in the under 16 population, with the respective numbers being 67, 53, 58, 67, 58 per annum, with proportions changing per annum respectively from 1.1, 0.84, 0.9, 0.86, to 0.62.

Search of the Medicare database showed that for the years 2007 to 2009 3rd and 4th quarters (item numbers were first introduced in May 2007) Chlamydia testing items rebated changed from 12179, 12781 to 12812 respectively. Medicare service provision age group categories are 0-4, 5-14, 15-24 etc therefore some relevant data is not accessible. For the under 14 age group the relevant numbers for the years 2007-2009 were 561, 396 and 415.

Both of these data sources suggest a decrease in sexual health care for young people. This is the first opportunity to link a change in legislation relating to mandatory reporting of sexual activity to levels of sexual health care access in the NT. As the legislation then changed again in August 2009 this data can be reassessed to give a clearer picture of whether the change in legislation can be linked to changes in service access by young people. This is important information in an area where there is little Australian data.

Background: Self-collected anal swabs are being increasingly used for gonorrhoea and chlamydia screening among men who have sex with men (MSM). However, self collection of swabs removes the opportunity for routine examination of the perianal area by the screening clinician. We aimed to ascertain the practice of self-collected anal swabs and assess the nature and burden of perianal abnormalities detected by conducting routine clinical examinations of asymptomatic MSM attending RPA Sexual Health clinic.

Methods: We performed a retrospective case note review of asymptomatic MSM attending RPA Sexual Health Men’s Clinic for a routine sexually transmitted infection (STI) screen.

Results: To date, the clinical files of 140 MSM who presented for an STI screen between January and June 2009 have been reviewed. Five attendees (3.6%) had no anal swab specimen collected. Of the remainder (n=135), 97 (71.9%) performed a self-collected anal swab, although 9 attendees (9.3%) were also examined by the clinician. MSM attending nurses for screening were more likely to self-collect an anal swab specimen than those attending a doctor (75.3% vs 46.5% respectively, p=0.001). All anal gonorrhoea (n=1) and anal chlamydia (n=3) infections were detected from self-collected swab specimens. The only abnormal clinical finding among those examined was a perianal skin tag in one attendee. Further data collection is in progress and the analysis will be extended to cover a longer period of study.

Conclusion: Most asymptomatic MSM attending our clinic are performing self-collected anal swab specimens for gonorrhoea and chlamydia detection. MSM attending a nurse are more likely to self-collect anal swabs than those attending a doctor. Thus far, the yield of perianal abnormalities has been low and all anal infections have been detected on self-collected swabs. These findings suggest limited benefit of routine clinical examination among asymptomatic MSM.
The Royal Women’s Hospital is the largest public provider of therapeutic abortions in Victoria. Prior to their medical or surgical termination, all women presenting to the Pregnancy Advisory Service (PAS) from August 2009 have been screened for Mycoplasma genitalium in addition to Chlamydia trachomatis and bacterial vaginosis (BV). The prevalence for M. genitalium was 4.1% (CI 1.8, 6.3), C. trachomatis 5.2% (CI 2.3, 8.0) and BV 16.8% (CI 7.6, 26.1). The 27 tests of cure completed after treatment for M. genitalium have all been negative. Furthermore, M. genitalium appears to be less associated with BV than C. trachomatis and both M. genitalium and C. trachomatis exhibit less clinical symptoms than BV.

Preliminary data for the first 9 months following introduction of M. genitalium screening, demonstrates the average age of women attending the PAS clinic as 26.4 years. The age range was 12 – 46 years with 45.3% of the women under 25 years. Women with M. genitalium appear to be a slightly older group of women (average age 24.1 years) than those with C. trachomatis (average age 21.9 years).

This presentation will report on the first 12 months of screening for M. genitalium in the PAS clinic and its implications for service provision within The Women’s. Given the role of M. genitalium in cervicitis, screening for this bacterium should be considered but the lack of a commercial test is problematic.

As genital dermatological conditions are common, doctors working in sexual health need to be competent in the diagnosis and management of conditions such as Lichen sclerosus (LS). While there are some published guidelines on LS management, there are few published audits and the Auckland Sexual Health Service (ASHS) had no service guidelines. The object of this five-year retrospective audit was to review the notes of all new patients diagnosed with LS at ASHS and compare their management to international guidelines.

There were 143 patients included for analysis, diagnosed with LS at the ASHS between 1st January 2004 and 31st December 2008. The mean age was 36.9 years (range 17-82 years), most were NZ European (74%), 90 were male and 53 were female, with self referral the most common mode of presentation. While presenting symptoms differed between the sexes, in 31% and 19% of males and females, respectively, the diagnosis was made on incidental examination findings. Punch biopsies were performed in 63 of ASHS patients with histological confirmation of LS in 37% of patients overall. Clobetasol cream was the initial treatment prescribed for most patients (89%) but only 17% received information regarding their diagnosis. By the end of the audit period 27% of patients were still under active follow up, while 34% had no follow up arrangements documented. Patients receiving verbal and written information regarding their condition were more likely to be under active follow up.

Strengths and weaknesses were noted comparing international guidelines to ASHS management of LS. Firstly, biopsy rates were low and adjunctive investigations such as thyroid function tests were often not requested. LS treatment was very appropriate, although documentation of information delivery to patients needed improvement. Finally follow up arrangements required clarification and as a result of this audit written guidelines for ASHS have been produced.
The counselling unit at Sydney Sexual Health Centre (SSHC) provides brief counselling interventions for sexual health related concerns to priority group individuals (as defined within the New South Wales (NSW) Health Sexually Transmissible Infection (STI) and Human Immunodeficiency Virus (HIV) Strategies). It was observed that some individuals falling outside priority groups and some with non-sexual health related concerns were being referred for counselling. In 2009, a guide to counselling referrals document and a check-box counselling referral form, used in other settings, were adapted and circulated to clinical staff. As a prompt for referral, the counselling referral form was placed in every new client’s medical record.

This project compared referral trends during a 2-month period in 2008 with a similar 2-month period in 2009 that followed the introduction of the guideline document and form. Assessment as to whether these documents affected trends in counselling referral practices was conducted. The medical records of 80 and 87 clients were reviewed for the 2008 and 2009 periods respectively, to determine the reason for referral to counselling.

Compared with 2008, in 2009 there was an increase in referral of men who have sex with men (MSM), culturally and linguistically diverse (CALD) clients, and HIV positive clients. These increases were 2.3%, 5%, 11.3% respectively. The total percentage of clients with high priority presentations increased from 21% in 2008 to 45% in 2009 and those with presentations not listed as priority fell from 32% to 14% respectively. Most notable increases in priority presentation referrals were of clients with issues related to HIV diagnosis, sexual risk-taking behaviours, post-exposure prophylaxis (PEP), and extreme STI/HIV anxiety.

Referral trends showed more targeted referral practices. This highlights the potential benefit of these referral tools in multidisciplinary sexual health settings to ensure more effective use of limited specialist resources.

Prevention and control of sexually transmitted infections (STI) were established in Sri Lanka (SL) in 1952 based on a British model. The government central STI clinic and the national reference laboratory is situated in Colombo; the administrative and business hub in the country and it networks with thirty peripheral clinics and is considered one of the best in Asia.

To study the STI profile in Sri Lanka.

Quarterly data on STI and prevention activities are reported to the central clinic from all other clinics on standard formats. The database for the year 2009 was analysed to study the STI profile. In 2009, a total of 15,205 were newly registered at all clinics. Of them 59% have had at least one episode of STI with the majority being among the 24-29 year age group. Of them 60% were married and 48% were employed. The leading STI was herpes genitalis which had increased from 6.92 per 100,000 in year 2000 to 10.56 per 100,000 population in 2009. The rate of human papilloma virus (HPV) infection had increased to 5.93 per 100,000 from 2.61 per 100,000 in year 2000. A total of 18,970 were screened for syphilis and 6% were VDRL reactive and 3.1% were confirmed to have syphilis and 90% were treated for syphilis. Infectious syphilis was 1.03 per 100,000. Four cases of early congenital syphilis (CS) were recorded. A total of 20,579 HIV tests were done and 66 were confirmed to be positive by Western Blot test.

In SL the prevalence of bacterial STI are declining while the viral STI show an increasing trend. Since the incidence of CS is low, the goal is to eliminate CS by 2015. SL has a window of opportunity to scale up preventive measures to maintain a low level epidemic.
Delays in the provision of positive HIV results or failure of individuals to be informed of their positive HIV result potentially lead to ongoing HIV transmission and suboptimal HIV control. To determine the possible impact of point of care testing for HIV, we determined the duration between testing of men who have sex with men (MSM) who were diagnosed with HIV at Melbourne Sexual Health Centre between July 2002 and May 2009 and when they were informed of their result together with their reported sexual risk prior to testing. The medical records of all MSM who were diagnosed with HIV at Melbourne Sexual Health Centre between July 2002 and May 2009 were reviewed for recent risk history and time between HIV testing and receipt of their positive result. Over the period, there were 174 MSM diagnosed with HIV. For the 172 men who received their result the median time between testing and being informed was 9 days (range 3-71 days) with 25% of men not receiving their diagnosis for over 2 weeks. There were two men who did not receive their result and who despite extensive efforts could not be contacted. Men reported a median of 1 (range 0-3) regular male partner and 10 (range 0-1000) casual male partners over the 12 months prior to their diagnosis. Among men who reported anal intercourse in the prior 12 months, 8% and 20% reported 100% condom use, 38% and 72% reported inconsistent use while 54% and 8% reported never used condoms with regular and casual sex partners respectively. Five percent of men reported current sex work while 13% reported recent intravenous drug use. Forty percent of men had a concurrent STI. While most men attending the service received their result promptly, delays for some and the potential for further exposure of partners is concerning. These could be eliminated if a point of care testing was available.

Introduction
Increased frequency of screening among men who have sex with men (MSM) could improve STI control in this population; however published data on interventions that improve screening rates is limited. The aim of this study was to determine if introducing a Sexual Health Practice Nurse (SHPN) into a general practice clinic could increase HIV and STI testing among MSM who attend.

Methods
In October 2008, Melbourne Sexual Health Centre introduced a SHPN into a Melbourne general practice with a high caseload of MSM. Our evaluation compared STI testing data for nine months before (Period 1) and after the SHPN was introduced (Period 2). Complete testing was defined as HIV and syphilis serology, urine test and anal swab for chlamydia, pharyngeal and rectal swabs for gonorrhoea, from the same man on the same date, as per the STIgMA guidelines.

Results
Among HIV negative MSM, the proportion of MSM tested, increased from Period 1 to Period 2 as follows; HIV from 57.8% to 66.2%; syphilis from 59.9% to 76.6%; urethral chlamydia from 67.7% to 75.8%; pharyngeal gonorrhoea from 62.5% to 69.9%; and rectal gonorrhoea/chlamydia from 58.5% to 69.5% (all p<0.001). The proportion of episodes of complete testing also increased from 41.1% to 51.9% (p<0.001).

Among HIV positive MSM, the proportion of MSM tested, increased from Period 1 to Period 2 as follows; urethral chlamydia from 66.5% to 80.2%; pharyngeal gonorrhoea from 58.7% to 77.2% and rectal gonorrhoea/chlamydia from 55.3% to 73.5% (all p<0.001). The proportion of episodes of complete testing also increased from 32.3% to 56.2% (p<0.001).

Conclusion
The introduction of a SHPN into general practice significantly increased HIV and STI testing among MSM patients. Given that the majority of sexual health care is provided in general practice settings, such a model could help to improve screening rates in other practices.
POSTER NUMBER: 23
PAPER NUMBER: 526
WHAT DO GENERAL PRACTITIONERS THINK ABOUT THE ROLE OF A SEXUAL HEALTH PRACTICE NURSE IN A CLINIC WITH A HIGH CASELOAD OF MEN WHO HAVE SEX WITH MEN?

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Introduction
Little is known about the role of practice nurses in relation to HIV and sexual health care in the general practice setting. In October 2008, Melbourne Sexual Health Centre undertook a pilot project which introduced a Sexual Health Practice Nurse (SHPN) into a Melbourne general practice, with a high caseload of men who have sex with men (MSM). For the initiative to be successful, General Practitioners (GPs) acceptance of the SHPN role was crucial.

Methods
In November 2009, we conducted semi-structured interviews with the clinic’s GPs (n=4), seeking their opinions about the role of the SHPN. Data was thematically analyzed and organized into major themes and related sub-themes.

Results
Thematic analysis revealed three major themes; ‘GPs Work Experience’, ‘Quality of Care’ and ‘The SHPN Role’ and ten sub-themes. The GPs saw the SHPN as a team member who constructively contributed to patient management. The work undertaken by the SHPN, such as, HIV/STI testing and HIV chronic disease management planning and care, was thought to decrease GP’s work-time pressure and increase the utility of their consultation time, in essence the GPs felt ‘…”freed up to do doctoring work’. The GPs also felt the SHPN had increased access to, and enhanced sexual health services. Importantly, the role of the SHPN in HIV management planning and care was seen to lead to more comprehensive care. GPs indicated they would like the SHPN role to develop further and continue beyond the life of the project.

Conclusion
The role of the SHPN was found to be acceptable to the clinic’s GPs. This provides evidence that the SHPN role supports and compliments the work of GPs in the MSM high case load general practice setting. As a result, other MSM high case load general practices may consider implementing and developing the SHPN role.

POSTER NUMBER: 24
PAPER NUMBER: 249
CASE REPORT - A VERY UNUSUAL HIV CASE

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Introduction
Jack is a healthy 50 year old man. He was diagnosed with HIV since 1982, thus has been living with the diagnosis of HIV for the last 27 years. The diagnosis of HIV has been confirmed many times with HIV serology total Ab screen and Western blot, reactive for HIV 1. He has never been involved with HIV vaccine trials. Since diagnosis he has never been on antiretroviral therapy. He always has undetected viral load and HIV proviral DNA studies- DNA not detected.
Anogenital warts are commonly treated in outpatient or community settings using a variety of ablative and immunomodulatory modalities. Occasionally, individuals present with so-called giant condylomata for which local treatments are inadequate. Such cases represent a management dilemma and definitive treatment is often delayed for a variety of reasons, often with adverse outcomes.

We present a case of giant condyloma accuminatum with malignant transformation in a 47-year-old male. The 20-year history and the various unsuccessful attempts at treatment provide an unfortunate example of the natural history of this condition. It also behoves a critical analysis of how management could have been optimised.

A review of the topic is presented, as well as recommendations for definitive management protocols.

The frequency of Chlamydia and Gonorrhoea coinfection occurring in an Australian Sexual Health Centre is established. A file audit over a 10 year period was conducted examining all diagnoses of Neisseria Gonorrhoea in men and women over the time span 1999-2009. From this data the chlamydia coinfection rate is determined. Discussion includes the clinical implications regarding the immediate management of treatment of urethritis of men in a Sexual Health Centre.
POSTER NUMBER: 27  
PAPER NUMBER: 463  
REPLY LETTERS TO GENERAL PRACTITIONER REFERRALS – AN AUDIT OF RESPONSE RATES, TIMELINESS AND QUALITY OF REPLY LETTERS FROM SEXUAL HEALTH CLINICIANS.

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Replies to referral letters are a management directive and a health interagency etiquette. A literature review showed that general practitioners (GPs) value timely and appropriate feedback on referred patients but rates of receipt of reply letters vary from 11-69%. Poor communication can impact on patient care, contribute to adverse outcomes and lead to decreased patient and clinician satisfaction. We aimed to assess the proportion of GP referral letters receiving a reply; the timeliness of the reply; the quality of the content of the reply.

This audit reviewed files of GP-referred clients from 1/1/2008 to 30/6/2008 to assess compliance with clinic policy and the quality of the reply letter using a scoring system developed by one author (SM). 89 referred clients were identified of whom 47 were referred by a GP with 39 reply letters found. Standards set for the audit were:

80% response rate
80% sent within 4 weeks of the last clinic attendance
3. 80% should score >25/50 on a scoring standard assessing the inclusion of patient identifying details, diagnosis, test results, management plan, follow-up, letter structure (prose versus list format), exclusion of useless information, educational content

Of those referred with letters, 87% were sent a reply and all within 4 weeks of last clinic visit. 62% scored > 25/50 for quality of reply. Improvements were needed in letter format, inclusion of results, follow-up information and educational content. Training of staff is necessary to achieve a ‘good’ reply letter and should form part of orientation of all new clinical staff. Underutilisation of the opportunity to provide GPs with further education about management of common sexually transmissible infections is occurring because letters do not include educational materials or links to web-based information.

POSTER NUMBER: 28  
PAPER NUMBER: 445  
IMPROVING PAP SMEAR REMINDER SYSTEMS WITHIN QUEENSLAND SEXUAL HEALTH CLINICS

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The Pap smear workplace instructions utilised at Clinic 87 Sexual Health/HIV service were reviewed and it was highlighted that no reminder system was in place for clients with normal Pap smear results. Following consultation with other Queensland based sexual health clinics and Family Planning Queensland (FPQ), it was identified that many services did not have a local reminder system in place and viewed the Queensland Pap smear Register as a “reminder” system for clients with normal results. However as recommended by the National Health and Medical Research Council (NHMRC) and in accordance with the Queensland Health Policy, Protocols and Procedures for Registered Nurses as Pap smear Providers, all clients with normal Pap smear results are to be offered a reminder system by the Pap smear Provider. The Queensland Pap smear Register’s role is to notify the client 3 months after the Pap smear is due; this is not a reminder system.

The revised workplace instructions, currently implemented in Clinic 87, ensure duty of care to the client by:
- Ensuring appropriate follow up of abnormal Pap smears through management guidelines;
- Providing an efficient system for notifying all normal and abnormal results to clients by Pap smear Providers;
- Providing a recall system to ensure adequate follow-up of clients with screen-detected abnormalities and
- Maintaining client’s participation in the Pap smear program by offering a reminder system for all clients with normal result.
BACKGROUND
Two rounds of integrated biological and behavioral surveillance were conducted in 2006 and 2009 among men who have sex with men (MSM) in two urban cities in Vietnam. We analyzed trends in HIV prevalence and behaviors among MSM to provide data for program planning in this population.

METHODS
Using respondent-driven sampling, we recruited 397 and 399 MSM in Hanoi and 393 and 399 MSM in Ho Chi Minh City (HCMC) in 2006 and 2009, respectively. Eligible participants were aged ≥ 15 years, living in Hanoi or HCMC, and reported sex with other men in the last year. We conducted behavioral interviews and collected blood specimens for HIV testing. Analyses were conducted using RDSAT v6.0 and z-test with RDSAT-adjusted proportions or sample proportions where n≤35.

RESULTS
Between 2006-2009, HIV prevalence increased in Hanoi (9.4% vs. 17.4%, p=0.029) and HCMC (5.4% vs. 16.7%, p<0.001). MSM who ever injected drugs were 7-15 (2006) and 2 (2009) times more likely to be HIV-infected than non-injecting MSM. The proportion that ever injected drugs did not increase in Hanoi (9.2% vs. 5.7%, p=0.111) and HCMC (3.8% vs 5.0%, p=0.420) during this time. In HCMC, however, there was an increase in MSM who reported that their sex partners had injected drugs in the past year (10.3% in 2006 to 25.6% in 2009, p<0.001). Consistent condom use in the last month increased with both non-commercial male partners (29.0% to 50.1%; p=0.018) and male sex workers (24.4% to 58.6%; p=0.001) in Hanoi, but did not change with non-commercial male partners (37.3% to 33.5%; p=0.648) and male sex workers (31.8% to 15.4%; p=0.555) in HCMC.

CONCLUSIONS
HIV prevalence has significantly increased and injection and sexual risks have remained high among MSM between 2006-2009. Prevention programs targeting MSM are urgently needed and should integrate both sexual and harm reduction interventions.

Sexually transmitted infections (STI) includes HIV&AIDS have becoming major problem that have created social, cultural, economy and political impacts. Group that is also at risk to be infected by STI is female café worker who are subtly involved in sexual transaction. This study aims to identify the association between the awareness, attitude and access to health services with inconsistent condom use among café workers.

The study was conducted in Denpasar from February to May 2009. It is a cross-sectional study, with 85 samples of female café workers. Samples were selected through cluster random sampling, using cafe as the cluster. From selected café, then samples were randomly selected. Data were collected through structured interview using questionnaire and were analysed descriptively. Meanwhile, the association between variables were measured by using logistic regression analysis.

The finding shows that consistent condom use among female cafe workers was very low around 14%. The awareness on STI and its prevention is significantly associated with the inconsistent condom use (adjusted OR=10,10; 95% CI=3,10-32,86; p value=0.00). Factor access to health service or programs also shown a positive association (adjusted OR=4,09; 95% CI=1,26-13,30; p value=0,00). However, attitude toward STI and its transmission is not associated significantly.

Based on the finding, increasing the awareness and making the service more accessible are important issues to be addressed. Recommendation toward the Primary Health Service, NGO and café manager to ensure access to health service/program includes clear information about STI and its prevention, condom promotion, also access to voluntary and counselling (VCT) service and STI clinic. Further qualitative research is needed to gain better understanding on other factors that influence risky behaviour among this group.
A RETROSPECTIVE REVIEW OF POST-EXPOSURE PROPHYLAXIS FOLLOWING SEXUAL EXPOSURE SEEN AT AN STI CLINIC IN SINGAPORE

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Introduction
Post-exposure prophylaxis (PEP) is the prompt administration of antiretroviral therapy (ART) after potential exposure to HIV in the attempt to prevent the establishment of infection.

Aim
To retrospectively review the management of PEP following sexual exposure at the DSC clinic with reference to the DSC STI guidelines 2003 and 2007.

Methods
The pharmacy records of patients prescribed PEP at the DSC clinic were reviewed along with the case notes within the electronic medical records.

Results
From 2003 to 2009, there were 70 prescriptions for non-occupational PEP (NO-PEP). Unprotected sex in 33 cases (47%) was the most common indication/reason for prescribing NO-PEP. 95.6% of PEP courses were prescribed within the recommended 72 hours of risk exposure. 67.1% had documented baseline HIV-negative result before starting on the PEP course. 94.3% received the recommended ART combination. 15 cases (21.4%) received Zidovudine (AZT) & Lamivudine (3TC) as Combivir with Nelfinavir. (Nelfinavir was withdrawn worldwide by Roche in June 2007). Thereafter 51 cases (72.8%) received Combivir & Kaletra (lopinavir/ritonavir). Only 46 cases (65.7%) completed the full 28-day course of medication. 25 cases (35.7%) reported various side effects. These included loose stool, nausea, headache, dizziness and fatigue.

Discussion
The majority of NO-PEP was prescribed in accordance with the DSC guidelines. The indications, recommended ART regimens and time of exposure to PEP are all above 90%. However the baseline HIV testing was below 70%, the number of cases completing the full course was barely two-thirds and only one third of cases had follow-up HIV testing documented. The high default rate coupled with 25% of cases being foreigners may account for the poor follow-up. The documentation of compliance and adherence could also be improved.

EVALUATION OF HEALTH MAP: A PATIENT CENTRED WEB BASED SERVICE FOR SUPPORTING HIV INFECTED PATIENTS.

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Introduction: Our aim was to describe the use and responses to a self management web site, 'Health Map', established to address key chronic health issues experienced by people living with HIV positive.

Methods: "Health Map" is an online service that allows HIV positive people to receive an individualized health report based on answers they provide online. The report covers: adherence to antiretroviral therapy; monitoring of CD4 counts and HIV viral load; psychological health; physical activity; vaccinations; cholesterol; blood sugar; blood pressure; alcohol consumption; smoking; body mass index; cervical screening and STI screening for men having sex with men (MSM).

Results: A total of 552 people, with a mean age of 37 years, completed "Health map" , 536(97%) were Australian, 425(77%) were male and 268(63%) men reported sex with men (MSM). Online responses to a number of health indices were of concern: 49% missed at least one dose of antiretroviral therapy per month and only 41% had had a HIV Viral load test in the prior four months. Regular physical activity was only reported 43%. Only 49% and 61% reported vaccination for Hepatitis A and B, respectively. The proportion tested within the recommended periods for fasting cholesterol (40%), fasting blood sugar (35%), and cervical cytological screening (43%) in women or STI screening for MSM(53%) were low. The small number of free text feed back responses indicated most were positive about the site. Others described challenges associated with providing general, rather than individual, information.

Conclusion: A substantial proportion of individuals completing the online survey reported information that would suggest their HIV and more general health care is suboptimal. These data are consistent with community surveys and indicate the need for improvement in the chronic management of HIV positive people.
Introduction: We aimed to determine the incidence of Hepatitis C virus infection among HIV infected men who have sex with men (MSM) attending the Melbourne Sexual Health Centre (MSHC).

Methods: A retrospective cohort study was carried out among HIV infected MSM seen on one or more occasions at MSHC between February 2002 and March 2010. Data were extracted from the centre’s computer database, testing data were obtained from the Victorian Infectious Diseases Reference Laboratory and medical records of Hepatitis C positive men reviewed.

Results: Among the 1065 HIV positive MSM who attended the clinic, 869 (82%) were tested for hepatitis C. Of them 620 (71%) were tested hepatitis C negative at any time after HIV diagnosis and were followed up for at least 6 months. The mean age of hepatitis C negative, HIV infected MSM was 46 years (range 22-80). There were 40 incident cases of hepatitis C in HIV positive MSM. Of the 40 hepatitis C positives, 11 (28%) were intravenous drug users at anytime. The overall incidence of hepatitis C among HIV positive MSM was 0.92/100 person years (PY) (95% CI 0.64-1.20). The incidence among HIV-positive intravenous drug users was 3.75/100 PY (95% CI 1.89-6.62) while the incidence among HIV positive non-intravenous drug users was 0.71/100 PY (95% CI 0.46-0.97). The proportion of hepatitis C cases identified by screening, symptoms or elevations in routine liver function tests will be presented.

Conclusions: A considerable proportion of HIV positive MSM not using intravenous drugs contracted hepatitis C, ostensibly via sexual transmission.

Issues: In Cambodia HIV-related stigma and discrimination (S&D) pose critical barriers to prevention, treatment, care and support programs. We lack concrete data and a deep understanding of how PLHIV experience S&D. In order to profoundly examine these issues, guided by GIPA, we worked with a team of PLHIV to implement the PLHIV Stigma Index. Together with evidence for improved programming and advocacy, a crucial benefit was the strengthened capacity of 50 PLHIV, as well as increased self confidence, and enhanced community coherence and solidarity.

Methods: The study was conducted in May 2010 in five provinces of Cambodia. 399 PLHIV were interviewed by trained PLHIV who were recruited through provincial PLHIV networks. Interviewers participated in 4 days training. The quantitative tool was adapted from a global questionnaire developed by IPPF, GNP+, ICW and UNAIDS, in consultation with a national advisory group, and pretested during training. 5 focus group discussions (FGD) and 10 key informant interviews were conducted by the research team to garner insight on experiences not captured in the quantitative survey. A half day of refresher training was conducted before data collection. The interviewers were supervised and assisted constantly by the research team during the interviews. 4 PLHIV interviewers were further trained in data entry and analysis.

Lesson Learnt: In spite of limited research experience and varied literacy levels of PLHIV interviewers, with intensive research team support in the field, PLHIV participation in research is possible and positive. Formal recognition of the valuable contribution of PLHIV interviewers is a good way to promote active participation and develop linkages between PLHIV researchers and PLHIV community. Sufficient notice in communicating with relevant stakeholders such as Home Based Care teams and Self Help Groups is really needed in order to assure full participation and timely data collection.

Next steps: Research findings will be disseminated to PLHIV, as well as government, civil society and development partners. Findings will be used by CPN+ to develop key advocacy messages, for both policy change and public awareness. This process will be implemented in an empowering and participatory way that puts PLHIV in control of identifying advocacy priorities.
Australian data relating to comparison of anal cytology and histopathology is limited, and the reliability of either sample is not clearly defined. As the rates of anal cancer are rising particularly in men who have sex with men methods of detection of anal cancer precursors need to be clearly defined and evaluated.

A retrospective evaluation of paired anal cytology and histology samples, and concurrent Digene Hybrid Capture 2 testing for high-risk strains of human papillomavirus was performed in sexual health clinic patients referred for either for high resolution anoscopy or surgical removal of warts. 248 paired samples from 154 subjects (21 females, 133 males) were obtained. Squamous abnormalities were tabulated according to the Bethesda system. Biopsy was used as the gold standard.

Good concordance between cytology and histology was achieved with a kappa adjusted for prevalence and bias of 0.73, p=0.013 for both samples being categorised as abnormal. Compared to histopathology cytology had a sensitivity of 96%, specificity of 14%, PPV 89% and NPV 31%. The Hr Digene HC 2 test was positive in 80% (192). HIV positive subjects had a high proportion of the high-grade squamous abnormalities: 60% (n=42/67), compared to 25% (n=22/87) in HIV negative subjects. HIV positive patients were much more likely to be Hr PHPV positive compared to HIV negatives Or 6.21 (95% CI 2.69-14.34)

Anal cytology is a sensitive method for detecting abnormal squamous cells however it has a low specificity for predicting the grade of abnormality. Clinics set up to perform high resolution anoscopy should not exclude patients with low grade cytological abnormalities especially if they are HIV positive.

It is not known if the genotype distribution in anal warts is different in HIV positive men compared to HIV negative men. It has been previously recognised that men with HIV infection have increased detection of HPV 11, and also have more HPV types present. Whether perianal skin has the same HPV genotypes as the anal canal is not known.

Anal/perianal samples were selected from 40 age matched male patients in the wart database established in 1996 at RPH. DNA was extracted from paraffin embedded tissues, and the Roche Linear Array Detection Kit was used to detect HPV genotypes, and a β-globin control was used. Bands were considered positive if they had an intensity equal to or greater than the β-globin control and samples, with a negative β-globin and low or no genotype were considered invalid.

In the anal canal the following HPV types were detected in HIV +ve men with IN: 6, 11, 16, 18, 26, 45, 46, 51, 52, 53, 55, 58, 59, 61, 62, 66, 70, 82, CP6108; and the following in the perianal samples: 6, 11, 18, 16, 26, 31, 40, 54, 66, 73. The following types were found in the anal tissue of HIV negative men with no IN: 6, 11, 16, 59; and the following in the perianal samples: 6, 11, 18. The most common oncogenic HPV types in the anal canal in descending order of frequency were: 16, 59, 45, 18, 51, 52, 58,82.

Oncogenic and non-oncogenic types were detected in both cases and controls in both the anal and perianal region. More HPV types were found in HPV positive men with IN compared to HIV negative men without IN. More HPV types were detected in the anal canal compared to the perianal skin.
Reports of treatment failure in gonorrhoea following therapy with the oral extended-spectrum cephalosporins (ESC) cefixime and ceftriaxone attribute this failure to antibiotic resistance manifested as increased minimal inhibitory concentrations (MICs) in Neisseria gonorrhoeae. There have been no confirmed cases of treatment failure with the injectable ESC ceftriaxone, despite a similar increase in MICs. Sentinel site surveillance for treatment failures allows full examination of gonococci from putative treatment failures in instances where resistance may be emerging to a previously satisfactory treatment regimen and invaluable insights into resistance mechanisms, relevance of existing MIC breakpoints and the spread of resistant gonococci may be obtained.

We studied prospectively treatment outcomes following 500 mg IM doses of ceftriaxone given for pharyngeal and rectal gonorrhoea in clients attending the Sydney Sexual Health Centre by taking test-of-cure (TOC) cultures at routine follow up of a culture-positive infection. MICs to ceftriaxone and other antibiotics, and the phenotype of the initial isolates were examined. Additionally, alterations in PBP2 (the target site for ESC), including the mosaic PBP2 lesion and substitutions at positions 501, 542 and 551, and also in mtrR and penB (antibiotic exclusion mechanisms) were investigated using a previously described real-time PCR approach.

No treatment failures were detected in 61 infections (32 rectal and 29 pharyngeal) over the 12 months period of surveillance. There were 37 strains with ceftriaxone MICs of 0.008, 9 of 0.016, 14 of 0.03 and 5 of 0.06 mg/l and a variety of subtypes and molecular changes were present in the gonococci examined. These outcomes provide reassurance of treatment efficacy for difficult-to-treat gonococcal infections currently being acquired, but continuation of TOC-based assessments is prudent in the current situation of declining gonococcal susceptibility to ESC.

Chlamydia trachomatis is one of the most common sexually transmissible infections (STI) in Australian men who have sex with men (MSM). However, there are few data on the distribution of specific C. trachomatis serovars among MSM outside clinical settings. We performed genotyping on chlamydia-positive samples from two community-based cohort studies of HIV-infected (Positive Health) and -uninfected (Health in Men) MSM in Sydney, Australia.

Participants were offered STI screening at annual face-to-face interviews, including testing of urine, anal and pharyngeal samples for C. trachomatis by strand displacement amplification (SDA). Nucleotide sequencing of the omp1 gene (encoding for MOMP) was used for serovar determination on all positive SDA chlamydia samples from January 2005 until study completion in June 2007.

A total of 2082 (90.2% of eligible visits in HIV-uninfected participants) and 521 (70.8% of eligible visits in HIV-infected participants) SDA chlamydia tests were performed. Among 40 HIV-uninfected and 19 HIV-infected participants with chlamydia, C. trachomatis was identified on 34 and 14 anal; 7 and 3 urine; and 1 and 2 pharyngeal samples, respectively. The median age of those infected with C. trachomatis was 39 years (range 25-61, IQR 34-48). Two HIV-uninfected participants had chlamydia infection at both urethral and anal sites. Serovar determination was possible for 56 of the 61 positive chlamydia samples. The most common serovars detected were D (51%) and G (19%). Only one lymphogranuloma venereum serovar (L2b) was identified on an anal swab from a symptomatic HIV-infected participant.

LGV was rare among predominantly asymptomatic HIV-infected and uninfected MSM in Sydney. C. trachomatis serovar distribution was similar to that observed in Sydney MSM from clinical samples.
Bacterial Vaginosis (BV) is common and associated with preterm delivery and HIV transmission. Although the cause is unknown, several bacterial candidate organisms (COs) have recently been shown to be highly specific for BV in sexually-experienced women. A recent study of young university students (FUSS) showed that BV was absent in sexually-inexperienced women and was significantly associated with increased numbers of vaginal-sex partners. No studies have examined COs in young sexually-inexperienced women, and whether these COs are sexually-transmitted, and how they relate to sexual activity is unknown.

FUSS enrolled 17-21 year old females attending Melbourne University. Follow-up samples from participants were collected 3-monthly for 12 months. Participants were posted study-kits containing an information/consent form, swab, slide and questionnaire addressing demographics and a broad-range of sexual practices. Gram-stained self-collected vaginal smears were scored by the Nugent method. Twenty-four BV cases and 168 normal flora samples were selected for analysis using quantitative PCR assays targeting a range of published COs.

Preliminary analysis found the following COs were strongly associated with BV: Gardnerella vaginalis (OR=15.4; 95%CI 4.0-98.7), Leptotrichia spp. (OR=16.4; 95%CI 5.4-49.8), Sneathia spp. (OR=16.9; 95%CI 5.8-49.4), Megasphaera spp. (OR=149.6; 95%CI 37.7-790.0), and the Clostridium-like bacteria BVAB2 (OR=22.0; 95%CI 7.1-74.3), while Lactobacillus crispatus was negatively associated with BV (OR=0.14; 95% CI 0.05-0.39). Analyses for the associations between BV and A.vaginae, and BVAB1 and 3, and the association between CO loads and BV are in progress. The association between COs and sexual activity will be presented.

Preliminary analysis shows that several COs are strongly associated with BV, and are uncommon in the normal flora of young women. Analysis is underway to understand the relationship between CO loads and BV, and to determine whether these COs are sexually transmitted and how they relate to sexual activity.
The Condom Credit Card (CCC) was an early intervention, capacity building health promotion strategy to reduce barriers for young people gaining access to reproductive and sexual health services and resources in the Blue Mountains, Hawkesbury and Penrith Local Government Areas (LGA). The project was implemented in partnership with The Junction Youth Health Medical Service and other youth services.

The target group was vulnerable, hard to reach young people who were socially and geographically isolated and who generally did not access mainstream services.

The project utilised health promotion and education strategies to encourage increased access to and use of condoms and water based lubricant, reduce stigma, embarrassment and other barriers to reproductive and sexual health information and services.

An important component of the CCC project was to train and build capacity of relevant youth workers and service providers in providing sexual health information, support and referrals. Training was provided to service providers on topics such as engaging with young people about safer sex practices, condom and lube demonstrations, the condom credit card system and processes, duty of care issues and appropriate referrals.

The Condom Credit Card project aimed to:
• Improve young people’s awareness of and access to sexual health information including, safer sex, sexually transmissible infections, pregnancy prevention and contraception.
• Implement an early intervention strategy to educate young people in to reproductive and sexual health issues
• Provide easy access to condoms for young people under the age of 24 in the Nepean LGA
• Capacity build relevant youth services and further develop external partnerships within the Nepean LGA

One of the successes of this project was the increase of young men accessing clinical and health promotion services.

This presentation will cover issues relating to the implementation of the project, strategies used to reach the intended target groups, including the types and style of the resources developed and how the outcomes were met.
Anal cancer is the most common cancer among HIV+ men, with rates as high as 137/100 000 in HIV+ Men who have Sex with Men (MSM). Both self-collected anal cytological sampling (using moistened Dacron swabs) and HRA (performed via anoscope, without anaesthetic) are proposed components of screening for early anal cancer detection. We conducted a prospective anal cancer screening study using these methodologies in HIV+ MSM attending a Sydney-based clinic. Participants with cytological gradings of Atypical Squamous Cells of Undetermined Significance, Atypical Squamous Cells - possible High-grade, and High-grade Squamous Intraepithelial Lesions were referred for HRA.

A four-question anonymous evaluation form regarding self collection was offered to all participants, for completion the following day. We evaluated ease and acceptability of self-collected swabs, degree of pain and amount of post-sampling bleeding. Each response was allocated 0-4 points (4 = highest and 0 = lowest score). The maximum possible score was 16/16 (= highly acceptable).

An eight question anonymous evaluation form regarding HRA was offered to all participants, for completion the following week. We evaluated HRA-acceptability including amount of pain (including duration), bleeding, analgesia requirements and any post-HRA intervention. Each response was allocated 0-4 points (4 = highest and 0 = lowest score). The maximum possible score was 32/32 (= highly acceptable).

Of 291 men who self-collected anal swabs, 263 (90%) returned completed evaluation forms. Of these, 193 (73%) scored ≥ 12/16, i.e. ≥ 75% acceptable. Of those who underwent HRA (n=73), 61 (84%) returned completed evaluation forms. Of these, 47 (77%) scored ≥ 24/32 i.e. ≥ 75% acceptable. There were no serious sequelae post-HRA; 4 participants needed paracetamol analgesia and three reported slight bleeding for up to one week.

Self-collected anal swabs and HRA were rated highly acceptable by those who completed the surveys.

To address the lack of online high quality and royalty-free images of Sexually Transmissible Diseases for educational purposes.

Members of the Atlas Group collected digital photographs and/or scanned 35 mm slides, which were then checked for quality, provenance and patient consent. We sourced images from individual collections, from those already existing at MSHC, and from donations by colleagues.

A new website was created, and acceptable images watermarked, tagged by keywords and topic and then uploaded, together with clinical case descriptions and links to further educational material pertaining to each image.

The Online Atlas will be freely accessible at stiatlas.org by the final quarter of 2010.

This initiative will provide a useful educational resource to our local and international colleagues.

Karen Berzins, Melanie Bissessor, Catriona Bradshaw, Mark Chung, Christopher Fairley, Kath Fethers, Stella Heley, Helen Henzell, Anna Morton, Tim Read, Tina Schmidt, Henrietta Williams, Seenivasagam Yoganathan
Getting hands on, raw, clinical experience is what medical students hope for during their placements. But do they always get it? Sexual health is often the first time students have this opportunity and so the example we set is most important.

We have devised a specific six week teaching package for students who are placed with us which has proven to be successful in providing a constructive and enjoyable placement. The package is in accordance with university expectations and our priority is for students to demonstrate an understanding of sexual health and to be confident in practicing their newly acquired skills autonomously.

“Tell me and I’ll forget; show me and I may remember; involve me and I’ll understand.” Chinese Proverbs quote.

Emergency contraception (EC) has been available as a Schedule 3 (over-the-counter, OTC) medication through Australian pharmacies since 2004. The recently formed Cairns inter-agency committee, Youth Accessing Contraception and Information (YACI) decided to provide an opportunity for pharmacies in the Cairns and Hinterland Health Service District to identify what, if any, additional support or resources are needed to improve OTC EC dispensing services.

We conducted semi-structured interviews with pharmacies to determine the availability, cost, dispensing processes and distribution estimates of EC and anonymous surveys of pharmacy staff to examine their knowledge and attitudes. Forty-six (88%) of the 52 local pharmacies participated; 43 (93%) provide OTC EC at an average cost of $28.95. The majority of pharmacies (86%) use a written checklist prior to dispensing and a range of written information is provided to EC customers by 23 (53%) of pharmacies. Women outside the criteria for OTC EC are directed to a general practitioner. Few pharmacies identified Family Planning Queensland (FPQ) or the Cairns Sexual Health Service (CSHS) as referral options.

One hundred and forty five staff surveys were returned; 34 from pharmacists and 111 from non-pharmacist staff, giving response rates of 31% and 38% respectively. Most respondents showed favourable attitudes to the provision of OTC EC, however pharmacists were evenly split over whether they should be able to refuse to dispense EC based on their personal beliefs. Over 30% of pharmacists believe that sexually transmitted infections will increase with EC being available over the counter and that EC discourages regular contraceptive use when used by young people.

The results of this study will inform future activities of YACI. It has also encouraged linkages between pharmacies, FPQ and the CSHS, providing an opportunity for future collaboration and research.
The way adults interpret sexual behaviours impacts on the ways they respond to support, educate and protect young people. It is critical to talk about ‘normal’ sexual development in order to educate and support children and adolescents. Family Planning Queensland (FPQ) uses the Traffic Lights as a conceptual framework for promoting healthy sexuality and for assisting professionals to understand and respond to sexual behaviours. Understanding the elements which differentiate between normal, concerning and harmful sexual behaviours is an essential requirement underpinning adults’ ability and confidence to respond positively.

This presentation will explore the paradigm shift that the Traffic Lights framework enables: although the starting point for many requests for training and resources is problem sexual behaviour, the framework requires an engagement with what constitutes healthy sexuality. Demonstrating a multi-response approach to health promotion, FPQ has presented this framework in training and at conferences to a range of professionals including; teachers, school and community nurses, child protection officers, social workers and allied health staff.


The National Centre in HIV Epidemiology and Clinical Research, Menzies School of Health Research and community partners in the Kimberly, Cape York and NT are implementing a community randomised trial in 21 or more geographical areas in Central and Northern Australia.

The trial known as ‘STRIVE’ aims to determine (1) whether targeted support to health services, including a quality improvement package can achieve improvements in the provision of sexual health clinical services in remote communities; and (2) whether the attainment of best practice levels in clinical activity can reduce the prevalence of bacterial STIs in communities. The trial runs for 5 years with 1 year assigned for consultation, engagement and trial development.

STRIVE is reaching the conclusion of the preparation phase and has achieved significant steps, including the engagement of around 60 remote health services and communities, the development of STI best practice indicators and a sexual health quality improvement program tailored for remote communities and plans are in place to upgrade patient management systems in three jurisdictions.

Despite randomised trials being recognised as the most definitive means of providing new clinical evidence, there have been relatively few such studies conducted in remote Aboriginal communities. Randomised trials in any setting can encounter a range of challenges, even when they are conducted under a model of community involvement and ownership. This paper will discuss progress in preparing and implementing STRIVE, its methodology and expected outcomes.
To address the lack of online high quality and royalty-free audiovisual materials for Sexual Health educational purposes.

A series of 10 minute videos and audios were produced by MSHC staff during 2009-2010. Videos take the form of mini lectures, and audios consist of interviews with Sexual Health Physicians. Topics were chosen to cover the questions most commonly asked by local General Practitioners (GPs) who call MSHC for clinical advice. Accordingly, the audiovisual presentations were pitched at the GP level.

All materials will be freely accessible at mshc.org.au via the Health Professionals portal, by the final quarter of 2010. All materials will be downloadable in a variety of formats.

This initiative will provide a useful educational resource to our local and international colleagues.

A cluster of cases of vulvar cancer has been identified in young women living in Indigenous communities in the Arnhem Land region of the Northern Territory (NT) of Australia. Although the aetiology of this cluster is unknown, it is thought to be associated with the presence of oncogenic human papillomavirus (HPV). The objectives of this study were to identify and compare oncogenic HPV genotypes and intratypic variants for those HPV 16 (+) and present in high grade VIN and invasive vulvar cancer biopsies from the Arnhem Land region with those from surrounding areas in the NT. All available archival paraffin vulval tissue biopsies from January 1996 to December 2005 (n=66) were examined for HPV DNA and genotyped using the INNO LiPA HPV test. Variants of HPV 16 were characterized by short length sequence analysis of the L1 and E6 genes. There was no statistically significant difference in the detection of high risk (HR) HPV in high-grade VIN or invasive cancer for the two areas (p=0.565). HR HPV was detected in 16/18 (89%) of high-grade VIN and 11/11 (100%) invasive cancer biopsies from Arnhem region, compared with 20/22 (82%) of high grade VIN and 11/13 (84%) of invasive cancer biopsies from the surrounding regions. HPV 16 was found in the majority of VIN and invasive cancer at 68% and 67% respectively. Intratypic HPV 16 variants of the European lineage were the most frequently detected in both areas. Determination of the presence of oncogenic HPV in this cluster of cases of vulvar cancer and dysplasia revealed no significant difference in the prevalence of oncogenic HPV or HPV 16 variants when compared with surrounding areas. Consequently, environmental and genetic factors in the region are being investigated as potential cofactors.

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It is unclear whether men who have sex with men (MSM) will derive any benefits from vaccination of women with the quadrivalent human Papillomavirus vaccine (HPV). Whilst some encouraging signs have emerged regarding reductions in genital warts presentations among heterosexual men, observation of a similar change for MSM presents unique estimation problems. In particular, benefit can only be obtained by men who have sex with both men and women, or men who have sex with such men. Because of relatively small numbers of MSM and a probably small effect size (little if any reduction in genital warts among MSM due to vaccination of women) problems of statistical power in estimating this question exist. We propose sequential sampling as an efficient means of sampling MSM to detect a reduction in genital warts prevalence. We designed and validated the performance of sequential sampling plans that could be used for surveillance in Australian and international clinical settings to detect early reductions in warts prevalence. These sampling plans require smaller sample sizes than other more commonly used estimation methods. For example, logistic regression would require a sample size of ~231 for estimation of a 5 percent decline in warts prevalence in comparison to our sampling plans, which would detect a possible reduction in prevalence using less than 100 samples in most cases. We also provide an Excel tool to enable our plans to be easily used, and to provide a means for conducting point-of-care surveillance of genital warts.

The 8th Deadly Sex Congress was held at the Watermark Hotel, Surfers Paradise in March 2010. Approximately 80 delegates attended this years Congress making it one of the largest events in its 8 year history.

This forum provided Aboriginal and Torres Strait Islander Sexual Health Workers working in Aboriginal and Torres Strait Islander Community Controlled Health Services, Queensland Health and Non-Government Organisations an opportunity to develop skills and knowledge in sexual health and Blood Borne Viruses as well as establishing and/or strengthening networks.

The program covered topics including STI/BBV epidemiology, contact tracing, developing and delivering a deadly presentation, designing and delivering health promotion programs and male and female reproductive health. A highlight of the Congress was the STI/BBV presentations from participants which kept the large gathering highly entertained.

The inaugural Deadly Sex Congress Awards were held during the event to recognise the contributions made by Aboriginal and Torres Strait Islander workers and organisations in this field. The categories included Innovation in Practice Award, Collaboration for Change Award, Excellence in Research and Evaluation Award and Outstanding Contribution in Aboriginal and Torres Strait Islander Sexual Health Award. The winners of the inaugural Deadly Sex Congress Awards are:

- Family Planning Queensland - ‘Sunshine Coast Indigenous Sexual Health for Young People’ project - Collaboration for Change Award
- Hepatitis Council of Queensland – Promotion and Information with Respect, PAIR project – Innovation in Practice Award
- Kambu Medical Service – Sexual health/STI Screening program within schools – Innovation in Practice Award
- Brendan Leishman – Outstanding Contribution to Aboriginal and Torres Strait Islander Sexual Health Award

This years Congress was deemed a huge success based on preliminary analysis of evaluations and verbal feedback from delegates.
Background
In 2006, the Health Promotion Board (HPB), in collaboration with the Ministry of Health (MOH) and the Ministry of Education (MOE), developed a new school-based STI/AIDS prevention programme titled ‘Breaking Down Barriers’, targeted at Secondary 3 students (aged 15 years old). The programme, implemented in all secondary schools since 2007, comprises a mass education component, followed by classroom sessions. The former utilizes multi-media, humour, and real-life testimonies to impart information on modes of transmission of and protection against STI/AIDS while the latter focuses on lifeskills namely decision-making, assertiveness and negotiation, to enable students to resist pressure to have sex.

Methods
Evaluation of the programme was conducted from 2007 to 2008. It involved some 3,000 students from 20 schools. The schools were randomly selected to best represent the different types of schools in the Singapore education system. Students involved were given self-administered pre- and post-programme questionnaires to assess their knowledge levels as well as their perceived susceptibility to STI/AIDS.

Results
After attending the programme, more students were aware of the main modes of STI/HIV transmission and the modes of protection against infection. For example, significant differences were observed for “casual sex” as a mode of transmission of STI/AIDS (Pre: 87%; Post: 93%) and for “abstinence” as a mode of protection against infection (Pre: 44%; Post: 53%). Students were also more aware of the misconceptions associated with HIV/AIDS transmission e.g. fewer students chose "mosquito bites" as a mode of HIV/AIDS transmission (Pre: 19%; Post: 9%) after attending the programme. In addition, students were more likely to perceive themselves as being vulnerable to STI/AIDS after the programme.

Conclusions
“Breaking Down Barriers” has been shown to be effective at increasing the knowledge levels of students with regard to STI/AIDS transmission and its prevention. It has also impacted on students’ perceived susceptibilities towards STI/AIDS.

Of Australian born citizens, Aboriginal and Torres Strait Islander young people are arguably the most marginalised group in contemporary Australian society. As a result this group faces extraordinary challenges in overcoming multiple disadvantages, manifesting in poor outcomes within the judicial, education and health systems. An increasing area of vulnerability for this population are the sustained rates of STIs and increasing risk of transmission of BBVs, due to factors including access to health services, risk behaviours and levels of knowledge about these infections. Over the next three years we plan to conduct the first Australian survey of young Indigenous people reaching from urban to very remote communities to assess levels of knowledge, risk practice and health service access in relation to sexually transmissible infections (STIs) and blood borne viruses (BBVs).

This periodic cross-sectional survey will collect data at cultural events enabling behavioural, demographic and access correlates of STI and BBV risk. This project is collaborative in its nature with National Aboriginal Community Controlled Health Organisation, UNSW and Latrobe University leading the project, together with 16 partner organisations comprising of every jurisdictional health department and peak Aboriginal Health organisation. The project has a capacity building component embedded that will ensure Indigenous people are acquiring skills in research throughout this project.

Surveys will be collected using personal digital assistants (hand held computers) enabling people with English as a second language to participate in the survey. Survey questions will be consistent with other Australian surveys, such as the Australian Study of Health and Relationships and the National Drug Strategy Household Survey to ensure comparability.

This project is of national significance, it aims to collect 5000 surveys from young indigenous people and will provide compelling results for communities and policy makers alike.
There is virtually no literature about how to evaluate health promotion interventions that use social networking sites. Among the scarce literature available, there is a clear acknowledgement that previous tried and true evaluation methods may no longer be adequate to assess the quality, use or impact of new web 2.0 web-based interventions. New evaluation models are needed that allow researchers to effectively evaluate collaborative, adaptive and interactive online interventions.

The FaceSpace Project uses fictional characters interacting on social networking sites to deliver sexual health promotion to key at-risk groups; young people and gay men. To evaluate the project, we adapted and combined evaluation methods from health promotion, information systems and creative spheres.

Formative evaluation involved workshops with the target audiences and actors to develop and refine the characters, story-based narratives and health promotion messages; as well as computer laboratory pre-testing to improve the sites’ usability. Process evaluation incorporated a) computer laboratory testing with users; b) online site usage data; c) online surveys to assess the usability and acceptability of Facebook as a health promotion platform and d) interactive and reflective feedback from Facebook users throughout the project. Impact evaluation involved baseline-follow up online surveys to assess users’ engagement and interaction with the project and measure changes in knowledge and sexual behaviour. Online and face-to-face focus groups; and reflections from the project staff have also contributed to the evaluation process.

Evaluation challenges included the inability to manipulate usage data available from social networking sites, developing appropriate tools to measure online engagement and assessing changes in knowledge and sexual behaviour and attributing them to the intervention.

The FaceSpace Project offers a new model for evaluating health promotion interventions via online social networking sites. We will present our findings, thoughts and insights into how to undertake evaluations in this new and challenging environment.

Passive surveillance has demonstrated that chlamydia is a substantial problem in Australia with over 60,000 cases reported in 2009, most (80.6%) among 16-29 year olds, and diagnoses have increased sharply over the past decade. We report on a new national chlamydia enhanced sentinel surveillance (ACCESS) system that aims to assist in the interpretation of passive surveillance data.

Established in 2008, ACCESS is comprised of six separate sentinel surveillance networks across Australia: sexual health services (SHS), family planning clinics (FPC), antenatal clinics (ANC), Aboriginal Community Controlled Health Services (ACCHS), general practitioners (GP), and diagnostic laboratories (LAB).

As of May 2010, 92 operational sites provided information on 677,576 episodes of care. Among young (16-29 years) females, chlamydia testing rates in 2009 varied by network: 7.6% at GPs, 37.9% at FPC and 79.8% at SHSs. Among young males, testing rates in 2009 were; 4.3% at GPs, 56.8% at FPC and 82.3% at SHSs. Across the networks, chlamydia positivity in 16-29 year olds ranged from 4.6% to 22.0% with the highest rates in 16-19 year olds. In heterosexual females <25 years attending SHSs, chlamydia positivity increased significantly from 11.7% in 2004 to 14.6% in 2008 (p<0.001). Among men who have sex with men (MSM) rectal chlamydia positivity was 6.6% in 2009 at LABs and there was no significant increase in chlamydia positivity in MSM attending SHSs between 2004 and 2008.

This new surveillance system is providing unique data on chlamydia testing and positivity trends among a range of priority populations in Australia. The 25% rise trend in chlamydia positivity among young women was lower than 50% increase in passive surveillance notifications in the same time period suggesting that the rise in notifications is strongly influenced by increased testing. The next phase of ACCESS will consider expanding to more sites and other sexually transmissible infections.
Introduction: We are able to capture data concerning all chlamydia tests conducted among the ACT population (~ 350,000 people).

Methods: To determine demographic and temporal trends in chlamydia testing and positivity rates in the ACT over a 10 year period, de-identified data concerning chlamydia tests performed between 1999 and 2009 were collected by all ACT pathology providers were reviewed.

Results: 177,378 tests were processed over the 10 year period, 71,807 in 1999-2004 and 105,571 in 2005-2009, an increase of 32%. Positivity rates in 1999, 2004 and 2009 were 3.7%, 5.1% and 5.2%. Between 1999 and 2004 the proportion of positive tests among females rose significantly (45.5%) from 3.3% to 4.8% while male positivity did not significantly change (5.1% to 5.7%). Between 2005 and 2009, there were non-significant decreases (10.0% and 20.0%) in the female and male positivity rates. In 2009, 15-24 year olds demonstrated the highest positivity rates for both females and males (5.7% and 10.9% respectively) and accounted for 43% of positive tests, while 25-29 year old females and males accounted for 18% of all positive tests and demonstrated positivity rates of 3.6% and 6.7% respectively. During 2005 - 2009, 51.0% and 24.4% of positive tests came from general practice and Canberra Sexual Health Centre respectively.

Conclusions: The rise in positive tests between 1999 and 2004 may be explained by an increase in the prevalence of chlamydia. Between 2005 and 2009 there was no increase in the proportion of positive tests despite an increase in testing, suggesting that the prevalence of the infection has not changed and that that current screening guidelines cannot detect changes in chlamydia transmission dynamics. By focusing on 16 to 25 year olds, around 45% of positive tests are missed and this approach ignores the effect of sexual networks (older men having sex with younger women) on chlamydia transmission.
Passive surveillance suggests that the greatest number of chlamydia infections in Australia are among women aged 15-24 years and that chlamydia notifications are relentlessly increasing among both men and women. Family Planning Clinics (FPC) see many sexually active young people providing opportunity for testing among this high risk population and were included as an ACCESS clinical network.

We collected two years retrospective non-identifiable consultation and chlamydia testing data among 16-29 year olds attending six FPC across six jurisdictions from computerised patient records. Chlamydia testing rates and positivity rates were estimated.

During 2008 and 2009, a total of 18,102 16-29 year old individuals attended the six FPCs, 17,101 (94.4%) were female and 1,001 were male. Of all attendees, 39.7% (n=7,185) were tested at least once for chlamydia. The overall testing rate among females was 38.9% and was higher among 16-24 year olds (42.3%) than 25-29 year olds (27.6%) (p<0.001). Over half (56.7%) of all males were tested and the highest testing rate (66.9%) was among 20-24 year olds. The proportion of positive chlamydia tests was lower among females (7.2%, n=384 tests positive) than males (19.7%) (p<0.001). By age, the highest positivity rates were among 16-19 year old females (10.5%) compared to 20-29 year old females (5.6%) and among 16-19 year old males (25.0%) compared to 20-29 year old males (16.1%).

FPCs test large numbers of young, sexually active females annually facilitating diagnosis and treatment of many chlamydia infections among this high risk population group. FPCs provide an important contact management role with the higher testing and positivity rates observed among males likely to reflect that many men attend as contacts of women testing positive for chlamydia. FPC are an important setting for chlamydia management and surveillance among young people.

The aim of this study was to evaluate an online partner notification service, Let Them Know (www.letthemknow.org.au), which offered email and text message notification services to individuals recently diagnosed with chlamydia.

The evaluation, which analysed visitor usage data and feedback, was undertaken between December 2008 and October 2009.

In this time the Let Them Know website was visited a total of 6481 times. Ninety-four percent of visits (n=6067) were by individuals within Australia. In total, 89% (n=5785) of visits were by new visitors. There was a significant increase in the number of new visitors to the website over the 11 month evaluation period from 350 to 552 (p<0.01). Fewer than five people reported receiving email or SMS notifications in error.

The Let Them Know service was used by individuals to send an increasing number of email and SMS messages, providing an alternative method of partner notification. Such web-based services have the potential to improve partner notification rates. Further evaluations should aim to determine if the website has been effective in increasing partner notification rates among users.
Introduction

SHLiRP, conducted on ACT government senior high school campuses comprises sexual health education, consultations and sexually transmissible infections (STI) and blood borne virus (BBV) screening.

Methods

To determine the (1) effectiveness of the SHLiRP model in engaging the target population, (2) screening rates for chlamydia, hepatitis B and other STI/BBV and (3) rates of alcohol use and cigarette smoking in this population data were collected from Year 11 and 12 students between 2004 and 2009 were analysed.

Results

13 SHLiRP sessions were conducted. An average of 66% (range 34% - 98%) of the student body at each college (~ 700 students) attended an education session. 2441 students, (1378 girls, 1063 boys, median age 17 years) attended a clinical consultation. 76.3% of students (1863/2441) reported having had sexual intercourse, 88.9% (1655/1863) reported being currently sexually active and 11.9% (197/1655) reported “never” using condoms. 3.6% (89/2441) reported same sex attraction, 1.6% (39/2441) reported being attracted to both sexes. Median number of partners in the past 6 months was 1 (range 0 - 15). 80.3% of students (1840/2289) reported drinking alcohol, 41.4% (761/1840) of these at unsafe levels, 23.5% (562/2394) smoked tobacco. 89.5% of sexually active students (1482/1655) were screened for chlamydia, 1.2% (18) testing positive; 0.6% of screened students (5/797) demonstrated no immunity to the infection. 1 student tested positive for hepatitis C (1/221 or 0.4%); no student tested positive for either HIV or syphilis. 165 students were referred to other agencies.

Conclusions

High rates of attendance at SHLiRP education and clinical sessions demonstrate the efficacy of this outreach program in engaging young people. Unsafe drinking and smoking remain common among this population. The low rate of immunity to hepatitis B among the tested population warrants further attention.
Many Australian young people experience or are at-risk of sexually transmissible infections [1], including Chlamydia, viral Hepatitis, and HIV. However, many have limited access to timely and appropriate care [2-4]. Although general practitioners (GPs) are the main providers of sexual health primary care in Australia [5], GPs do not always use evidence-based practice. This is partly because of the void between research evidence and practice. The transition from ‘bench to bedside’ [6] is typically cumbersome; one estimate suggests that the transition can take some 15 to 20 years [7]. This in turn has significant implications for the sexual health of Australian young people.

This paper presents findings on current practices among GPs when consulting young patients about sexual health. The study involved semi-structured interviews with 15 GPs, all affiliated with one of three divisions of general practice in New South Wales. Interviews were complemented with closed-questions about three vignettes.

Findings presented in this paper include the factors hinder and support the use of evidence-based practice; factors that influence the provision of sexual healthcare; current practices when working with young patients to document sexual history and manage sexual health; as well as levels of satisfaction with current practices.

These findings are significant because they help to identify opportunities to bridge the gap between the bench and the bedside. In turn, these opportunities can help GPs to provide evidence-based practice; they can help to improve youth access to timely and appropriate healthcare; and they can help to meet the aims of public health policies.

Introduction: Gardasil® is a vaccine providing protection against infection with human papilloma virus types 6,11,16,18 which cause the majority of cervical cancers and genital warts. The Australian federal government funded a school-based program to vaccinate all 12 year old girls, and a general practice (GP) based catch up program for all women aged 13 to 26 years commencing July 2007 until December 2009. Nationally the uptake of free vaccine outside of school based programs has been disappointing. The Warehouse Youth Health Centre in Penrith is an independent not-for-profit service providing sexual and reproductive healthcare to clients aged 12-24, many of whom are from more marginalised social backgrounds, have left school before year ten, and do not have a GP.

Methods: Approval was obtained from the NSW Department of Health to administer Gardasil® to clients aged 16-24 in The Warehouse Youth Health Centre and its outreach clinic in Richmond NSW. An intensive health promotion activity was undertaken to target young people through the local TAFEs, universities, newspapers, public space advertising, and opportunistically in clinic. Vaccination commenced in July 2007 and continued until May 2010. Clients who defaulted on the second or third vaccine were contacted by at least two methods of phone, email, or letter.

Results: 451 young women commenced the course, and 67% completed the 3-dose vaccination schedule. Of those who started but did not complete, half received the second dose. Reasons for non-completion included concerns over adverse publicity in the media, forgetting, and pregnancy.

Conclusions: A significant number of women who had not accessed the free program via school or their general practitioner, completed a full course of Gardasil® vaccination through this youth sexual and reproductive health clinic. This supports the role of non-governmental organisations and other non-GP clinical services in increasing uptake of immunisation programs.

Introduction:
To estimate the prevalence and genotypes of carcinogenic genital Human Papillomavirus (HPV) infection and its determinants among married women between 20-59 years in the district of Gampaha, Sri Lanka

Methods:
Two thousand married women of 20-59 years residing in the Gampaha district were invited to participate in a community based cross sectional study. Multistage cluster sampling was used to identify the sample. Clinical and laboratory examinations were carried out. HPV was detected by PCR testing (GP 5+/GP6+ primer system) and subsequent direct sequencing and genotype identification was done with assistance of GenBank. Pap smears were carried out to identify cervical cell abnormalities.

Results:
The participation rate was 99.5% (n=1990). The overall prevalence of cervico-vaginal HPV infection was 3.3% (95%CI 3.2-3.4). Prevalence among cytologically normal women was 3.1% (95%CI 3.0-3.2). The prevalence of highly carcinogenic genotypes 16 and 18 was 1.2% (95%CI 1.15-1.25). Prevalence of HPV infection was observed to decrease with age with a second peak between 50-59 years. In univariate analysis, the HPV infection was significantly associated with lower family income (OR =2.5; 95%CI 1.4- 4.4), lower social class (OR=2.3; 95% CI 1.3-4.0), sexual debut at <19 years (OR=2.1: 95%CI 1.2–3.2), experience of forced sex (OR=7.8; 95%CI 2.2–22.4), and husband having multiple sex partners (OR=2.9; 95%CI 1.4– 5.6). Multivariate analysis showed lower family income (OR=2.2, 95%CI 1.2-3.8), experience of forced sex (OR=5.6, 95%CI 1.9-16.3) and husband having multiple sex partners (OR=1.3, 95%CI 1.2-4.5) were associated with HPV.

Conclusion:
Community prevalence of overall HPV and the highly carcinogenic genotypes of HPV infection among married women between 20-59 years of age in the study group are low in Sri Lanka.
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HUMAN PAPILLOMA VIRUS (HPV) GENOTYPE DISTRIBUTION IN INVASIVE CERVICAL CANCER IN SRI LANKA AND THE RISK FRACTION ATTRIBUTABLE TO GENOTYPES 16 and 18.

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POSTER NUMBER: 64  
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SYPHILIS TESTING AND INCIDENCE AMONG MSM IN VICTORIA; USEFUL BASELINE DATA TO MONITOR IMPACT OF THE NATIONAL GAY MEN’S SYPHILIS ACTION PLAN

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PREVENTION AND EPIDEMIOLOGY

INTRODUCTION

Despite high burden of cervical cancer, studies identifying attributable risk fraction of carcinogenic high-risk HPV is lacking in Sri Lanka. A hospital based case control study was carried out to identify the HPV genotype distribution in invasive cervical cancers and the risk fraction of cervical cancer that could be attributed to HPV genotype 16 and 18.

METHODS

HPV detection and genotyping on cervical swabs was carried out in newly diagnosed cervical cancer patients (n=40). Four disease free controls were selected for each case (n=160) and matched for age and area. HPV-DNA was detected by PCR testing using GP5+/6+ primer system and subsequent direct sequencing with genotype identification.

RESULTS

Overall 80% (32/40) of cervical cancer patients and 3.8% (6/160) controls were HPV positive. Of the 32 HPV positives identified, 91% (29) HPV-16, 6% (2) HPV-18 and 3% (1) HPV-42. Univariate analysis of possible risk factors found HPV, young age (<19 years) at first vaginal sex, high parity, time elapsed since last delivery, extramarital sexual exposures, multiple partners, extra marital sex exposures of the husband, and being employed were associated with cervical cancer. In multivariate analysis only HPV (OR 172, 95% CI: 35-857), time elapsed since last delivery (OR=9, 95% CI: 2-47), extra marital sexual exposures (OR=32, 95% CI: 5-227) and employment status (OR=8, 95% CI: 2-38) were associated. Adjusted risk of cervical cancer associated with genotypes 16 and 18 HPV infection was 190 (95% CI: 37-991). The attributable risk percent for cervico-vaginal HPV infection with genotype 16 and 18 was 69%.

CONCLUSIONS

Study suggests that HPV genotypes associated with clinically and histopathologically confirmed cervical cancer cases are similar to that reported in other countries in the region and high proportion of cervical cancers are attributed to genotypes 16 and 18.

Since 2000, Australia has experienced a resurgence of infectious syphilis among men who have sex with men (MSM). A recent development in Australia’s epidemic response is the National Gay Men’s Syphilis Action Plan (NGMSAP) that recommends six monthly syphilis testing in highly sexually active HIV negative men and quarterly syphilis testing for sexually active HIV positive MSM when undergoing routine care. We compared testing frequency and syphilis incidence in two time periods among MSM by HIV status at three Victorian clinics.

Laboratory syphilis testing data from April 2006 to June 2009 for three MSM-focussed clinics in the Victorian Primary Care Network for Sentinel Surveillance on BBVs and STIs were analysed. Tests in individuals <60 days apart were excluded. Testing frequency was calculated and syphilis incidence estimated using the person time method during two time periods (T1=Apr06-Dec07; T2=Jan08-Jun09). Incident syphilis was based on laboratory evidence of seroconversion via specific treponemal test or a fourfold or more rise in non-specific treponemal antibody titre.

There were 16,068 syphilis tests conducted in 8,346 HIV negative MSM and the proportion tested two or more times in T1 and T2 was 33.4% and 33.8% (p=0.76), respectively. There were 10,706 syphilis tests conducted in 1,969 HIV positive MSM and the proportion tested four or more times in T1 and T2 was 37.5% and 44.9% (p<0.001), respectively. Syphilis incidence was 2.9 per 100PY (95%CI 2.6-3.3) overall; 2.0 per 100PY (95%CI 1.6-2.4) in HIV negative MSM and 4.4 per 100PY (95%CI 3.7-5.2) in HIV positive MSM. Syphilis incidence did not change over time in HIV negative or HIV positive MSM.

Our analysis shows that testing frequency in HIV positive MSM is increasing but transmission appears stable. These results will provide valuable baseline data to monitor the impact of the NGMSAP on syphilis testing and transmission.
To describe the implementation process of the Australian National HPV Vaccination Program and our experiences in the 3 years since its inception.

Australia introduced the quadrivalent HPV vaccine (Gardasil®) into its National Immunisation Program in April 2007. From April 1 of that year the vaccine was offered free of charge to all girls at secondary school and free vaccine was also offered to women between the ages of 18-26 up to the end of December 2009. The target population was around 2.4 million girls and young women, and the cost of the program was AUD 590 million from 2006 - 07 to 2009 - 10, including AUD 23 million for an educational campaign and the establishment of an HPV vaccine register. The vaccination program is now ongoing for girls in year 7 (ages 12-13).

This paper will describe the implementation process including the development of the National HPV Vaccine Register (NHVPR) and the effects to date on Pap test participation in the age group 20-26.

HPV, vaccination, adolescent health, public health policy

Oral cavity and oropharyngeal squamous cell carcinomas (SCC) arise from the mucosa of the oral cavity and oropharynx. Human papillomavirus (HPV) infection is now recognised as an aetiologic agent for oral SCC specifically those arising from the oropharynx. Studies report that between 35% – 90% of oropharyngeal SCC is attributable to HPV. Therefore, there is scope for the prevention of HPV-associated oropharyngeal SCC through vaccination.

This paper examines trends in the incidence of SCC of the oropharynx and oral cavity in Australia from 1983 to 2005. Oral cavity and oropharyngeal SCC can be classified as HPV-associated (tonsil, base of tongue or other oropharyngeal sites) or non HPV-associated (tongue, gum, floor of mouth, palate or larynx). Data were obtained from the Australian National Cancer Statistics Clearing House for the period 1982 – 2005.

From 2000 – 2005 an average of 219, 159 and 110 invasive SCC of the tonsil, base of tongue and other oropharyngeal sites were diagnosed annually, respectively, with annual age-adjusted incidences of 1.09 (95% CI: 1.03, 1.15), 0.79 (0.74, 0.84) and 0.55 (0.50, 0.59) per 100,000. An average of 1242 non-HPV-associated oral cavity SCC were diagnosed annually with an incidence of 6.2 (95%CI: 6.0, 6.3) per 100,000. From 1982 – 2005 there were significant increases in the incidence of tonsil SCC [1.4% pa (0.9, 1.9)] and base of tongue SCC in males [3.0% pa (2.3, 3.8)] and base of tongue SCC in females [3.5% pa (2.2, 4.7)]. There was a significant decrease in non HPV-associated oral cavity SCC in men [-1.69% pa (-1.95, -1.41), but no change in females [-0.39 (-0.81, 0.03)]

The burden of potentially HPV-associated oropharyngeal SCC in Australia is increasing, with decreases in non-HPV-associated oral cavity SCC, particularly for men. These results suggest that HPV vaccination has the potential to reduce oropharyngeal SCC.
The ‘Safe Sex No Regrets’ campaign was conducted in the Northern Territory (NT) from September 2008-September 2009 to address the high rates of genital chlamydia. It targeted the most-at risk age group of 15-29 years in urban areas. This study evaluated the effectiveness of the broad media and social marketing campaign aimed to enhance awareness of chlamydia and promote testing. The intervention activities included radio broadcasts, posters, pamphlets, TV commercials, a dedicated campaign website and other promotional resources.

The qualitative evaluation was conducted using semi-structured interviews with stakeholders for their feedback about the campaign; and anonymous surveys as well as a focus group discussion with the target group to assess the effectiveness of the media campaign. The quantitative evaluation was conducted by assessing the number of chlamydia tests conducted in the local public sexual health clinic before and during the campaign. The publicly available Medicare data on chlamydia testing were also used to investigate the levels of testing in relation to the Campaign.

Results from the interviews and surveys showed that the campaign was effective in promoting access to sexual health services and enhancing awareness of chlamydia for young people. Chlamydia testing at the sexual health clinic showed statistically significant increase during the campaign period compared to comparable past periods: a 35% and 30% increase was noted in the 15-19 and 20-24 year age groups respectively, and overall there was a 26% increase in those aged 15-29. However, there was no significant change in the total number of chlamydia tests in the NT during the campaign.

This mass media campaign for chlamydia awareness appeared to be effective in achieving its aims, and therefore can be recommended as a health promotional measure for delivering STI messages to young people in similar settings.

We report prevalence and incidence of herpes simplex virus types 1 and 2 (HSV-1 and HSV-2) infections from two community-based cohorts in homosexual men; also, the interaction between the two HSV types.

Participants were men in the Health in Men (HIM, HIV negative) and Positive Health (pH, HIV positive) studies. They were offered type specific HSV serology testing using stored serum collected at annual visits. They also reported whether they had had an episode of anogenital herpes in the last 12 months.

At baseline, the sero-prevalence of HSV-2 was significantly higher in the pH cohort (66.1%, 95% CI 59.6-72.2) than in the HIM cohort (23.3%, 95 CI 21.1-25.6) after age adjustment (OR=4.56, 95% CI 3.32-6.25). There was no difference in the prevalence of HSV-1 (75.2%, 95% CI 72.8-77.5 in HIM and 79.1%, 95% CI 73.3-84.2 in pH). Among those susceptible, 70 seroconverted to HSV-1 and 75 to HSV-2 in the HIM cohort, giving an incidence of 7.50 (95% CI 5.89-9.37) and 2.35 (1.85-2.94) per 100 person-years (PY), respectively. In the pH cohort, 6 seroconverted to HSV-1 and 5 to HSV-2, giving an incidence of 10.59 (95% CI 73.3-84.2) and 5.10 (95% CI 1.68-11.51) per 100 PY, respectively. In both cohorts, those who were seropositive to both HSV-1 and HSV-2 were significantly less likely to report a recent episode of anogenital herpes than those who were seropositive to HSV-2 only (OR=0.36, p=0.007 and OR=0.45, p=0.048, respectively). In HIM participants, prior HSV-1 infection was predictive of future HSV-2 acquisition after adjustment for age (HR=2.29, 95% CI 1.10-4.76).

Both HSV-1 and HSV-2 infections were highly prevalent in homosexual men, and among those susceptible, the incidence of HSV-1 infection was markedly higher than HSV-2 infection. Infection with both HSV types was protective against recent anogenital herpes symptomatic episodes compared with infection with HSV-2 only.
We report the prevalence and risk factors for high grade anal intra-epithelial neoplasia (HG-AIN), the precursor of anal cancer, in two community-based cohorts of HIV-negative and HIV-positive homosexual men in Sydney, Australia.

A cross-sectional study of consecutive participants in both cohorts was performed in 2005 (204 HIV-negative and 127 HIV-positive men). Anal cell samples collected by the research nurse were used for anal cytological analysis using the ThinPrep procedure. The residuum of PreservCyt vials was tested for HPV using Digene Hybrid Capture 2. Participants with anal squamous cell of undetermined significance (ASCUS), atypical squamous cells, cannot rule out a high grade lesion (ASC-H), or high grade squamous intra-epithelial lesions (HSIL) were offered high resolution anoscopy (HRA).

Cytologically, 3 (2.3%) HIV-positive men and no HIV-negative men had HSIL. A total of 77 men who had cytological changes of ASCUS, ASC-H or HSIL (16.7% HIV-negative and 33.6% HIV-positive men, p<0.001) were referred for an HRA. Of these, 63 (81.8%) underwent HRA, and 21 (33.3%) had histologically confirmed HG-AIN. The prevalence of HG-AIN was significantly higher in HIV-positive men (n=14, 12.6%) than in HIV-negative men (n=9, 5.0%, OR=2.73, 95% CI 1.14-6.53). HG-AIN was not related to age, current smoking status, anal symptoms, or reporting receptive anal intercourse in the last six months. The presence of HG-AIN was strongly associated with the detection of high risk types of anal HPV (OR=11.20, 95% CI 1.48-84.49), but not with low risk types (OR=1.80, 95% CI 0.72-4.53).

HG-AIN was prevalent in sexually active homosexual men across all age groups and almost three times as common in HIV-positive men as in HIV-negative men. The presence of high risk anal HPV was highly predictive of HG-AIN. More studies are needed to better determine the incidence and the natural history of HG-AIN in this population.

Data worldwide has been somewhat similar with high rates of reporting of syphilis during World War 2 and postwar years. Its prevalence gradually decreased especially after the introduction of penicillin in the late 1940’s. There was an upsurge again in the 1970’s especially in MSM (men who have sex with men). However, the incidence of syphilis dramatically decreased in the early 1980’s to mid 1990’s with the emergence of HIV.

Then, since the late 1990’s and the beginning of the 21st century, the incidence of early syphilis has steadily rebounded and increased dramatically in the developing world. This increase has occurred most exclusively in MSM. A consistently described feature of re-emergent syphilis in MSM is a disproportionate representation in HIV infected males. In most locations, more than 50% of cases of syphilis reported amongst MSM are also HIV positive.

Trends in syphilis notifications have generally been similar in various states in Australia. Prior to 2000, majority of reported syphilis cases were in the ATSI (Aboriginal and Torres Straight Islander) population. From early 2000 onwards, the increase in syphilis notifications has been in MSM. We report the trends associated with syphilis notifications in South Australia from data collected over 20 years from 1986-2009. Information that will be presented will include the age, sex, racial origin, sexual identity, employment status, stage of syphilis infection, likely location where syphilis infection was acquired and HIV co-infection, by the year of notification. There will also be a contact tracing analysis report.

We will also report how the trends of syphilis notification in South Australia compare with trends in 2 other Australian states.
In Western Australia (WA), syphilis is historically a disease among Aboriginal people from remote regions. This paper aims to describe the epidemiology of syphilis from 1991 to 2009 in WA and associated prevention and control strategies.

Data on syphilis notifications were obtained from the WA Notifiable Infectious Diseases Database (WANIDD). In addition to standard demographic and clinical data, behavioural risk factor data were obtained from the enhanced syphilis surveillance database which was established in 2007.

Information on syphilis prevention and control programs implemented in WA from 1991 to 2009 were obtained from key stakeholders and by reviewing documents related to sexually transmitted infection policies, strategic plans and guidelines.

The majority of infectious syphilis notifications from 1991 to 2005 were among Aboriginal people with several documented outbreaks. From 2006 to 2009, the majority of notifications were among non-Aboriginal people with an outbreak among Perth metropolitan men who have sex with men (MSM) beginning in 2006.

The majority of non-infectious syphilis notifications from 1991 to 2000, and in 2009, were among non-Aboriginal people who were born overseas and acquired their infection overseas, while the majority of notifications from 2001 to 2008 were among Aboriginal people.

Syphilis continues to affect young, heterosexual, Aboriginal people in remote WA areas and older, non-Aboriginal MSM in the Perth metropolitan area. Infections in these groups have the potential to impact on antenatal females. Intervention strategies aimed at these three target groups will be described in detail.

A collaborative approach involving primary healthcare services and community-based organisations has been used to prevent and control syphilis in WA. While these appear to have had some impact, syphilis remains endemic in WA. It is therefore essential for prevention and control efforts to be sustained.

Almost three quarters of all confirmed chlamydia cases in Hunter New England region are found in young people aged 15 – 24 years. In 2008, the New England zone rates (248.3 per 100,000 population) were well above the NSW rates (145.9 per 100,000 population). The general practice (GP) setting is ideally placed to support chlamydia prevention initiatives for a number of reasons, including: 55% of all sexually transmitted infections or blood borne virus‘ are treated in general practice (GP) settings; between 70-90% of young people aged 15-24 years will visit their GP at least once annually; and the GP setting has a vast geographical reach, particularly in remote and rural locations.

In 2009, Hunter New England population health entered into a partnership with the Barwon, North West Slopes and New England Divisions of General Practice to conduct a Royal Australian College of General Practitioners approved chlamydia care quality improvement activity. The project included three phases – GP needs assessment and capacity building, structured clinical audit and pre and post intervention evaluation.

The aim of the audit was to provide GP’s with chlamydia specific tools and training in a “learning by doing” approach. Practice receptionists identified young people eligible for inclusion in the project and prompted the GP to complete the “youth chlamydia checklist” to assist them in conducting a chlamydia risk assessment, prevention, testing and treatment.

The presentation will include results from the audit phase. Over nine clinical sessions, twenty GPs provided chlamydia prevention advice and testing with approximately 147 young people using a “youth chlamydia checklist” tool.

The presentation will detail GPs high acceptability to this approach and increased confidence in conducting routine of at risk young people in daily practice. The unexpected positive consequence of using a paper based chlamydia prompt to testing will be discussed.
Oropharyngeal gonorrhoea and Chlamydia infection occurs in a sexual health population, but protocols do not usually encourage testing except in high risk groups such as men who have sex with men (MSM).

Data for oropharyngeal gonorrhoea cultures and Chlamydia PCR throat swabs were extracted from the Royal Perth Hospital Microbiology Database from January 2000-11 June 2010, and age, sex and sexual preference were cross-linked from the Sexual Health Access database. Statistical associations between variables were examined using the likelihood ratio chi square and linear logistic regression.

Between 2000-2009 there were 6942 throat swabs collected. 46 cases of oropharyngeal gonorrhoea were found: 36 male and 10 female patients. Of the males, 21 were MSM/BSM, average age 29.5 years (range 14-64). Over the same time period 31 cases of oropharyngeal Chlamydia were detected, 12 male, 19 female, 4 were MSM, average age 23.8 years (range 15-49).

There appears to be an increase in detection of oropharyngeal gonorrhoea in the last 6 months (9 cases), and the epidemiology of these new cases will be presented.

Oropharyngeal Chlamydia occurred in a younger age group than gonorrhoea, and was more commonly detected in heterosexual women than heterosexual men or MSM. Gonorrhoea was detected more commonly in MSM. The upsurge is interesting and may reflect more gonorrhoea in the community, a change in sexual practices or more MSM attending the clinic. Oropharyngeal infection occurs and testing in at-risk populations should be offered. Further studies need to be undertaken to see if oropharyngeal gonorrhoea is a reservoir of unrecognised infection in the MSM community.

The Western Australia Department of Health (WA Health)'s Sexual Health and Blood-borne Virus Program has developed a new website for young people aged 14-17 years. “Get the Facts” (www.getthefacts.health.wa.gov.au) aims to provide young people with an avenue to access information, advice, referral, skill-development activities and resources on sexual health, sexually transmitted infections (STIs), blood-borne viruses (BBVs), sexuality and relationship topics.

This website was designed in response to increasing sexual activity and the increase in the number of STIs reported in young people. In 2009, 65% of chlamydia notifications in WA were reported in 15-24 year olds. In the same time period, 52% of gonorrhoea notifications were reported in this age group.

There has been a strong commitment to ensure youth participation in all stages in the development of the web-site, including focus groups and online feedback forums, with both metropolitan and regional young people. Local young persons also participated in two photo shoots to provide images for the website, and recorded their voices for the “Life Stories” section. The website development was also guided by a multi-disciplinary Reference Group.

As well as providing sexual health and relationships information in clear and simple language, the website includes many interactive features. These include animations, a Find a Service tool and a Send to a Friend function. Users can also submit anonymous questions to be answered by a health professional.

Within the first 12 months, the following data has been collected:
the website has received 54169 unique visitors
8.49% are returning visitors
the average time on the website is 2min 37sec
the most popular topics are:
Different kinds of sex (4.77%)
What is sex (2.85%)
The first time you had sex (2.78%)
Types of contraception (2.42%).
Objective: (1) Assess and compare the effectiveness of SMS and web-based survey methodology for health promotion in a young population attending a Year 12 graduation festival --‘Gold Coast Schoolies 2009’ (GCS).

(2) Assess Chlamydia awareness and interest in a Postal Urine Chlamydia test

Methodology: Around 6000 business size survey invitation cards were distributed by Year 12 students and DRUG ARM Australasia during the first week of GCS. Participants were entered into a draw for a cash voucher to the value of $500.

The web-based survey and SMS survey consisted of 11 and 3 questions respectively, addressing knowledge about Chlamydia, interest in the postal Chlamydia test and subsequent surveys. Basic demographic data were collected. Entry to the survey closed at the end of the first week of schoolies.

Results: The SMS survey and web-based survey were completed by 32 subjects and 11 subjects respectively. Postal Chlamydia test kits were posted out to two subjects but none were returned. Three subjects expressed interest in future surveys. Three subjects stated that they have had a Chlamydia test previously. One subject thought Chlamydia always causes symptoms. Three subjects were not aware that Chlamydia is easily treated with tablets.

Conclusions: Our results have shown that health promotion projects such as this is highly labour intensive with minimal cost-benefit return. Health promotion strategies have to be built into the school curriculum and a certain level of basic knowledge should be mandatory. This information has to be then reinforced by public health messages through the mass media and in settings such as doctor’s surgeries, work places, educational institutions and sports venues.

In Indonesia, cervic cancer is the highest factor as woman death caused. It’s hard to prevent and identifying because of the lack of women awareness to get pap smear test as cervic cancer early detection.

Setting
Developing the integrated HIV VCT and pap smear test program. It’s mean, when client coming to HIV VCT service, they also getting information and pap smear test as one package. To spread up and socialize pap smear service, information about cervic cancer and pap smear test also carried on HIV VCT socialization.

Result
614 person get VCT tested after 6 month (268 : male and 346 : female). 271 person from total client, also get pap smear test. After client did the pap smear test, they also given sexual and reproductive consultation as follow up of pap smear test.

Recomendation
government must take responsibility for service expanding of HIV VCT and pap smear examination. Cervic cancer early detection efforts can be done by extending services pap smear examinations for women who are sexually active.
The number of HIV / AIDS cases in the Bali province continues to increase in an alarming level. The fact that there has been a mushrooming bars established in rural areas, most of which provides sex services, is an important issue that greatly contributes to the spread of HIV/AIDS in rural areas in Bali. This study explored the sexual knowledge and behaviours of men who lived in rural areas in Bali.

Qualitative research was conducted by performing a participatory interview among 150 rural men by four field workers in Gianyar regency. Respondents were selected based on snowball sampling. Respondents were gained from their gathering places such as village shops, paddy fields, village roads, Balai Desa (a village meeting place). Respondents were interviewed about their habits by using an interview guide. In addition, direct observation was also conducted to clarify some issues.

Survey results revealed that knowledge of rural men about HIV / AIDS was very limited because of the lack of intervention from government, NGOs, health office. Rural men usually go to prostitution establishment accompanied by their group, only 20% of those who use condoms most of the time do not feel comfortable of using it. Some of them have never acquired to sexual transmitted diseases and usually buy their own drugs or was told by a friend. The habit of buying their own drugs without the proper dosage and not using a health care facilities increase the risk of HIV spreading.

Knowledge of rural men with regards to HIV / AIDS is still lacking. Unsafe sexual behaviours such as not using condoms and multiple sexual partner increased their risk of HIV / AIDS transmission. Health promotion interventions need to be performed to rural area so that the knowledge, attitude and behaviour toward HIV can be improved.

Partner notification is important for both clinical management of the index case (in terms of re-infection), as well as having a potential population health impact in terms of disease spread. Patient Referral is the term employed when index cases notify sexual contacts of their potential exposure to sexually transmitted infections (STIs) themselves. It is the most common form of partner notification undertaken in Australia, as it uses fewer health resources and patients often prefer this to having professionals inform their partners. However, Patient Referral partner notification rates are not generally high, and as STI notifications (particularly chlamydia) increase in Australia it is important to improve the success of this referral type. This study aimed to assess whether scheduling a reminder phone-call from the diagnosing clinic to index patients increases rates of partner notification via Patient Referral.

A literature review and 30 key informant interviews from five states and territories was undertaken to assess partner notification in relation to the NSW context. Two randomised controlled trials were identified which compared scheduled telephone follow-up with standard care. One study lacked power to show a difference. The second study, which combined counselling with follow-up contact, reported that at six months the prevalence of gonorrhoea or chlamydia re-infection was six percent of the intervention group and 11% in control participants (AOR 2.2 (1.1- 4.1)). A recent NSW study noted that there was a significant difference between pre-study audit rates of partner notification and both study arms (where a follow-up phone call was scheduled for all study participants)(1.83 versus 1.02 p = 0.00). Experienced Contact Tracers invariably schedule follow-up phone-calls in this setting. Scheduling a follow-up phone call appears to be an effective tool in increasing partner notification rates by index patients. A practice nurse could perform this cheap intervention in the general practice setting.
**POSTER NUMBER: 79**
**PAPER NUMBER: 639**
**PRACTICE NURSES IN PARTNER NOTIFICATION OF SEXUALLY TRANSMITTED INFECTIONS: HOW CAN THEY BE UTILISED IN THE AUSTRALIAN CONTEXT?**

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Chlamydia notification rates are increasing throughout Australia. Management of chlamydia includes notification and treatment of regular sexual partner(s). Diagnosis of chlamydia is an uncommon event in general practice. However the majority of diagnoses are made in this setting and not in sexual health clinics (SHCs). Moreover in general practice there is often poor knowledge about partner notification responsibilities and processes. General practitioners (GPs) also have little time to take on further tasks, especially in rural areas. This study assessed whether practice nurses could be employed to aid the process of partner notification in general practice.

A literature review and 30 key informant interviews from five states and territories was undertaken to assess partner notification in relation to the NSW context. A UK study showed that when practice nurses counselled patients, elicited partner(s) names and scheduled a follow-up phone call a similar number of partners were notified that when patients were referred to SHCs and partners notified by health professionals. The practice nurse option was also cheaper. In Australia there are over 8000 practice nurses in 60% of practices. Rural areas have more practice nurses where anecdotally less partner notification takes place. Practice nurses are increasingly performing pap smears and sexual health screening and counselling. One NSW regional public health unit sends chlamydia follow-up faxes addressed to both the practice nurse and the clinician, using the practice nurse as a conduit by which information reaches GPs. Key informants suggest that other partner notification tasks could include post-test counselling and name elicitation, anonymous notification of partners on a patient’s behalf, or performing follow-up phone-calls reminding index cases to notify partners and offering assistance if necessary.

This study shows that practice nurses could aid the partner notification process in general practice in several ways.

**POSTER NUMBER: 80**
**PAPER NUMBER: 641**
**PARTNER NOTIFICATION OF SEXUALLY TRANSMITTED INFECTIONS AND THE INTERNET: ANONYMOUS PROVIDER REFERRAL ON SEXUAL NETWORKING SITES.**

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Partner notification of casual partners potentially has a greater population health benefit than notifying regular partners. However index patients often don’t inform casual partners of their exposure to sexually transmitted infections (STIs). The internet is becoming more popular for finding casual sexual partners, particularly for men who have sex with men (MSM). If met on a sexual-networking site, sometimes only a website alias of a sexual partner will be known. Therefore tools that enable anonymous STI exposure messages to be sent to email addresses or mobile numbers cannot be employed. This study explored the benefit of clinics notifying sexual partners via sexual-networking sites and the means in which to do it.

A literature review and 30 key informant interviews from five states and territories was undertaken to assess partner notification in relation to the NSW context. Numerous case-studies and audits from the US and the UK indicate that anonymous provider notification of sexual partners via the internet can yield high numbers of partners notified per index case. Experienced Victorian Contact Tracers report relatively high rates of responses to partners notified in this way, especially if a contact name and phone number accompanies the message. Experiences in the US state of Massachusetts support the use of a single person per centre to have charge of internet notifications of partners. This study shows that clinic-initiated anonymous partner notification of casual sexual partners sourced through sexual-networking sites is of benefit. NSW Sexual Health Clinics could develop protocols to enable this to be offered to all MSM with STIs and partners sourced over the internet.
Several literature reviews have shown improved rates of partner notification for bacterial sexually transmitted infections (STIs) when Provider Referral is used (where health professionals notify the infected person’s partners of their potential exposure to a STI), as opposed to asking patients to inform their partners themselves (Patient Referral). However when assessed across the range of index patients and partnerships the improved notification rates of Provider Referral are not large. Provider Referral is also more expensive. This has raised the question of whether Provider Referral may be more effective and therefore cost-effective in different situations. This paper aimed to determine the circumstances under which it might be more appropriate to encourage Provider Referral in relation to the NSW context, where Patient Referral is currently generally encouraged for bacterial STIs.

A literature review and 30 key informant interviews from five states and territories was undertaken. Based on the findings of the review it appears that Provider Referral is more effective than Patient Referral for casual, ex-partners or incarcerated partners of index cases. Studies show that such partners are less likely to be informed by patients, whilst alternatively patients prefer to inform regular partners themselves. Preliminary data from the US also suggest that ‘triaging’ index cases with multiple partners, or an ex-partner perceived to be the transmitter, or who are men who sleep with men, can appropriately direct Provider Referral services towards where they will be most effective. The literature also reports that other indicators of reduced-effectiveness with Patient Referral include: if the index case has a repeat infection; is male; or has reduced self-efficacy.

Based on these findings it appears that health professionals should offer to anonymously inform casual, ex or incarcerated partners, particularly if the index case is male, has a repeat infection or has reduced self-efficacy.

Sexual violence, a global public health issue, has been widely reported from developed countries. However, the magnitude and severity are increasingly recognized in developing countries as well. The objective of this study, based on data from a task force project by Indian Council of Medical Research, is to report the prevalence and correlates of sexual violence against women from southern region of India.

It is a population-based study involving both married women (n=2175) and men (n=2175) from three of the four states of Southern India, selected via a systematic multistage sampling strategy. The interviews were carried out using pre-piloted structured questionnaires for women (victims) and men (perpetrators). Socio-demographic data and prevalence of sexual violence were obtained through direct interviews and correlates of sexual violence were determined using descriptive statistics and logistic regression analyses.

The overall prevalence amongst all three states ranged from 2% to 11%. Women reported more victimization (9.36%) than men acknowledging the act (6.86%). The prevalence was higher in rural (8.11%) than urban population (7.11%). Multivariate logistic regressions revealed that lower personal income, lesser dowry, alcohol consumption by the husbands and refusal of sex by women had significant association with sexual violence in all three states. Also, coerced sex was the most prevalent form of perpetration followed by denial of sex.

The prevalence of sexual violence was comparatively higher than most of the available data from India, providing evidence of under reported sexual violence. The results highlight the dynamics that put women under a high risk of being sexually abused and these predictive factors can steer the focus of public health interventions in the future.
Chlamydia notifications and new HIV diagnoses in Australia have steadily increased in this decade. Testing for these infections commonly occurs in general practice; however, data regarding testing patterns are limited. This study aimed to ascertain how frequently general practitioners (GPs) test patients for HIV and chlamydia and to determine predictors of and barriers to testing.

We analysed data from the Bettering the Evaluation and Care of Health (BEACH) programme (April 2000-March 2008), a cross-sectional, national survey of GP activity in which each GP recorded 100 consecutive encounters. We compared the demographic and practice characteristics of GPs who tested for chlamydia and/or HIV and identified all GP, patient and encounter characteristics associated with higher testing rates. Multiple logistic regressions were used to measure the independent effect of GP, patient and encounter characteristics on testing.

19% of GPs performed at least one chlamydia test and 19% at least one HIV test within their 100 encounters. Testing rates for chlamydia increased significantly for all age groups, however, HIV testing rates remained constant. On multiple logistic regression, independent predictors of both chlamydia and HIV testing included the management of a ‘risk factor’; younger GP age; practice in a metropolitan area, younger patients, being new to that practice and being Indigenous. Female GPs were more likely to test than males for chlamydia but not HIV. If a risk factor or screening was managed at encounter, male patients were more likely to be tested than females for either HIV or chlamydia.

This study suggests that to increase testing for HIV and chlamydia, we must target older, rural GPs and find ways to encourage at-risk patients to bring these issues to the attention of their GP; thus providing them an opportunity to test as the ‘opportunity’ appears to be a barrier to testing.

Introduction

Annual population-based estimates of the number of men who have sex with men (MSM) living with diagnosed HIV infection (HIV prevalence pool), and the proportion of all MSM this represents (HIV prevalence), have been insufficiently described over the long term. We investigated the dynamic effects of ongoing HIV diagnoses, lower mortality due to antiretroviral therapy, and growth in the MSM population over 25 years on these two epidemic indicators.

Methods

National routine HIV/AIDS surveillance data in New Zealand were examined from 1985-2009. These included HIV diagnoses through Western blot antibody testing, cases identified through viral load testing, AIDS diagnoses, and information on losses of diagnosed individuals where the mode of transmission was MSM. Annual HIV prevalence among MSM was derived by applying various estimates of the annual MSM population to the HIV prevalence pool.

Results

Surveillance data suggest that 1,313 MSM were living with diagnosed HIV in New Zealand as at the end of 2009, under the assumption that all MSM diagnosed with HIV and not known to have died or gone overseas were still living in this country. The diagnosed HIV prevalence pool rose 79% between 1989 and 1999, and 137% between 1999 and 2009 when antiretroviral therapy had reduced mortality and new HIV diagnoses among MSM were rising.

Population-based estimates of diagnosed HIV prevalence as a proportion of MSM were strongly dependent on the assumptions made about the denominator MSM population. These began at 0.2% of MSM in 1985 and were between 1.5% and 5.0% of MSM by 2009. HIV prevalence increased over time, unless the MSM population grew at a faster rate than the male population aged 15-59. In this case, HIV prevalence stabilised, or even declined during some years.

Conclusion

New Zealand still has a low prevalence HIV epidemic among MSM. Nevertheless, 25 years after HIV testing was introduced the number of MSM living with diagnosed infection is growing rapidly. Strengthened prevention responses are needed, and the health needs of an expanding population of HIV positive MSM planned for.
This study examined the recent trends in notification and testing for genital gonorrhoea in the Darwin Remote District of Northern Territory (NT), Australia, between 2004-2008.

Laboratory testing data and surveillance data were used to calculate sex and age-specific notification rates, testing rates and positivity rates. The correlation between testing rates and notification rates was assessed. An estimation of the proportion of population tested was made by using deterministic matching method to calculate the estimated number of individuals in the data set. An analysis on the numbers and yields of nucleic acid tests and cultures by specimen types was also performed.

The notifications rates for the 15-24 year age group increased between 2004-2005, and trended downwardly between 2005-2008 with a decrease of 48% in females and 60% in males. No evident trends were found in testing rates. Between 2004-2008, the positivity rates for the same age group decreased by 46% in females and 70% in males. A significant correlation was found between notification and testing rates. The test yields for urine and low vaginal swabs in females and for urine in males were close to that for cervical swabs. Culture yield from urine in females was comparable to that for high vaginal and low vaginal swabs. The number of urine specimens cultured decreased to a low level in 2007 and 2008 in both sexes.

The rates of gonorrhoea decreased significantly between 2005 and 2008, which was most likely due to a true decrease in prevalence. Judging by the test and culture yields, urine and low vaginal swabs commonly used in screening settings can be confidently used in this region. However, the sharp decrease in urine specimens cultured in 2007-2008 is a concern for the effectiveness of gonococcal sensitivity surveillance.

This study was aimed at determining the prevalence of repeat infection (RI) with the most commonly diagnosed sexually transmitted infections (STIs), namely chlamydia and gonorrhoea, among clients of the only dedicated sexual health clinic in Darwin, Clinic 34, for the period of 2005-2009, and identifying demographic, clinical, and behavioural factors that had significant association with RI.

A retrospective audit study using laboratory testing data, demographic and behavioural data extracted from the clinic database. Prevalence of RI was calculated and the association with the selected risk factors examined.

A total of 11,881 tests for gonorrhoea and chlamydia were identified during the study period for 7,732 clients. After excluding travellers/backpackers, 6,515 clients were included for analysis (3,083 females and 3,432 males), of which 1,304 (20.0%, 95% confidence interval [CI]: 19.0-21.0%) tested positive for either STI. The overall prevalence of RI was 11.3% (95%CI: 9.7-13.2%), 11.8% (95%CI:9.4-14.5%) in females and 10.9% (95%CI: 8.6-13.6%) in males. The median time to the first RI was 259 days (interquartile range: 104-481). 22.0% of first RIs occurred within three months (27.8% in females and 15.7% in males). The risk factors with significant association with RI were being Indigenous (odds ratio [OR]: 3.5, 95%CI:1.2-3.7) and having male homosexual contact (OR: 2.1, 95%CI:1.9-6.7) in males, and aged less than 25 years (OR: 2.3, 95%CI:1.3-4.1) in females.

This study found a high prevalence of RI with chlamydia and gonorrhoea among Clinic 34 clients and they tended to occur soon after the index episode. Clients presenting with the identified risk factors should be targeted for enhanced intervention and follow-up, including re-screening within 3 months. A prospective cohort study is required to validate the findings of this study.
PREVENTION AND EPIDEMIOLOGY

POSTER NUMBER: 87
PAPER NUMBER: 420
KUNGKAKU YANGUPALAKU HEALTHY RELATIONSHIPS PROJECT (OATS]H IMPROVING SEXUAL HEALTH IN ABORIGINAL AND TORRES STRAIT ISLANDER YOUTH DEMONSTRATION PROJECTS)

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Young Aboriginal people on the Ngaanyatjarra lands experience disproportionately high rates of STIs and have limited access to culturally appropriate information about sexual health. The Kungkaku Yangupalaku Healthy Relationships Project (KYHRP) is a community-based health promotion project that aims to encourage the development of healthy relationships by increasing young people’s ability to make informed decisions, reduce risk-taking behavior and to improve access to sexual health care and related services. KYHRP is a demonstration project mid-way through its term. Community involvement and innovative strategies are utilised to accommodate low levels of literacy and to foster cultural and social relevance. Working collaboratively with other agencies and utilising innovative approaches has resulted in significant gains. Approaches, successes, barriers and future plans will be presented.

POSTER NUMBER: 88
PAPER NUMBER: 480
ANAL CANCER IN TASMANIA 1973-2010: USING A RETROSPECTIVE HOSPITAL ADMISSIONS COHORT TO INFORM FUTURE SCREENING PROGRAMS

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Background: Exposure to oncogenic human papillomavirus genotypes is the principal risk factor for anal cancer. Anal cancers are preceded by dysplastic changes amenable to cytological screening and local treatments. Those most at risk are traditionally regarded as men who have sex with men (MSM) and HIV-positive individuals.

We have reviewed hospital admissions for anal cancer to provide evidence for a targeted screening program in Tasmania.

Methods: Retrospective cohort study of anal cancer diagnoses in Tasmania over 1973-2010. Cases were identified from Tasmanian hospital records, which were reviewed for relevant explanatory and outcome variables. Significances of trends were evaluated using linear and logistic regression, as appropriate.

Results: A total of 155 cases from 120 persons were found (42 male, 78 female). Median age at first diagnosis was 66 for men and 62 for women. Twenty-three persons went on to have 35 recurrences – these were evenly distributed by sex.

42% of cases were current or ex-smokers. A history of anogenital warts was noted in 46% of cases. 10% of women had a history of cervical, vulvar, or vaginal dysplasia/neoplasia; 7% of men had a history of penile dysplasia/neoplasia. Only two patients were known to be HIV-positive.

Forty-one cases (26%) were diagnosed in the 26 years prior to 1999 and 114 (74%) thereafter. Sixty-two percent of fatal cases occurred prior to 1999 (p=0.013); survival time was not significantly different between these two periods (p=0.110) nor time to remission (p=0.968). This may be due to the greater proportion (17% vs. 7%) number of detections at early stage (≤T1) after 1999, though the overall difference in stage at presentation (mean 4.3 vs. 4.0), while lower, did not reach significance (p=0.448).

Discussion: Anal cancer is not a common condition, however diagnosis frequencies indicate its incidence may be increasing in the Tasmanian population.

Our data suggest that diagnosis at an earlier stage leads to improved outcomes. Increased screening would therefore confer public health benefits and should be encouraged. Such screening should include populations outside the traditional at-risk groups (HIV+, MSM), and must include women, perhaps at the time of cervical screening.
While most Pacific Island countries and territories (PICTs) excluding Papua New Guinea (PNG) have very low HIV prevalence, this is not true for other sexually transmitted infections (STIs). The prevalence of Chlamydia is particularly high. In 2004/5, Second Generation Surveillance (SGS) surveys conducted in six PICTs found that 18% of the 1,618 antenatal women tested were positive for Chlamydia using high sensitivity assays.

Similar SGS surveys of antenatal and other populations were conducted in 18 PICTs between 2005 and 2009, including a second round in the six original PICTs. Data analysis is incomplete, but we present here data from antenatal surveys conducted in 2008.

Data from the six antenatal surveys were combined, giving a sample size of 1,325 women. Risk factors significantly associated with higher Chlamydia prevalence included being under 25 years old (24.6%), having more than one sexual partner (34.2%) or concurrent sexual partners (38.9%) in the last 12 months, or being unmarried (27.7%). There was no significant difference in Chlamydia prevalence in women with planned or unplanned pregnancies. However, Chlamydia prevalence in women with no reported risk factors was still at epidemic levels in many PICTs. The overall prevalence of Chlamydia in antenatal women with only one reported sex partner in the last 12 months was 18.2%.

Chlamydia prevalence in antenatal women in PICTs is amongst the highest in the world, despite the majority of these women reporting very low risk behaviours. Most women in PICTs are presumably exposed to Chlamydia by their only or long term sex partner. This suggests that the main risk factor for Chlamydia is therefore the behaviour of the male partner. There is an urgent need for a comprehensive strategy involving the whole community, but targeting young men and those with high risk behaviours, in order to control the STI epidemic in PICTs.

Chlamydia is a common sexually transmitted infection (STI) worldwide, particularly among sexually active young people. Second Generation Surveillance (SGS) surveys in the Pacific have shown high prevalence of STIs. Chlamydia prevalence among antenatal women under 25 years was as high as 40% - among the highest in the world.

Most Chlamydia infections are asymptomatic, but if left untreated, chlamydia can cause pelvic inflammatory disease, ectopic pregnancy and infertility in women and conjunctivitis and pneumonia in newborns. Amongst both men and women, HIV transmission is facilitated by the presence of any STI, including asymptomatic Chlamydia.

In January 2010 the Pacific Sexually Transmitted Infections Working Group (PSTIWG), comprised of a number of regional development partners including SPC, WHO, UNICEF, WHO and OSSHHM, met to consider options to control STI epidemic in PICTs. It was agreed that a comprehensive and aggressive strategy to reduce the prevalence of STIs and prevent an increase in HIV in the region was urgently needed.

The control measures recommended are designed to be implemented as a package and to work synergistically. Underpinning all the measures is strategic health communication to raise awareness of STIs, promote the availability of testing services and enable safer sexual behaviours. The overall aim is to reduce Chlamydia prevalence by 50% from 2008 levels by 2013 and eliminate the neonatal consequences of parental STIs.

Among the package of measures, we describe here a recommended aggressive short term strategy - epidemiological (presumptive) treatment for Chlamydia of all antenatal women and their partners in particularly high burden PICTs. This would ensure access to treatment for all antenatal women, including those currently unable to access testing facilities. In addition it would free up laboratory capacity to offer Chlamydia testing to other potentially higher risk and vulnerable groups, such as sexually active youth.
POSTER NUMBER: 92
PAPER NUMBER: 227
TRENDS IN CHLAMYDIA AND GONORRHOEA POSITIVITY AMONG HETEROSEXUAL MEN AND MEN WHO HAVE SEX WITH MEN ATTENDING A LARGE URBAN SEXUAL HEALTH SERVICE IN AUSTRALIA, 2002-2009.

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Introduction: In Australia, STI testing rates remain low among heterosexuals but have been increasing among men who have sex with men (MSM). This analysis aimed to determine whether chlamydia positivity among men who have sex with women (MSW) and chlamydia and gonorrhoea positivity among MSM have changed over time.

Methods: Computerized records for men attending a large sexual health clinic between 2002 and 2009 were analysed. Chlamydia and gonorrhoea positivity were calculated and logistic regression used to assess changes over time. Testing data from the Victorian Infectious Diseases Reference Laboratory (VIDRL) was also included to supplement the MSHC data.

Results: 17769 MSW and 8328 MSM tested for chlamydia and 7133 MSM tested for gonorrhoea. In MSW, 7.37% (95% CI: 6.99-7.77) were chlamydia positive; positivity increased by 4% per year (OR = 1.04, 95% CI: 1.01-1.07) in multivariate analysis. In MSM, 3.70% (95% CI: 3.30-4.14) were urethral chlamydia positive and 5.36% (95% CI: 4.82-5.96) were anal chlamydia positive; positivity did not change over time. In MSM, 3.05% (95% CI: 2.63-3.53) tested anal gonorrhoea positive and 1.83% (95% CI: 1.53-2.18) tested pharyngeal gonorrhoea positive. Univariate analysis found anal gonorrhoea positivity had decreased (OR = 0.93, 95% CI: 0.87-1.00), but multivariate analysis found no change. The gonorrhoea and chlamydia positivity in MSM from VIDRL fell at all sites, but only univariate analysis was possible.

Conclusions: These data suggest that chlamydia prevalence in MSW is rising and chlamydia and gonorrhoea prevalence among MSM is stable or declining. High STI testing rates among MSM in Australia may explain differences in STI trends between MSM and MSW.
Chlamydia is the most commonly notified sexually transmissible infection (STI) in Australia. Incidence analysis of chlamydia in men who have sex with men (MSM) is rare and offers important public health information.

To estimate the incidence of chlamydia in MSM presenting for testing and identify risk factors and subpopulations at high risk for chlamydia.

The Victorian Primary Care Network for Sentinel Surveillance of blood borne viruses and STIs (VPCNSS) links testing, demographic and behavioural data from individual testers at participating clinics. Data captured from the VPCNSS between April 2006 and December 2008 was used.

MSM who had more than one chlamydia test at a VPCNSS site were included. Survival analysis of multiple failure-times data including robust standard errors was used. Incidence is reported as positive tests for chlamydia per 1000 person-years at risk (PYAR) and Cox regression was used to examine predictors of chlamydia incidence.

A total of 3653 participants contributed 4459.64 person-years with 472 positive tests for chlamydia. The overall incidence rate was 105.8/1000 PYAR (95% CI = 96.7-115.8). Participants aged 16-29 years had an incidence rate of 132.3/1000 PYAR (95% CI =114.4-153.1) were more likely to test positive for chlamydia (HR=1.8, 95% CI:1.3-2.4). HIV positive MSM had an incidence rate of 186.3/1000 PYAR (95% CI=157.0-221.1) and were more likely than HIV negative MSM to return a positive Chlamydia result (HR=2.6, 95% CI 1.6-4.1). Risky sexual behaviour, which was determined from survey responses, older age, country of birth and ATSI status were not associated with a positive test for chlamydia.

The results show that chlamydia incidence and risk of infection was highest in younger MSM and those who were HIV positive. Identification of high risk sub-populations amongst MSM is important for the development of clinical and public health policy. Future analysis should aim to quantify how repeat infections with chlamydia modify behaviour and/or risk of STIs including HIV.

Little is known about risky scenarios and condom use in oral sex among ethnic Han Chinese men who have sex with men (EHCMSM).

To understand risky scenarios and condom use in oral sex and its implication for HIV prevention among EHCMSM.

Between June and August 2007, prospective participants were recruited via the Internet and surveyed offline in voluntary counseling and testing (VCT) centers in Beijing and Urumqi, China. Interviews were conducted between 6 and 10 pm. Consented participants were administered with a face-to-face questionnaire. Participants’ demographic characteristics, sexual behaviors and condom use were recorded and a blood specimen collected to test for syphilis and HIV.

A total of 362 EHCMSM were recruited, with a median age of 25. Seventy-one point eight percent (333/362) had post-secondary education or above. Median number of lifetime male sexual partner was 10. Median age for first sex with man was 20. Infection rates of HIV, syphilis and HIV/syphilis were 4.8 (17/353), 11.6 (41/353) and 1.7% (6/353). Ninety-six point seven percent was 10. Median age for first sex with man was 20. Little is known about risky scenarios and condom use in oral sex among ethnic Han Chinese men who have sex with men (EHCMSM).

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HIV/syphilis infection rates are high among EHCMSM. Condom use during oral sex is rare and scenarios potentially implicating HIV/STIs infection are common among this population. It is urgent to adopt measures to promote safer sexual practices in oral sex, and condom-use-in-oral-sex promotion might be one option.
This study assesses cognitive and emotional factors and processes that influence the decision to test for STIs in young people. An evaluation of pros and cons is thought to be central to the decision to test for STIs and acting upon this decision depends on people’s perceived behavioural control (PBC). The study explores how these factors are affected by fears about testing.

An online survey launched in May 2010 (www.gettingdowntoit.net) recruited 906 sexually experienced young people living in NSW (Mean age = 20.7 years, range 16-26; 61% female and 39% male). The survey included questions on sexual risk taking, STI-testing and potential determinants: perceived pros and cons, fears, PBC and intention to test.

Half of participants (54%) had tested for STIs and most (67%) had unprotected sex in the previous six months. Participants had a high perception of pros associated with testing for STIs (Mean=4.3/5.0) and a moderate perception of cons (Mean=2.8/5.0). More perceived cons was associated with a lower testing intention and less uptake of testing, whereas perceiving more pros had a positive influence. Perceived behavioural control was high (Mean=4.2/5.0) and positively related to testing. Fears were also evident (Mean=3.0/5.0) and a higher level of fear was associated with perceiving more cons and less pros, as well as lower PBC.

This study confirmed the importance of perceived pros and cons and PBC in the decision to test for STIs. Findings suggest that testing in young people can be promoted through campaigns that address pros and cons using medical and lay arguments. However, in the presence of fears related to STI testing, the delivery of this information needs to be accompanied by interventions aimed at reducing emotions that negatively affect PBC and are detrimental to a rational appraisal of pros and cons associated with STI-testing.

Human Papillomavirus is the sexually transmitted precursor for cervical and anal cancer. Anal cancer occurs at rates of up to 137/100,000 in HIV + men who have sex with men (MSM). Anal cancer screening is not currently standard of care for HIV + MSM in Australia, but is suggested in some guidelines. Studies of cervical screening have shown psychological impacts including increased anxiety, reduced quality of life and diminished sexual well-being. There are no comparable studies in men. Therefore we initiated the first known study of the psychological impact of anal cancer screening on HIV + MSM.

Self report measures were used in a prospective, multi-wave longitudinal study of 291 men undergoing anal screening. Using previously validated methods, we determined baseline psychological well-being (worry, depression, anxiety, stress and sexual interest) and changes to well-being after cytological and histological sampling procedures and receipt of results.

Three groups were identified. The “Low Threat” group received cytology results of negative or LSIL and no further investigation. Both the “Reassured” and “High Threat” groups received ASC-H, ASCUS or HSIL cytology results and were referred for High Resolution Anoscopy (HRA). At HRA, the Reassured group were either not biopsied (negative HRA) or were given LSIL histology results. The High Threat group received histology results of HSIL. The Reassured and High Threat groups differed significantly to the Low Threat group in four areas: more worry about cancer, worse anal and future health and more distress after receiving histology results. These results are similar to cervical studies.

Men were psychologically impacted by the anal cancer screening processes, particularly in terms of worry about cancer, both by referral to and results from HRA investigation. The introduction of any screening program needs to consider the psychological impact of the procedures and offer appropriate psychosocial support.
The poster details a qualitative study that interviewed eight rural antenatal midwives and an obstetrician about how they implemented a universal chlamydia screening program and issues relating to the screening process.

In 2004, midwives at Mersey Community Hospital in rural Tasmania commenced universal screening of antenatal women for chlamydia infection and they agreed to provide reflective narratives about their practice in one rural hospital.

During 2008–2009, antenatal midwives completed 999 tests which detected 32 cases of chlamydia infection. Of the 32 women with chlamydia infection, 30 women were aged 14–25 years and two women were 33 years old. All 32 women subsequently tested negative for chlamydia in the third trimester.

While antenatal staff clearly identified the benefits of the chlamydia screening program, they had not considered the potential harms associated with screening. With increasing calls for routine chlamydia screening programs to be instituted, there is limited information about the process and potential harms associated with chlamydial screening in antenatal clinics.

Currently, each Tasmanian antenatal unit takes a different approach to chlamydia screening from (no screening, ad hoc screening, universal screening) and the Australian College of Midwifery offers minimal guidance to antenatal midwives who screen women for chlamydia infection. Reflective practice narratives provide useful qualitative information to further policy design, guide clinical practice, education and research about chlamydial screening programs.

Introduction
The Consider Chlamydia Campaign, conducted September 2008 - March 2009, used a social marketing approach to educate young women and general practitioners about chlamydia and the importance of testing especially in conjunction with Pap tests.

Methods
To determine if chlamydia testing increased in the ACT, during and after the conduct of the campaign, de-identified data concerning all chlamydia tests conducted in ACT general practices during the study period, the corresponding 7 months in the previous 12 months (pre-study period) and in the 7 months immediately following the study (post-study period) were reviewed. Changes in the rate of overall testing, the rate and type (chlamydia alone testing vs. chlamydia with Pap test, hereafter joint test) of testing among the target population and the rate of testing among men were determined.

Results
There was a 16.2% increase in overall chlamydia testing during the study period compared to the pre-study period (8677 vs. 7468) and a further 4.7% increase in testing during the post-study period (8677 vs. 9086). The overall number of tests conducted among women aged 15-29 years increased by 14.9% during the study period compared to the pre-study period (5.5% for joint and 20.4% for chlamydia tests conducted alone). In the post-study period there was further 2.1% increase in the number of tests; 5.5% increase in chlamydia alone tests and 5.0% decrease in joint tests. In respect to males, there was a 21.4% increase in chlamydia tests during the study period and a 10.7% increase in the post-study period. The proportion of positive tests (5.9%, 5.6% and 5.4% for the pre-study, study and post-study periods respectively) did not change.

Conclusions
Increases were seen in the number of chlamydia tests conducted in the ACT during and after the Consider Chlamydia campaign. Targeting both the provider and the consumer at the same time may increase chlamydia testing.
Background
Consistent solid international evidence supports sexuality education as a vital element of any long-term successful health promotion strategy aimed at secondary students. While sexual health is expected to be covered within the Victorian curriculum, additional factors such as geographical location, the socioeconomic environment of the school, financial resources and facilitator skills, training and confidence all impact the actual delivery of sexuality education. In Ballarat, Victoria’s third largest city, external providers are heavily relied on to deliver various puberty and sexual health programmes in both primary and secondary schools. This research utilises youth consultation to examine various aspects of the current delivery of sexual health information within government schools in the Ballarat region.

Aims
This study aims to report on the perceptions of secondary school students in the following three areas;
(A) Perceived knowledge of sexual health topics;
(B) Perceived effectiveness of various puberty and sexual health sources and
(C) Perceived relevance of topics taught in schools.

Methods
Ballarat Community Health together with the University of Ballarat are evaluating the sexual health programmes in two large government secondary schools by engaging with year 7, 8 and 9 student participants. A mixed-method approach combining questionnaire-based responses (analysed by qualitative software - SPSS) and focus group methodology (analysis is progress) have been primarily used in this research. There are 6 broad topic headings, each with sub-categories for the students to comment on. These include: Physical changes at puberty, teenage parenthood, risks associated with sexual activity, homophobia, masturbation and abstinence.

The relevance of this research: This research presents the voice of students who are directly involved with sexual health education as specified by the Victorian curriculum and it is hypothesized that this research will open doors into exploring improvements for these young people and potentially others in similar circumstances.

Computer-assisted self-interview methodology has demonstrated its value in increasing response rates and interviewee enjoyment, improving data quality, and enhancing respondents’ perception of confidentiality when used in a variety of settings. Handheld computers, or Personal Digital Assistants (PDAs), are a useful technology to support behavioural surveillance, particularly among highly computer-literate youth and other populations who may have valid concerns about disclosing stigmatized or illicit behaviour in a face-to-face interview setting.

In 2009, the Cook Islands undertook a survey of transgender (akavaine) and men who have sex with men (MSM), a sub-population potentially at higher risk for HIV infection. The survey goal was to recruit self-identified akavaine and MSM to collect sexual health knowledge, attitudes and behaviour data in the Pacific region. It was decided to pilot the use of PDAs to try to overcome some of the potential constraints experienced in previous surveys undertaken in Cook Islands and elsewhere in the Pacific. As this was the first time PDAs had been used in the Pacific to collect sensitive data of this type, a review of the survey process was undertaken in the Cook Islands in 2010, to evaluate potential application of the technology for future surveys in other Pacific islands countries and territories.

Key informants felt that the PDA method was more confidential than a paper questionnaire. Increased confidentiality was cited by multiple interview informants as the major benefit of using PDAs. Another advantage noted was having data immediately available in electronic format, instead of as a separate follow-up activity (a major source of delay for many surveys), and the increased accuracy of data due to automatic “skip” functions. Overall, key informants were positive about the survey process and using PDAs, and would recommend using PDAs for future surveys, particularly with questions of a sensitive nature.
**Introduction**
Recent studies have questioned whether a flexible approach to HIV result-giving may be warranted in NSW sexual health clinics. The aim of this study was to ascertain the relevance of the NSW Health policy directive regarding provision of HIV test results to current clinical practice.

**Methods**
A brief telephone survey was conducted with a senior staff member in NSW public sexual health clinics to ascertain what options are being given to patients for collection of HIV results.

**Results**
A total of 37 clinics (10 metropolitan, 3 regional, 24 rural/remote) responded to the survey (response rate 95%). In 59% of services negative HIV results are routinely given in person. For the 41% of services offering HIV results by telephone to some of their patients, the patient’s assessed level of HIV risk determines the method of result-giving in all the metropolitan and regional clinics. Staffing levels and clinic accessibility are the criteria used to determine the method of HIV result-giving for 7 of the 8 rural clinics. All clinics provide positive HIV results in person. At 19% of clinics staff wait for patients to attend booked appointments to receive positive HIV results. When dealing with a positive HIV result, half of the remaining 81% of clinics actively recall the patient and the other half assess each case individually and decide whether or not to actively recall the patient.

**Conclusion**
Most sexual health services are delivering HIV results in line with NSW Health guidelines. However, some services are offering telephone results to low-risk patients. Most negative HIV results are provided via telephone in some rural clinics due to distance and lack of staff. The NSW Health guidelines regarding HIV-result provision in person are not fulfilling the needs of many patients and staff in NSW public sexual health clinics and require revision.

**Sexual minorities** are often neglected in cultural competency training for health practitioners, despite significant data indicating negative health outcomes in this population as a result of discrimination and exclusion from services.

Cultural competency training for practitioners working with sexual minorities was an integral part of Mind the Gap, a primary HIV prevention project in rural Victoria targeting same sex attracted young people and their communities funded by the Victorian Department of Health. The evaluation of that training demonstrates practitioners can change both personal and practice attitudes and behaviours in ways that benefit clients from sexual minorities.

To demonstrate the impact of a four-hour sexual minority cultural competency workshop for health practitioners on knowledge, behaviours and attitudes and implementation of that knowledge into the workplace.

Workshop participants completed three surveys, pre- and post-workshop and two months post-workshop.

11 people: 5 general practitioners, 5 registered nurses and 1 student welfare coordinator completed the workshops and all three surveys. Despite small numbers, the data showed an overall trend towards positive change in most measurements after the workshop with a significant change in attitudes towards sexual minorities.

A reduction in this positivity was seen between surveys two and three in most parameters. The data suggest this may reflect participants’ first hand and often first experience of institutionalised heterosexism. However, nearly all were able to make changes to improve access to services for these clients.

**Conclusions:** Cultural competency training can change practitioners’ attitudes towards clients from sexual minorities and effect changes that improve access to health services for this high-risk group. Further research is required to assess whether or not this impacts on client satisfaction and health outcomes.
**Value of directly observed therapy with older generation of antiretroviral, prior to starting on new generation antiretroviral: Experience from a resource poor setting in United Kingdom (UK)**

Adherence to antiretroviral is crucial in the management of HIV infection. In a recent meta-analysis by Nathan Ford et al, directly observed therapy was found to not be useful in HIV patients at a population level.

The purpose of the audit is to determine the effects of directly observed therapy in patients with difficulties in adherence resulting in the fall of CD4 count below 300 among a cohort of 300 HIV positive patients, between 31/08/2007 and 31/03/2010 with older generation of antiretroviral.

Patients who agreed to supervised therapy with older generation of antiretroviral:
- Warranting new generation of antiretroviral (intergrase inhibitors, chemokine receptor inhibitors, etravirine
- Wish to go on new generation antiretroviral
- Unavailability of pharmacist at the point of care (resource poor setting)
- Patients declined supervised therapy
- Patient failing, but CD4 count over 300
- Two patients who met the exclusion criteria were excluded
- Six patients who met the inclusion criteria were included in the audit

Level 1: greater than 3/7 week
Level 2: greater than 5/7 week
Level 3: greater than 7/7 week

66.6% (4/6) achieved VLM below 400 within 7/12
33.3% (2/6) achieved VLM below 50 within 7/12
33.3% (2/6) achieved CD4 count over 350 within 7/12
100% remained free of hospital admissions, opportunistic infections and new resistant mutations

Significant improvement of viral load and CD4 counts achieved in all patients, during the period of directly observed therapy with older generation of antiretrovirals.

This audit shows that, in patients with significant adherence difficulties, still possible to achieve VLM < 400 with older generation of antiretroviral by directly observed therapy (provided no genotype resistant).

**References**

Nathan Ford MPH, Jean B Nachega MD, Mark E Engel MPH
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**HPV is highly implicated in cervical cancer, as well as a range of other malignancies. Previous research has shown that knowledge about HPV amongst young people is generally poor, but knowledge is implicated in the rate of vaccine uptake for HPV as well as other vaccine-preventable diseases. Vaccine acceptability and uptake in older adolescents and young adults is particularly important for HPV as the distribution of the HPV vaccine outside of the school setting has targeted this age group.**

This study aimed to assess the level of knowledge of HPV in young people aged 18-26, gauge the level of HPV vaccine uptake in the study population and explore the motivations and attitudes of young women to HPV vaccination/non-vaccination. A cross-sectional, descriptive mixed methods study was undertaken utilising interviews, focus groups and an online survey to collect data from a random sample of young people living in rural areas. The key findings were that despite the efforts of the campaign to educate this target group about HPV, its consequences and the value of vaccination, knowledge of HPV was poor. There was little difference between participants, whether vaccinated or non-vaccinated, in their knowledge of STIs, cervical cancer, HPV and the HPV vaccine, barriers to vaccination and the Gardasil® campaign. Our results demonstrate that the majority of young people in the study had heard about the HPV vaccine through the media campaigns, but a third of them still felt that they did not have sufficient information to make a decision about the vaccine.
In November 2006 the Federal Government announced $500 million to place the HPV vaccine, Gardasil®, on the National Immunisation Program. The reasons for it doing so were ostensibly to reduce the morbidity and mortality from cervical cancer however there was more to the decision making process than concerns for public health. The aim of this study was to describe and analyse the policy by examining Government documents in an effort to discover what influenced the Government to make the decision to publicly fund the vaccine. This study used a qualitative methodology to guide an analysis that was informed by content analysis and critical discourse analysis. The sample included publicly available Government documents from the period January 2006 through to April 2007. The results show that one of the main concerns of Government was the cost of the vaccine despite the Pharmaceutical Benefits Advisory Committee (PBAC) having other concerns. Further comparisons with policy frameworks highlight how this policy deviated significantly from normal policy making processes. The factors influencing the Government’s decision are partially obscured by the fact that the decision was made in secret in Cabinet. The success of the HPV vaccination program is yet to be determined, however, whatever measure of success this vaccine has, the way in which it came to be funded, and the reasons for that decision appear to have little to do with the health of Australian women and more to do with political clout.

The Western Australian Department of Health (WA Health)’s Communicable Disease Control Directorate contracted Estill and Associates to review and evaluate the impact on the teaching and work practices of those teachers and school nurses who have participated in the professional development (PD) course in sexual health education and the use of the Growing and Developing Healthy Relationships Curriculum Support Materials (GDHR). These courses, funded by WA Health and approved by the Department of Education, have been conducted by contracted specialist consultants Concord Training Services/WA Health Education Services since 2002.

The purpose of the evaluation was to both review and assess the PD program and to conduct a review of the literature making recommendations about preferred future models of teacher PD in this area of school health education.

The evaluation process consisted of:
- a review of the current national and international literature
- examination and analysis of previous evaluation surveys completed by participants before and after each PD course
- a follow-up telephone interview evaluation survey with teachers, school health nurses and other non-teaching professionals who had previously undertaken this PD.

Results obtained indicated that:
- the course provided high quality training and good practical content
- the course increased understanding and use of the GDHR resource
- participants found the course made a valuable contribution to their teaching practice including undertaking more sexual health education and adopting a more student-centred teaching style, which has been maintained up to five years later.

The literature review found that the face to face PD was consistent with international best practice and would be well supported by the introduction of other combined flexible learning PD categories.
Currently, little is known about norms with respect to HIV/STI risk and risk reduction behaviours in the Australian gay communities. The Connect study will explore the norms and how they affect HIV-related practices and will use innovative recruitment methodology. We present the study methodology and the results of feasibility testing.

The Connect study will be conducted in three Australian cities (Sydney, Melbourne and Perth) and will recruit gay men using respondent-driven sampling (RDS). The recruitment will start in October 2010. The methodology was pretested in a pilot study. The pilot RDS study was conducted in 2008 and assessed: (1) the feasibility of using RDS among Australian gay men (2) the appropriateness of the methodology (particularly, of the referral process and incentives), and (3) the composition of the sample recruited through RDS. It recruited 100 men. Data from the pilot was analyzed using network analyses methods. The lessons from the pilot study were incorporated into the Connect study design. The findings from the RDS pilot study suggest that RDS methodology was acceptable in the gay community: The RDS pilot study successfully recruited the desired sample. Community partnership, innovative management and communication approaches and computerised data collection increased the effectiveness of the referral and recruitment process. The RDS sample was similar to those recruited in behavioural surveillance studies. Larger studies may have a potential to recruit samples representative of the broader MSM population. RDS also allowed the expanded analyses of data on the level of network connections.

RDS has been effectively used among homosexual men worldwide and has now been successfully tested among Australian gay men. This methodology will allow studying of norms in gay communities in Sydney, Melbourne and Perth and their effect on sexual and testing practices as related to HIV transmission.

Genital herpes is one of the most common sexually transmitted infections (STIs) worldwide. In Australia, a population-based survey revealed that 16% of women and 8% of men over 25 had antibodies to Herpes simplex virus type 2 (HSV-2). Most patients with genital herpes are diagnosed and treated in general practice. However data about the patient’s experience with health care providers and treatment is limited.

The online survey was designed and reviewed by the AHMF. Questions were asked about demography; strategies for reducing transmission, major concerns related to herpes, satisfaction with health care, symptomatic treatment, alternative remedies and experience with antiviral therapy.

The survey opened in May 2009. By the end of April 2010, 402 patients had completed the survey. 94% were born in Australia and 58% were female. 2.7% were aged 16 or less, 11.2% were aged 17-24, 26.9% were aged 25-34, 27.1% were aged 35-44 and 38% were aged over 45. The most common strategy for reducing transmission was not having penetrative sex during a recurrence (77.9% used this always), followed by condom use (56.7% always). Major concerns were emotional (93.9%) transmission (93.8%) and shame and embarrassment (90.5%). Levels of dissatisfaction with health care providers were high, with 32.9% dissatisfied or highly dissatisfied with the amount of time that the health care worker provided. Dissatisfaction levels for information from the health care provider, support and treatment information were 40.3%, 53.2% and 42.2%. Younger patients and those whose sex lives were adversely affected were more likely to be dissatisfied.

Many patients are dissatisfied with the service they have received from health care providers. Mechanisms for improving communication between patients and providers need to be developed.
The use of social media to decrease stigma associated with genital herpes

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Genital herpes is one of the most common sexually transmitted infections throughout the world. In Australia, 16% of women and 8% of men over the age of 25 have antibodies to Herpes simplex virus type 2 (HSV-2). 60% of people have unrecognised symptoms and could potentially be transmitting the virus without being aware that they have it. Yet the stigma associated with genital herpes creates feelings of shame and guilt for individuals with genital herpes. With the increasing use of social media to communicate information, we have established an online video competition that is driven by Facebook and Twitter, to determine if we are able to decrease stigma about genital herpes and promote a change in attitude towards the virus.

An online video contest is being launched in July 2010 that invites contestants to create a short film (3 minutes) based on specified criteria to break down the stigma of genital herpes. A competition website has been established and social media sites will be used to promote the competition and to view the videos. Facebook will be the primary tool used to distribute information via its social network capability (an average Facebook user has 130 friends and nearly 60% of Facebook users are between the ages of 18-34 years). There are two judging aspects to the competition first, a panel of judges will choose a winner based on the competition criteria and second, the general public will vote for video that they like the best.

We anticipate that the campaign will reach over 3,000,000 and that 20,000 people will view the videos and vote. We expect to have 10 final videos and the two winning videos will be shown.

Social media are a novel method of disseminating public health messages.
Little is currently known about the impact of chlamydia infection and its potential long-term consequences such as pelvic inflammatory disease (PID) on the mental health, sexual health and reproductive health of Australians. This qualitative study set out to address these gaps in the literature by conducting semi-structured interviews with 33 key informants involved in funding or delivering Australian chlamydia health promotion programs and/or working clinically with individuals diagnosed with chlamydia or PID.

There were two primary objectives to this study. Firstly, it aimed to obtain key informant perceptions of the effectiveness of health promotion programs targeting chlamydia awareness and prevention, and to identify the particular factors perceived to be the most effective components within these programs. Secondly, this study aimed to explore health care practitioners’ perceptions of the key factors affecting health care utilisation among individuals diagnosed with chlamydia and/or PID with a specific focus on barriers and facilitators to health care access.

Data analysis revealed that key informants perceive chlamydia and PID to be a significant burden on the Australian health care system. A number of factors perceived by key informants to be essential components of chlamydia health promotion programs were identified. Recommendations of resources and support aimed at addressing this burden were made. Health practitioner key informants perceived that a chlamydia or PID diagnosis impacted on patients in a number of areas including their identity, moods, feelings about their health (sexual health, reproductive health and general health), and their relationships with sexual partners, family, and friends. Barriers and facilitators to health care access for individuals diagnosed with chlamydia and/or PID were also identified by key informants.

It is anticipated that the information derived from these interviews will be helpful in informing future health prevention opportunities, interventions, and health promotion campaigns related to chlamydia and sexual and reproductive health treatment.
Introduction
Inadequate knowledge about sexuality, limited ability to access friendly services, low use of contraception including condoms are strong indicators of the need for sexuality education among hearing impaired youth (HIY). This research describes the knowledge, attitudes and practice (KAP) of Vietnamese HIY on sexuality and HIV/AIDS and evaluates the impact of an educational intervention designed and implemented by World Population Foundation.

Method
A cross-sectional study describing the KAP of 291 HIY aged 10-24 (143 female/148 male) from 6 secondary schools. Another non-randomized, quasi-experimental study measured the change of 48 HIY’s KAP before and after the one-year classroom-based intervention, comparing with 93 HIY of a comparison group. Quantitative and qualitative research methods were used.

Results
70.8% of HIY did not know that they could be infected with HIV by having unsafe sex with a sex worker only once; 69.5% of HIY did not care about the consequences of sexual intercourse; 81.5% of HIY could not answer correctly the way to use condoms. Percentage of HIY who answered correctly more than 60% of questions in the questionnaire increased significantly after the intervention (29.2% to 68.7%), but it is unclear in the comparison group (11.8% to 15.1%). Therefore, probability for HIY of intervention group to correctly answer more than 60% of questions after the intervention was much higher than in the comparison group (OR = 10.29, p<0.001). Slip-plot Anova test showed a statistically significant different effect between the intervention group and comparison group (partial eta square = 0.23, p < 0.001).

Conclusion
Poor knowledge and practical skills, and inappropriate attitudes in sexuality are serious risks for Vietnamese HIY. The implementation of this model has had a strong impact on the KAP of HIY; therefore it has the potential to meet the sexuality education needs of all Vietnamese HIY.

The Internet is a useful resource for obtaining information. We evaluated the accuracy and coverage of reproductive health information on the Internet in English- and Persian-language sites accessed from Iran.

An expert committee decided on 5 reproductive health topics to be evaluated and specified a checklist of content for these (36-items in total). We submitted keywords in search engines between February and March 2006. About one out of every 4 screened websites (n=200) addressed at least one target topic and underwent in-depth assessment. Three medical doctors independently rated each of the selected websites. Accuracy and coverage percentages were calculated for each site.

In total 168 English and 32 Persian language web-sites were found addressing the specified topics. The mean accuracy and coverage percentages of 200 websites assessed were 98.8% (95%CI: 98.1 – 99.6%) and 45.2% (95%CI: 41.0 – 49.3%), respectively. Thirty-four (17%) websites, all in English, achieved a coverage percentage of 80% or more. Academic referencing was not present in 152 (76%) websites. ‘Sexually transmitted diseases’ and ‘family planning’ were the topics with highest coverage in both the English and Persian websites studied. ‘Reproductive system and puberty’ had the least coverage in Persian websites. The top 20 websites found for the general population on reproductive health are reported.

Websites providing comprehensive reproductive health information are not easy to locate from Iran, in particular Persian-language sites and sites targeting young people are scarce. However, there was acceptable accuracy of information provided. There is a need to identify high-quality, easily accessible websites for both professionals and public and to develop new ones.
Previous research on women’s attitudes to chlamydia testing consistently demonstrates that women experience a number of practical and psychosocial barriers to chlamydia testing. This paper aims to describe the psychosocial implications, barriers and screening preferences of a large cohort of young Australian women tested for chlamydia. We compare the differences between women who tested negative and women who tested positive with a view to inform future screening policy.

Women aged 16 to 25 years were recruited from medical clinics in south-eastern Australia to participate in a 12-month longitudinal study. Participants returned questionnaires and self-collected vaginal swabs by post. At the end of the study a psychosocial questionnaire was sent to all women. Women who tested negative for chlamydia were asked to report what they anticipated their reaction to testing positive to chlamydia might be and positive women were asked what their experience of testing positive was; all women were asked about their experience of being tested.

Overall, 1116 women were recruited from 29 clinics with a 79% retention rate. All women reported perceived or real anxiety about testing positive (84.8%), however compared with women who tested negative, women who tested positive were more likely to change their sexual behaviour in the future (AOR: 5.1, 95%CI, 2.9, 8.9), talk with others about a positive test result (AOR: 2.5, 95%CI, 1.3, 4.8) and were less concerned about their future health, (AOR: 0.3, 95%CI, 0.1, 0.7), less concerned about their partners responses to a chlamydia positive test (AOR: 0.3, 95%CI, 0.1, 0.7) and less concerned about how other people would perceive them (AOR:0.5, 95%CI 0.3, 0.8).

Differences between what women perceive they will experience can be different to what actually happens when women test positive for chlamydia. Such differences may impact on a women’s decision to screen for chlamydia.
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