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<th><strong>Australian Government Department of Health and Ageing</strong> – Major Supporter</th>
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<td><strong>GlaxoSmithKline</strong> (GSK) – Gold Sponsor</td>
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AUSTRALASIAN SEXUAL HEALTH CONFERENCE 2007
"VENUS & MARS AT JUPITERS"

Monday 8 – Wednesday 10 October 2007
CONRAD JUPITERS, GOLD COAST, QUEENSLAND, AUSTRALIA
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On behalf of the 2007 AChSHM Scientific Advisory & Organising Committee, welcome to the Gold Coast and this year’s Australasian Sexual Health Conference.

The theme of the conference is ‘Venus & Mars at Jupiters’. Some of the proposed presentations this year include HIV, STIs, HPV, Sex Therapy and Women’s Sexual Health Issues. The International and local speakers are experts in their fields and their presentations will both educate and entertain.

We are very grateful for the support of our sponsors and trade exhibitors. They make a vital contribution to the overall success of this Conference.

As always, we aim to create a conference at which delegates are informed and stimulated, but where they can also enjoy networking and socialising. The conference gala dinner will be held on Tuesday 9 October and promises a night of good food, entertainment and spectacle that will be ‘out of this world’.

The conference hotel is near the fabulous Gold Coast beaches and the Oasis Shopping Centre, which is only a two-minute monorail ride away.

Thank you for attending the 2007 Australasian Sexual Health Conference. We look forward to meeting you.

Dr Darren Russell  
Cairns Sexual Health Service  
2007 Conference Convenor

---

**Scientific Advisory & Organising Committee**

**Convenor: Darren Russell**  
Cairns Sexual Health Service

**Stuart Aitken**  
Gold Coast Sexual Health Clinic

**Natalie Edmiston**  
Royal Newcastle Hospital

**Christopher Fairley**  
Melbourne Sexual Health Centre

**Jane Howard**  
Lillian Cooper Centre

**Stephen Lambert**  
Queensland Sexual Health Society

**Suzanne Marks**  
Australasian Chapter of Sexual Health Medicine

**Maree O’Sullivan**  
Sexual Health Service Tasmania

**Diane Rowling**  
Brisbane Sexual Health & AIDS Service

**Kevin Sesnan**  
North Coast Area Health Service

**David Smith**  
North Coast Area Health Service

**Professional Conference Organisers**

Daliah Szwarc, Nadine Giatras  
Australasian Society for HIV Medicine, Sydney, Australia

Australasian Society for HIV Medicine  
LMB 5057, Darlinghurst NSW 1300  
Tel: 61 2 8204 0770  
Fax: 61 2 9212 4670  
Email: conferenceinfo@ashm.org.au  
Website: www.ashm.org.au
Before prescribing please review product information. Indications: Genital herpes (GH) treatment and prevention; GH transmission reduction in patients with recurrent genital herpes (safer sex practices also recommended). Herpes zoster (shingles; duration of rash 72 hours); ophthalmic zoster. Cytomegalovirus (CMV) prophylaxis, following solid organ transplantation. Contraindications: Hypersensitivity. Precautions: Dehydration; renal impairment; high doses in hepatic impairment, liver transplantation; pregnancy (CAT.B3); lactation; children; elderly; GH transmission risk is reduced but not eliminated. Adverse Events: Headache; GI disturbances; Uncommon/rare neurological reactions; for more details/other ADEs, see full PI. Interactions: No clinically significant interactions have been identified. Caution: Coadministration of high dose valaciclovir and other drugs excreted via tubular secretion (eg cimetidine, probenecid; mycophenolate mofetil) or drugs affecting other aspects of renal physiology (eg cyclosporin, tacrolimus). Dose: Genital Herpes — initial: 500mg BD for 5–10 days. Recurrent: 500mg BD for 5 days. Prevention of recurrent genital herpes: 500mg OD (immunocompetent <10 recurrences/year), 1000mg OD (immunocompetent >=10 recurrences/year), 500mg BD (immunocompromised). Reduction of transmission: 500mg OD (taken by infected, immunocompetent, heterosexual adult <10 recurrences/year; susceptible partner discordant for HSV-2). Herpes Zoster/Ophthalmic Zoster: 1000mg TDS for 7 days. CMV prophylaxis: 2g QID for 90 days adjusted for renal function. PBS dispensed price: Treatment or suppression; $154.33 - 30 x 500mg tablets + 5 repeats. Further information is available on request from the Medical Department GlaxoSmithKline Australia Pty Ltd on 1800 033 109. ABN 47 100 162 481. 1061 Mountain Highway, Boronia, Victoria 3155. ® Valtrex is a registered trade mark of the GlaxoSmithKline group of companies. PC0707172 GW7347/H&T

Diagnosing genital herpes can be confusing. Patients often self diagnose their symptoms as thrush, fungal infections or other STIs. So next time you see a patient with recurrent genital symptoms, it could be genital herpes which can be easily treated once the correct diagnosis has been made.

It’s not her treatment that’s failing – it’s her diagnosis
THE GOLLOW LECTURE
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 MORRIS M GOLLOW
AM, MRCS (Engl.), LRCP (Lond.), DepVen (Lond.), PPACSHP
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.
Now you can help protect women over 26 against cervical cancer*

*Cervarix is indicated in females aged 10 to 45 years for the prevention of cervical lesions and cervical cancer caused by HPV 16 & 18.

MINIMUM PI FOR CERVARIX. Human Papillomavirus Vaccine Types 16 and 18 (Recombinant, AS04 adjuvanted). Indications: CERVARIX is indicated in females from 10 to 45 years of age for the prevention of cervical cancer by protecting against incident and persistent infections, cytological abnormalities including atypical squamous cells of undetermined significance (ASC-US) and cervical intraepithelial neoplasia (CIN), CIN 1 and pre-cancerous lesions (CIN 2 and CIN 3) caused by human papillomaviruses (HPV) types 16 and 18. Immunogenicity studies have been conducted in females aged 10 to 14 years and 26 to 45 years to link efficacy in females aged 15 to 25 years to other populations. Contraindications: Hypersensitivity to any vaccine component. Precautions: Cervarix is not intended for the treatment of persistent infection or lesions present at the time of vaccination or to prevent the progression of established lesions. Cervarix may not prevent HPV infection and related clinical outcomes due to other oncogenic HPV types. Vaccination is not a substitute for regular cytological screening or for precautions against exposure to HPV and sexually transmitted diseases. Other Precautions: acute severe febrile illness; thrombocytopenia; bleeding disorders; impaired immune system; intradermal, intravascular or subcutaneous administration; pregnancy (Category B2); lactation. Interactions: Systemic immunosuppressive medications; use separate sites for concomitant administration of CERVARIX with other vaccines. Adverse Reactions (not a complete list): Injection site reactions such as pain, redness, swelling; fever (≥38°C), fatigue, headache, myalgia, gastrointestinal symptoms including nausea, vomiting, diarrhea and abdominal pain, itching/pruritis, rash, urticaria, arthralgia, upper respiratory infection, dizziness. Dosage and Administration: Shake well before use. The primary vaccination course consists of three doses (intramuscular injection in the deltoid region). The recommended vaccination schedule is 0, 1, 6 months. If flexibility in the vaccination schedule is necessary, the second dose can be administered between 1 month and 2.5 months after the first dose. The necessity for a booster dose has yet to be established. Storage: Cervarix must be stored between +2°C and +8°C. DO NOT FREEZE. PLEASE REVIEW CERVARIX PRODUCT INFORMATION BEFORE PRESCRIBING. Full Product Information is available from GlaxoSmithKline Ph: 1800 033 109. Reference: 1. Cervarix Product Information. GlaxoSmithKline Australia Pty Ltd. ABN 47 100 162 481 . 1061 Mountain Highway, Boronia, Victoria 3155. CERVARIX is a registered trade mark of the GlaxoSmithKline Group of Companies.

PBS information: This product is not listed on the PBS.
AUSTRALASIAN SEXUAL HEALTH CONFERENCE 2007
"VENUS & MARS AT JUPITERS"

Monday 8 – Wednesday 10 October 2007
CONRAD JUPITERS, GOLD COAST, QUEENSLAND, AUSTRALIA

PROGRAM AT A GLANCE
**MONDAY 8 OCTOBER 2007**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tr>
<td>8.30am - 9.30am</td>
<td>Registration opens</td>
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<tr>
<td>8.30am - 9.30am</td>
<td>Arrival Coffee/Tea &amp; Exhibition Opens</td>
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<tr>
<td>9.30am - 11.00am</td>
<td>Opening Ceremony and Gollow Lecture</td>
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<tr>
<td></td>
<td>Surfers Paradise Room 2 &amp; 3</td>
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<tr>
<td></td>
<td>Chairs: Darren Russell and Katherine Brown</td>
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<tr>
<td>9.35am - 9.55am</td>
<td>Welcome to the Conference</td>
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<td>9.55am - 10.05am</td>
<td>Katherine Brown - Chair of the Australasian Chapter of Sexual Health Medicine</td>
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<td>Introduction re: Gollow Lecture</td>
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<td>10.05am - 10.50am</td>
<td>Ron Jones - Professor of Obstetrics &amp; Gynaecology at the University of Auckland</td>
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<td>Gollow Lecture: Sex and Cancer</td>
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<td>10.50am - 11.00am</td>
<td>Questions and Discussion</td>
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<td>11.00am - 11.30am</td>
<td>Morning Tea &amp; Exhibition Viewing</td>
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<td>11.30am - 1.00pm</td>
<td>Symposium: Sexual Aversion</td>
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<td>Surfers Paradise Room 1</td>
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<td>Chairs: Jane Howard and Juliet Broadmore</td>
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<td>11.30am - 1.00pm</td>
<td>Symposium: HIV and Women</td>
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<td>Surfers Paradise Room 2 &amp; 3</td>
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<td>Chairs: Suzanne Garland and Maree O’Sullivan</td>
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<tr>
<td>1.00pm - 2.00pm</td>
<td>Lunch in Southport Room &amp; Exhibition Viewing</td>
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<td>2.00pm - 3.30pm</td>
<td>Chlamydia - Novel Strategies ‘Rocket Science’</td>
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<td>Chairs: Ron Ballard and Suzanne Garland</td>
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<td>2.00pm - 3.30pm</td>
<td>TechSex</td>
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<td>Surfers Paradise Room 2</td>
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<td>Chairs: Kit Fairley and Cheryl Palmer</td>
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<td>2.00pm - 3.30pm</td>
<td>Houston we have a Clinical Problem</td>
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<td>Surfers Paradise Room 3</td>
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<td>Chairs: Di Rowling and Catriona Ooi</td>
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<tr>
<td>3.30pm - 4.00pm</td>
<td>Afternoon Tea &amp; Exhibition Viewing</td>
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<td>4.00pm - 5.30pm</td>
<td>MSM ‘Mars’</td>
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<td>Surfers Paradise Room 1</td>
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<td>Chairs: Stuart Aitken and Ian Denham</td>
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<td>4.00pm - 5.30pm</td>
<td>Womens Health ‘Venus’</td>
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<td>Surfers Paradise Room 2</td>
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<td>Chairs: Janet Say and Henrietta Williams</td>
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<td>4.00pm - 5.30pm</td>
<td>HIV/Epidemiology ‘Mercury Rising’</td>
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<td>Surfers Paradise Room 3</td>
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<td>Chairs: David Lewis and Basil Donovan</td>
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<td>5.30pm - 7.00pm</td>
<td>Welcome Reception in Gold Coast Rooms sponsored by Novartis</td>
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<tr>
<td>7.00pm</td>
<td>AChSHM Trainee Dinner sponsored by GSK</td>
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## TUESDAY 9 OCTOBER 2007

### Registration

**Time:** 7.00am - 9.00am  
**Location:** Surfers Paradise Room 1  
**Chair:** Brian Hughes  
**Expert Panel:** Dr David Bradford, Dr Cheryl Palmer, and Dr Basil Donovan

### Trainee Update Breakfast Session sponsored by Sexual Health Society of Qld

**Time:** 7.00am - 9.00am  
**Location:** Surfers Paradise Room 1  
**Chair:** Brian Hughes  
**Panel:** Dr David Bradford, Dr Cheryl Palmer, and Dr Basil Donovan

### Arrival Coffee/Tea & Exhibition Viewing

**Time:** 8.00am - 9.00am

### Plenary: STIs in Developing Countries

**Time:** 9.00am - 10.30am  
**Location:** Surfers Paradise Room 2 & 3  
**Chairs:** Adrian Mindel and Andrew Grulich

### Morning Tea & Exhibition Viewing

**Time:** 10.30am - 11.00am

### Plenary: Older Women's Sexuality

**Time:** 11.00am - 12.30pm  
**Location:** Surfers Paradise Room 2 & 3  
**Chairs:** Jane Howard and Eleanor Freedman

### Lunch in Southport Room & Exhibition Viewing

**Time:** 12.30pm - 1.30pm

### Symposium: ‘Sticky Moments’

**Time:** 1.30pm - 3.00pm  
**Location:** Surfers Paradise Room 1  
**Chair:** Stuart Aitken

### Symposium: ‘New HIV Infections on the rise - why is it so and what can we do?’ sponsored by ASHM and ACHSHM

**Time:** 1.30pm - 3.00pm  
**Location:** Surfers Paradise Room 2 & 3  
**Chairs:** Levinia Crooks, Kit Fairley, and John Kaldor

### Afternoon Tea & Exhibition Viewing

**Time:** 3.00pm - 3.30pm

### Oral Poster Session ‘Meteorites’

**Time:** 3.30pm - 4.30pm  
**Location:** Pavilion Gallery  
**Chairs:** David Bradford and Virginia Furner

### Trainee Session ‘Comets’

**Time:** 3.30pm - 4.30pm  
**Location:** Surfers Paradise Room 2 & 3  
**Chair:** Katherine Brown

### ACHSHM General Meeting

**Time:** 4.30pm - 5.30pm  
**Location:** Surfers Paradise Room 1

### Out of this World’ Gala Dinner at the Gold Coast Arts Centre. Sponsored by GSK and supported by the Australian Government Department of Health and Ageing

**Time:** 7.00pm - 11.00pm
WEDNESDAY 10 OCTOBER 2007

7.30am - 9.00am  Registration

8.00am - 9.00am  Arrival Coffee/Tea & Exhibition Viewing

9.00am - 10.30am  HPV 'The Black Hole'
                   Surfers Paradise Room 1
                   Chairs: Ron Jones and Jenny McCloskey

9.00am - 10.30am  Chlamydia 'Asteroids'
                   Surfers Paradise Room 2
                   Chairs: Richard Hillman and Carolyn Shand

9.00am - 10.30am  Sexuality and Attitudes 'Sexuality Supernova'
                   Surfers Paradise Room 3
                   Chairs: Rick Franklin and Rosey Cummings

10.30am - 11.00am  Morning Tea & Exhibition Viewing

11.00am - 12.30pm  Plenary: Testing, Testing, Testing
                   Surfers Paradise Room 2 & 3
                   Chairs: Kit Fairley and Basil Donovan

12.30pm - 1.30pm  Lunch in Southport Room & Exhibition Viewing

12.30pm - 1.30pm  National Centre in HIV Epidemiology & Clinical Research and National HIV Social Research
                   Surfers Paradise Room 1

1.30pm  Exhibition and Poster Viewing Close

1.30pm - 3.00pm  Sexual Health Conference Plenary and Closing: Prevention
                   Surfers Paradise Room 2 & 3
                   Chair: Darren Russell and Jenny McCloskey

1.30pm - 2.00pm  Angela Williams - Victorian Institute of Forensic Medicine, Australia
                   Is Sexual Assault Preventable?

2.00pm - 2.35pm  Ron Jones - Professor of Obstetrics & Gynaecology at the University of Auckland
                   Preventing Cancer

2.35pm - 2.50pm  Basil Donovan - The Australian Collaboration in Chlamydia Enhanced Sentinel Surveillance (ACCESS) Project

2.45pm - 2.50pm  Prize Presentations and Closing Remarks by Katherine Brown - Chair of the Australasian
                   Chapter of Sexual Health Medicine

2.55pm - 3.00pm  Presentation of next years’ conference by Jenny McCloskey - Committee Convenor of
                   Australasian Sexual Health Conference 2008

3.00pm  Conference Close
BEFORE PRESCRIBING, PLEASE REVIEW FULL PRODUCT INFORMATION AVAILABLE BY CALLING MEDICAL ENQUIRIES ON 1800 067 567. MINIMUM PRODUCT INFORMATION. 

INDICATIONS: Reyataz is indicated for the treatment of HIV 1 infection, in combination with other antiretroviral agents. 

DOSEAGE: Adults – two 200 mg capsules (400 mg) once daily with food or alternative dosage – two 150 mg capsules (300 mg) with ritonavir 100 mg once daily with food. See Full PI for dosing recommendation in combination with specific antiretrovirals. 

CONTRAINDICATIONS: Hypersensitivity to atazanavir or any excipient; severe hepatic insufficiency; concomitant use of any medicine with a narrow therapeutic window that is a substrate of the CYP3A4 enzyme. 

PRECAUTIONS: Impaired hepatic function; pre-existing cardiac conduction system disease (first – third-degree AV block), haemophilia; fat redistribution and hyperglycaemia. Pregnancy – Category B2; use in lactation; use in children. 

INTERACTIONS: Complex – see Full PI. Atazanavir is an inhibitor of CYP3A4 and UGT1A1; co-administration of Reyataz and drugs primarily metabolised by these enzymes may result in increased plasma concentrations of the other drug. Atazanavir is also an inhibitor of P-gp and MDRI. 

ADVERSE REACTIONS: Nausea; hyperbilirubinaemia and jaundice; rash; lactic acidosis; headache; altered LFTs and bilirubin; others – see Full PI. 

PRESENTATION: 150 mg caps x 60s, 200 mg caps x 60s. 

AUSTRALASIAN SEXUAL HEALTH CONFERENCE 2007
“VENUS & MARS AT JUPITERS”

Monday 8 – Wednesday 10 October 2007
CONRAD JUPITERS, GOLD COAST, QUEENSLAND, AUSTRALIA

INVITED SPEAKERS
**INVITED SPEAKERS**

**RON BALLARD** *(SPONSORED BY QLD HEALTH)*

Ron Ballard is Head of the Laboratory Reference and Research Branch within the Division of Sexually Transmitted Disease Prevention at the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia, USA, where he has worked for the past five years. The Branch contains three WHO Reference Laboratories, comprising the Syphilis Serology, Gonococcal, and STD Diagnostics Initiative Reference Laboratories. Dr Ballard is also an Adjunct Professor in the Department of Pediatric Infectious Diseases at Emory University School of Medicine in Atlanta. Previously, he held the post of Head of the Reference Centre for STDs at the South African Institute for Medical Research and the University of the Witwatersrand in Johannesburg, where he was also a Professor in the Department of Medical Microbiology and Infectious Diseases. He was the founder, and previously president, of the STD Society of Southern Africa, Secretary-General of the International Union against Sexually Transmitted Infections (IUSTI) and a member of the Board of the International Society for STD Research (ISSTDR).

He is currently a member of the Board of the American STD Association. His main research interests include development and application of new diagnostic and typing tests for STDs, tropical STDs and conventional STD/HIV interactions.

**RON JONES**

Ron Jones has been a member of the consultant staff of the National Women's Hospital in Auckland for more than 30 years and Honorary Professor of Obstetrics and Gynaecology at the University of Auckland. He has published widely, particularly on the natural history of the precursor lesions of lower genital tract cancer. He co-authored the paper that ‘blew the whistle’ on the ‘unfortunate experiment’ into the natural history of carcinoma in-situ of the cervix in the hospital.

Professor Jones is Past President of the International Society for the Study of Vulvovaginal Disease and current Chairman of the Scientific Committee of the International Federation of Cervical Pathology and Colposcopy.

His contributions have been recognised with many prestigious lectures and awards including the Fairbairn Lecturer at the Royal College of Obstetricians and Gynaecologists of London, the Gold Medal of the Asia and Oceania Federation of Obstetrics and Gynaecology and the Annual Lecture of the Memorial Sloan-Kettering Society of Gynecologic Oncologists in New York.

**DAVID LEWIS**

David Lewis is Head of the Sexually Transmitted Infections Reference Centre at the National Institute of Communicable Diseases in Johannesburg, South Africa. He has worked in the field of STIs since 1989, training in both microbiology and clinical STIs/HIV in the United Kingdom. In 2000, he obtained his PhD for studies on the molecular pathogenesis of Haemophilus ducreyi infection (Wellcome Trust Fellowship).

Until his move to South Africa in 2004, he held the position of Consultant Physician in Genitourinary and HIV Medicine at Guy’s and St. Thomas’ Hospital NHS Trust in London. His research interests include STI surveillance, male sexual health, gonorrhoea, genital ulcer disease and outreach service delivery. Professor Lewis is the International Union Against Sexually Transmitted Infections’ Regional Director for Africa and participates as a member of WHO STI expert consultation groups. He is an Assistant Editor of *Sexually Transmitted Infections* and a Joint Editor of *Sexual Health*. 
LORRAINE DENNERSTEIN
Lorraine Dennerstein holds a Personal Chair at The University of Melbourne, Australia, where she is Foundation Director of the Office for Gender and Health and Professor in the Department of Psychiatry. Her contribution to women’s health was recognised by the award of the Order of Australia in 1994. She has been a consultant to the Commonwealth Secretariat (London), the World Health Organization, the Global Commission on Women’s Health (WHO) and UNESCO. For over 30 years she has researched the relationship of ovarian steroids to women’s sexual functioning. Studies included effects on women’s sexual functioning of: changes in endogenous hormones with menstrual cycle and menopause; hysterectomy and bilateral oophorectomy; oral contraceptive pill; and hormone therapy.

Publications include 24 books authored/edited and over 300 journal articles/chapters. She is a Past President of the International Society for the Study of Women’s Sexual Health and is currently Review Editor of the Journal of Sexual Medicine. In July 2005 she was awarded a Gold Medal for Lifetime Achievement in Sexuality Research by the World Association of Sexology.

SUZANNE GARLAND
Suzanne Garland established and developed the research infrastructure of the Department of Microbiology and Infectious Diseases. This facility has not only been involved in providing routine clinical diagnostic services with NATA accreditation, but also supports the clinical and basic science research programs of the Department. Professor Garland, with her team, has been a leader in the role of patient self-collected genital sampling in the detection by molecular techniques (polymerase chain reaction (PCR)) of reproductive tract infections, particularly those sexually transmitted, such as Chlamydia trachomatis, and has published extensively on clinical epidemiology of sexually transmissible infections in Australia.

She is the inaugural President of the newly formed society, Asian-Oceania Research Organization on Genital Infection and Neoplasia (AOGIN), which brings together clinicians and scientists within the Asian and Oceania regions and whose work is related to genital infections and neoplasia. AOGIN’s aims are to promote and develop, at an Asia-Oceania level, research, training, screening, prevention and information concerning genital infections, pre-cancers and cancers in women. This organisation brings together representatives from the Asia-Oceania region, of a multidisciplinary specialist areas including: gynaecologists, sexual health physicians, dermatologists, pathologists, molecular biologists, oncologists and basic scientists.
RUTH SAPSFORD
Ruth Sapsford is a physiotherapist who has worked in the area of pelvic floor function and dysfunction for more than 25 years. She is a clinician; lectures to undergraduate and postgraduate physiotherapists both in Australia and overseas; has spoken on the topic to GPs, gynaecologists and members of the public; has completed a number of research projects and is co-editor of and contributor to Women’s Health, a text book for physiotherapists. Her doctoral research focuses on the synergy of the abdominal and pelvic floor muscles.

SEPEHR TABRIZI
Sepehr Tabrizi is a senior scientist in charge of the Molecular Microbiology Laboratory of the Royal Women’s Hospital and Associate Professor at Department of Obstetrics and Gynaecology, University of Melbourne. He has been involved with developing diagnostic and molecular methods and its application to infectious diseases and discovery of disease aetiology with a focus on sexually transmitted infections. He currently leads a surveillance of Chlamydia trachomatis genotype project in men who have sex with men.

PATRICIA WEERAKOON
Patricia Weerakoon is the academic coordinator of the new Graduate Program in Sexual Health. Her primary research interest is in the area of sexuality and sexual health. She is the recipient of many teaching development grants for human sexuality and has presented papers on the topic of sexuality at national and international conferences.

Patricia facilitates a “Sexuality Research Group” of students, staff and external researchers in the Faculty of Health Sciences University of Sydney. The aim of this group is to provide a forum for the nurturing of research student’s ideas and progress as well as the discussion of new and innovative research in sexuality and sexual health. Dr Weerakoon has recently extended her research to the study of student learning in a flexible on-line environment, especially in the area of sexuality education, in which she also coordinates a highly popular on-line faculty elective “Sexuality for Health Professionals”. Dr Weerakoon is a member of the International Academy of Sex Research and the Australian Society of Sexuality Educators, Researchers and Therapists.

ANGELA WILLIAMS
Angela Williams is a Senior Forensic Physician at the Victorian Institute of Forensic Medicine and Senior Lecturer in the Department of Forensic Medicine at Monash University. Her other current appointments include Fellow of the Australian College of Legal Medicine and President of the Forensic and Medical Sexual Assault Clinicians Australia and a member of the Victorian Statewide Steering Committee to Reduce Sexual Assault. Other positions currently held include that of Consultant to the Child Protection Unit of the Victorian Forensic Paediatric Medical Service, Project Manager for the Victorian Forensic Nursing Initiative – Department of Justice and Coordinator of Postgraduate Forensic Medical Unit – Adult Sexual Assault. She is the Course Coordinator of the Graduate Certificate in Nursing (Forensics).
The Sexual Health Society of Queensland (SHSQ) is a membership based organisation that provides quality educational opportunities for its members and encourages open strong debate on issues that affect Sexual Health in Queensland. Benefits to members include opportunity to attend clinical meetings; subscription to the journal ‘Sexual Health’; possible sponsorship to attend the SHSQ AGM and national sexual health and related conferences; as well as opportunity to engage and develop debate on issues in sexual health.

Contacts:
A: Sexual Health Society Of Queensland Inc
   PO Box 44
   MIAMI QLD 4220
P: 07 5576 9033
F: 07 5576 9030
E: s.lambert@uq.edu.au (secretary)

The Sexual Health Society of Queensland is proud to be a bronze sponsor of the 2007 Australasian Sexual Health Conference and of the Trainee Breakfast Session.

2007 – 2008 Committee Members:
President: Dr Kay Haig
Vice President: Dr Diane Rowling
Treasurer: Ms Brenda Henry
Secretary: Mr Steve Lambert
Ordinary Members:
Ms Katie Barker
Ms Dene Campbell
Ms Judith Dean
Dr Stuart Aitken
AUSTRALASIAN SEXUAL HEALTH CONFERENCE 2007
"VENUS & MARS AT JUPITERS"
Monday 8 – Wednesday 10 October 2007
CONRAD JUPITERS, GOLD COAST, QUEENSLAND, AUSTRALIA

GENERAL INFORMATION
GENERAL INFORMATION

DISCLAIMER
All information disclosed in the Conference Program is correct at the time of printing. The Conference Secretariat reserves the right to alter the Conference Program in the event of unforeseen circumstances. All speakers were invited to contribute abstracts for inclusion in the Conference Handbook. Unfortunately not all speakers were able to provide us with their abstracts at the time of printing. The Conference Secretariat accepts no responsibility for errors, misprints or other issues with abstracts contained in this handbook.

INTERNET CAFÉ
An Internet café is available in the CSL Biotherapies booth number 19, in the Gold Coast Rooms (Exhibition area) of Conrad Jupiters Hotel.

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 whilst 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.

POSTER DISPLAY
Posters will be displayed for the duration of the Conference in the Gallery Foyer near the Exhibition area. Posters will be available for viewing on Monday 8 October from 11.00am until Wednesday 10 October at 1.30pm. Poster boards will be numbered as indicated in the Poster Program section of this handbook. Delegates are encouraged to visit all the poster displays during coffee and lunch breaks and the Conference Reception.

REGISTRATION DESK
All inquiries should be directed to the Registration Desk in the Gallery Foyer, open at the following times:
Monday 8 October: 8.30am – 6.30pm
Tuesday 9 October: 7.00am – 5.30pm
Wednesday 10 October: 7.30am – 3.30pm

SMOKING
This conference has a no smoking policy.

SPEAKER PREPARATION ROOM
A speaker preparation room will be located in Broadbeach 1 Room.
This room will be open at the following times:
Monday 8 October: 7.30am – 5.30pm
Tuesday 9 October: 7.15am – 5.30pm
Wednesday 10 October: 7.30am – 1.30pm

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.
GENERAL INFORMATION

TRADE EXHIBITION
An exhibition will be held in the Gold Coast Rooms of Conrad Jupiters Hotel. The exhibition will open on Monday 8 October 2007 at 8.30am and conclude on Wednesday 10 October 2007 at 1.30pm.

The exhibition will be open during the following times:
Monday 8 October: 8.30am – 7.00pm
Tuesday 9 October: 8.30am – 5.30pm
Wednesday 10 October: 8.30am – 1.30pm
(closes after lunch)

VENUE
Conrad Jupiters Hotel will host the plenary and concurrent sessions in the Surfers Paradise Rooms, accessible via the main venue entrance.

Conrad Jupiters Hotel
Broadbeach Island
(off the Gold Coast Hwy)
Broadbeach QLD 4218

A seated buffet lunch will be held in the Southport Rooms each day.

CME POINTS
Fellows of the Chapter of Sexual Health Medicine receive 0.5 CME Points per hour to a maximum of 20 points. GPs receive 2 CME Points per hour to a maximum of 15 points. Sign-in sheets for RACGP will be available at the conference and must be signed by GPs. Certificates of attendance will be provided after the conference.
ASSOCIATED EVENTS

WELCOME RECEPTION SPONSORED BY NOVARTIS
5.30pm, Monday 8 October 2007 –
Conrad Jupiters Hotel

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 friends and make new friends,
while enjoying drinks and canapés.

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 UPDATE BREAKFAST SESSION
SPONSORED BY SEXUAL HEALTH SOCIETY
OF QUEENSLAND
7.00am, Tuesday 9 October 2007 –
Conrad Jupiters Hotel

Special presentations will take place at this early-
morning session. These presentations are based on
the areas of sexual health medicine in which trainees
have indicated they would like to receive updates.
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.

Ticket cost: A$22.00 for all registrants except trainees
and students

CONFFERENCE GALA DINNER SPONSORED
BY GSK AND SUPPORTED BY AUSTRALIAN
GOVERNMENT DEPARTMENT OF HEALTH
AND AGEING

7.00pm, Tuesday 9 October 2007 –
The Gold Coast Arts Centre
135 Bundall Road, Surfers Paradise

The Gold Coast Art Centre sits on the banks of
the Nerang River and is only 10 minutes from the
conference venue. Transport is provided to and
from the dinner.
Please meet in the foyer of Conrad Jupiters Hotel at
6.30pm.

The theme for this year’s dinner is ‘join us in space’
and the venue will be ‘out of this world’. Delegates
are welcome to attend in costume and be part of the
space adventure.

Please call the Gold Coast Art Centre Costume Hire
department on 61 7 5588 4021 to hire a costume or
just to be inspired.

One ticket to the Gala Dinner is included with every
registration except day registrations and guests.

TICKETS TO ASSOCIATED EVENTS

Tickets will be required for entry into all associated
events. All tickets will be given out on registration, or
inserted in the delegate’s name badge.

If you would like to purchase tickets to the Trainee
Update Breakfast Session you may do so at the
Registration Desk until 12:30pm on Monday 8
October.

If you have a ticket to the Gala Dinner but do
not wish to attend, please advise staff at the
Registration Desk by 12:30pm on Monday 8
October.

No cancellations of function tickets are allowed.
The following awards will be presented during the closing session of the conference on Wednesday 10 October.

- **THE JAN EDWARDS PRIZE, SPONSORED BY NOVARTIS**
  For the best proffered paper presented orally by a trainee of the Australasian Chapter of Sexual Health Medicine.
  Value: A$500.00

- **THE SEXUAL HEALTH SOCIETY OF VICTORIA PRIZES**
  One for the best poster presentation on clinical/epidemiological research, the other for the best poster presentation on social/behavioural research.
  Two prizes of A$250.00 each

- **THE SEXUAL HEALTH PRIZE**
  For the best written abstract.
  The author will be awarded a full print and online subscription to the journal.
  Value: A$120.00

The following Chapter Awards will be presented this year in the Gold Coast.

- **SEXUAL HEALTH MEDICINE AWARD FOR COMMITMENT TO EDUCATION AND TRAINING IN SEXUAL HEALTH (OPEN CATEGORY)**
  To be awarded to a Fellow or Trainee of the Chapter nominated by their peers for:
  Outstanding commitment to education and training in sexual health medicine as demonstrated by the development of a tertiary education program, a Continuing Professional Development program or a publication such as a textbook or set of clinical guidelines pertaining to any aspect of sexual health. The contribution must have appeared as a published work in the two-year period preceding the award.

- **OUTSTANDING CONTRIBUTION TO RESEARCH IN SEXUAL HEALTH MEDICINE AWARD (OPEN CATEGORY)**
  To be awarded to a Fellow or Trainee of the Chapter nominated by their peers for:
  - Research, with emphasis on building of research teams and mentorship, particularly of Fellows
  - Profile and standing, at the national and international level
  - Quality and output of the publications, overall and in the last five years
  - Contributions to the discipline, including peer review activities and involvement in professional societies and the community
Patients Prefer to be Treated in the Privacy of their Own Home

Many patients with external genital warts respond extremely well to home therapies preferring the comfort and dignity of home treatment. In contrast with the situation only a few years ago, home therapies have taken over as the mainstay of treatment.1

PBS Information: Authority required for superficial basal cell carcinoma. Refer to PBS Schedule for full information. This product is not listed on the PBS for solar keratosis or external genital warts. For RPBS Information, refer to PBS Schedule.

Before prescribing, please review full product information. Further information is available on request from Inova Pharmaceuticals: toll free: 1800 ALDARA or 1800 253272. ALDARA™ (imiquimod 5% cream). Indications: Aldara 5% cream is indicated for treatment of solar (actinic) keratosis (SK) on the face and scalp; primary treatment of confirmed superficial basal cell carcinoma where surgery is considered inappropriate; and treatment of external genital and perianal warts/condyloma acuminata in adults. (See Precautions). Dosage: Solar (Actinic) Keratosis – apply cream to a treatment area no larger than 25cm² once daily 3 times per week for up to 16 weeks. The treatment period should not be extended beyond 16 weeks due to missed doses or rest periods. Superficial Basal Cell Carcinoma – apply cream once daily for 5 consecutive days per week for 6 weeks. External Genital/Perianal Warts – apply cream once daily 3 times per week until total clearance or for a maximum of 16 weeks. Contraindications: Hypersensitivity. Precautions: Should severe local skin reactions occur, wash off cream from treatment area. After reaction has subsided, treatment can be resumed. May exacerbate inflammatory conditions of the skin. Not recommended until tissue is healed from any previous therapy or procedure. Solar (Actinic) Keratosis – avoid or minimise exposure to natural or artificial sunlight. Avoid contact with eyes, lips and nostrils. During treatment, sub-clinical SK lesions may become apparent in the treatment area and may subsequently resolve. Aldara cream should not be used on hands and arms. Safety and efficacy on re-treatment of residual SK’s has not been established. There are limited data of Aldara cream on recurrence of SK. Aldara should not be used in an area >25cm² due to potential to cause local skin reactions. Superficial Basal Cell Carcinoma - The diagnosis of superficial BCC should be confirmed by biopsy or specialist opinion before starting treatment and the patient should be carefully followed up after treatment to ensure that the tumour has been eradicated. Not evaluated for treatment of sBCC within 1cm of hairline, eyes, nose, mouth or ears. Avoid or minimise exposure to sunlight (incl. sunlamps). Genital/Perianal Warts - not indicated for urethral, intra-vaginal, cervical, rectal or intra-anal warts. Efficacy may be reduced in patients with HIV. Uncircumcised males treating warts under the foreskin should retract the foreskin and clean the area daily. Special care should be taken if applying at the opening of the vagina, as local skin reactions can result in pain or swelling and may cause difficulty in passing urine. Pregnancy: (Category B1) Not recommended for use during pregnancy. Lactation: Not recommended for use during lactation. Children: Safety and efficacy not established below 18 years. Adverse Reactions: Local skin reactions are common (erythema, scabbing/crusting, erosion/ulceration, flaking/scaling/dryness, oedema, weeping/exudate, vesicles, itching, burning, tenderness, pain) plus headache and influenza-like symptoms. Hypo- and hyperpigmentation may occur; some changes may be permanent. The PBS and RPBS dispensed price for one box of 12 single use sachets is $158.68. The PBS and RPBS supply quantity of 12 single use sachets and one repeat allows for treatment rest periods – refer to Dosage and Administration in the Product Information for further details. Reference: 1. O’Mahony, C. Genital Warts: Current and future management options. Am J Clin Dermatol 2005;6(4):239-243. iNova Pharmaceuticals (Aust) Pty. Ltd. A.B.N. 88 000 222 408. 9-15 Chivers Road, Thornleigh NSW 2120. www.inovapharma.com © 2007 iNova Pharmaceuticals (Aust) Pty. Ltd. URSA 009338
AUSTRALASIAN SEXUAL HEALTH CONFERENCE 2007
"VENUS & MARS AT JUPITERS"

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CONRAD JUPITERS, GOLD COAST, QUEENSLAND, AUSTRALIA

EXHIBITION
BOOTH LISTING
### EXHIBITION BOOTH LISTING

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AUSTRALASIAN SEXUAL HEALTH CONFERENCE 2007
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EXHIBITOR DIRECTORY
Sexual health medicine is the specialised area of medical practice concerned with healthy sexual relations, including freedom from sexually transmitted infections, unplanned pregnancy, coercion and physical or psychological discomfort associated with sexuality. Its practice encompasses the individual, population, social, interpersonal, microbial and immunological factors that contribute to Sexually Transmissible Infections (STIs), sexual assault, sexual dysfunction and fertility regulation.

Sexual health medicine is concerned with the promotion of the sexual health of the community by identifying and minimising the impact of the above problems through education, behaviour change, advocacy, targeted medical and laboratory screening, clinical service provision, surveillance and research.

Sexual health medicine is a well-established field of medicine with equivalents in the United Kingdom and Europe. In Australia there are two well-established academic chairs of sexual health medicine (Melbourne and Sydney) actively involved in both teaching and research. There are several international journals devoted to sexual health medicine including the Australian journal 'Sexual Health'. All State and Territory health departments recognise and employ specialists in sexual health medicine.

For more information on becoming a specialist in sexual health medicine go to the Chapter’s website www.racp.edu.au or please contact the Chapter direct on:

Contact:
Australasian Chapter of Sexual Health Medicine
145 Macquarie Street
SYDNEY NSW 2000
Australia
Phone: 61 2 9256 9643
Fax: 61 2 9256 9693
Email: sexualhealthmed@racp.edu.au
Web: www.racp.edu.au

The Australasian Society for HIV Medicine (ASHM) is the peak representative professional body for medical practitioners and other health care workers in Australasia who work in HIV and related disease areas.

It was formed in 1988 (as the Australian Society of AIDS Physicians), changed its name in 1989 to reflect a broader membership base and was incorporated in New South Wales in 1990. It became a registered charity in 2003.

ASHM is a key partner in the Australasian and regional response to HIV, hepatitis and related diseases. It works closely with government, advisory bodies, community agencies and other professional organisations. It conducts broad education programs in HIV and viral hepatitis for medical practitioners, health care providers and allied health workers and manages programs of continuing medical education. The ASHM International Program focuses on collaborations and partnerships to provide training and support for professional health care workers in regional countries, including Papua New Guinea, the Pacific, Timor Leste and Indonesia.

ASHM is governed by an elected voluntary board and managed by a secretariat. It receives support from the Australian Government’s Department of Health & Ageing, the Australian Government’s Agency for International Development (AusAID), State and Territory Departments of Health and the private sector, and has established the ASHM Foundation to raise funds to support educational activities. ASHM convenes committees on a range of issues affecting its members including education, HIV treatment, viral hepatitis, international/development issues and professional affairs. ASHM conducts an annual medical scientific conference, and the Conference Division provides professional conference organisation to third parties in the sector.

Contact:
Australasian Society for HIV Medicine (ASHM)
LMB 5057
DARLINGHURST NSW 1300
Australia
Phone: 61 2 8204 0700
Fax: 61 2 9212 2382
Email: ashm@ashm.org.au
Web: www.ashm.org.au
AUSTRALIAN HERPES MANAGEMENT FORUM
(BOOTH 6)
The Australian Herpes Management Forum (AHMF) is an independent organisation developed in 1996 to bring together clinicians, specialists, researchers and health care professionals in a unique, multidisciplinary environment with the primary objective of providing clinicians and consumers with the most up to date information based on current evidence for the management and treatment of herpes virus infections within Australia.

BOEHRINGER INGELHEIM
(BOOTH 7)
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 1,000,000 mother-child pairs through 162 programmes in 59 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
Phone: 61 2 8875 8833
Fax: 61 2 8875 8712

BRISTOL MYERS SQUIBB
(BOOTH 4)
Bristol-Myers Squibb is a global pharmaceutical and related health care products company with a mission to extend and enhance human life.

Operating in Australia since 1930, Bristol-Myers Squibb is dedicated to discovering and developing innovative medicines that address significant medical needs in key disease areas.

Bristol-Myers Squibb's effort to address the global HIV/AIDS pandemic is best demonstrated through its focus on leadership in science, its enduring commitment to expand access to treatment and care for HIV/AIDS patients, and philanthropic initiatives such as Secure the Future.

CARADATA
(BOOTH 8)
CaraData is a successful Queensland based technology company that specialises in the development of health informatics software for use in the management and surveillance of sexual health, communicable diseases, HIV/AIDS, Hepatitis C and Family Planning clinics. CaraData’s core product SHIP (Sexual Health Information Program) is installed in more than 65 clinics throughout the world including Malaysia, New Zealand, Barbados, Ireland and six states in Australia – Queensland, New South Wales, Australian Capital Territory, Tasmania, Northern Territory and Western Australia. CaraData has recently completed a web based version, SHIPweb as part of the Australian Federal and State Government’s push for better and real time access to patient data and disease surveillance.

Contact:
Administration and Support Manager
CaraData
11 Evergreen Court
Parkwood QLD 4214
Phone: 61 7 5594 9328
Fax: 61 7 5571 5376
Web: www.caradata.com
CSL BIOOTHERAPIES
(BOOTH 19)
CSL Limited is a global, specialty biopharmaceutical company that develops, manufactures and markets products to treat and prevent serious human medical conditions. The CSL Group has a combined heritage of outstanding contributions to medicine and human health with more than 90 years experience in the development and manufacture of vaccines and plasma protein biotherapies. Our strong commitment to funding research and development of protein based biological medicines for unmet medical needs underpins our continuing growth.
Headquartered in Melbourne Australia, the CSL Group includes CSL Bioplasma, CSL Biotherapies and CSL Behring incorporating ZLB Plasma. With major facilities in Australia, Germany, Switzerland and the U.S., CSL has over 8500 employees operating in 27 countries.

GILEAD
(BOOTH 10)
Gilead's mission is to advance patient care by developing ground-breaking therapeutics to treat life-threatening infectious diseases. We apply the best of biopharmaceutical science to create innovative medicines that bring new hope in the battles against HIV/AIDS (Truvada, Emtriva, Viread), chronic hepatitis B (Hepsera), serious bacterial and systemic fungal infections (AmBisome).

Contact:
Level 1, 128 Jolimont Road, East Melbourne
Victoria, 3002, Australia
Phone: 61 3 9272 4400
Fax: 61 3 9272 4411

GLAXO SMITH KLINE
(BOOTH 11,12,13, 14)
GlaxoSmithKline (GSK) Australia is one of Australia's largest pharmaceutical and healthcare companies and is committed to improving the quality of human life by enabling people to do more, feel better and live longer.

GSK is Australia's largest supplier of vaccines and a leading supplier of medicines for asthma, bacterial and viral infections, depression, migraine, gastroenterological disease, epilepsy, smoking cessation and pain relief.

More than 16 million Australians rely on at least one of GSK's medicines, vaccines or consumer healthcare products.

INOVA PHARMACEUTICALS
(BOOTH 9)
The ultimate goal of iNova Pharmaceuticals is to develop new technological platforms to improve the health of patients and help solve treatment challenges facing health care professionals today. iNova Pharmaceuticals are innovative developers and manufacturers of prescription medicines relating to women's health in the area of skin cancer, anti-obesity and sexual health. Recent focus has been given to Aldara™ Cream (5% imiquimod), the world's first immune response modifier for its expanded approved uses in various dermatological conditions.

Through partnering with health care professionals, iNova Pharmaceuticals is committed to delivering solutions that enhance patients' quality of life.
EXHIBITOR DIRECTORY

MIDMED
(BOOTH 1)

Midmed Pty Ltd, one of Australia’s market leaders in the Health Equipment Industry has a proven record in the supply and maintenance of the world’s best examination furniture and medical equipment.

The range of examination tables and couches has been established to provide the busy medical practitioner and clinics with the easiest methods of use, ease of cleaning, 5 year warranties plus ensure patient safety, comfort and peace of mind.

Midmed offers finance packages, a rental option and a total cost service plan.

Midmed is based on one belief – COMMITMENT TO THE CUSTOMER.

Contact:
Unit 2, Nautilus Business Park
210 Queensport Rd
Murarrie QLD 4172
PO Box 113
Pinkenba QLD 4008
Phone: 61 7 3348 9155
Fax: 61 7 3348 9950
Email: sales@midmed.com.au
Web: www.midmed.com.au

NOVARTIS
(BOOTH 17, 18)

Novartis is a world leader in the research, development and supply of products to protect and improve health and wellbeing.

Novartis Pharmaceuticals researches and supplies a broad range of innovative and effective prescription medicines to treat patients in both general and specialist practice and hospitals.

Created in 1996 from the merger of Swiss companies Ciba and Sandoz, Novartis has a history in Australia going back over fifty years. Novartis employs about 80 000 people and operates in over 140 countries around the world.

In Australia the company now employs more than 500 people, and invests over A$27million annually in local research. This research not only assures the effectiveness of the company’s current range of treatment, but also secures the promise of improving health for the future.

Novartis medicines treat some of the most serious health conditions confronting healthcare professionals and their patients. The company’s work is spread across many disease areas including Primary Care, Oncology, Transplantation and Ophthalmics.

Contact:
Marcelle Hammond
Marketing Coordinator, General Medicines
Novartis Pharmaceuticals Australia
54 Waterloo Road, North Ryde NSW 2113
Phone: 61 2 9805 3606
Fax: 61 2 9888 9374
SEXUAL HEALTH SOCIETY OF QUEENSLAND (BOOTH 2)
The Sexual Health Society of Queensland (SHSQ) is a membership based organisation that provides quality educational opportunities for its members and encourages open strong debate on issues that affect Sexual Health in Queensland. Benefits to members include opportunity to attend clinical meetings; subscription to the journal Sexual Health; possible sponsorship to attend the SHSQ AGM and national sexual health and related conferences; as well as opportunity to engage and develop debate on issues in sexual health.

Contact:
PO Box 44
Miami, QLD 4220
Email: s.lambert@uq.edu.au
Website: www.som.uq.edu.au/hivandhcvprojects/shsq.htm

UNIVERSITY OF QUEENSLAND (BOOTH 3)
The HIV & HCV Education Projects are based within the School of Medicine, The University of Queensland and have been operating since the beginning of 1998. They are recognised at a state level, nationally and internationally as centres of expertise in clinical education, facilitation, monitoring & evaluation and resourcing.

Originally, the primary responsibility of the project was to design, develop, implement and evaluate courses for medical practitioners who wished to prescribe HIV antiretroviral therapies in Queensland, Australia. This remains a core component of the organisation.

By 2003 the HIV & HCV Education Projects were providing clinical education, facilitation, monitoring & evaluation and resourcing in its three core domains of HIV, Sexual Health and Viral Hepatitis across a range of health disciplines including medical practitioners, nurses, dentists, allied health and community health workers. By 2007 this expanded to include other domains.

The HIV & HCV Education Projects also offer customised education activities on topics of choice and for particular target audiences, as well as established education activities in the three core domains of HIV, Sexual Health and Viral Hepatitis on a state, national and international level.

Contact:
School of Medicine-The University of Queensland
288 Herston Rd
HERSTON QLD 4006
Australia
Phone: 61 7 3346 4813
Fax: 61 7 3346 4757
Email: hivandhcvprojects@uq.edu.au
Less outbreaks*
<table>
<thead>
<tr>
<th>Time</th>
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<tr>
<td>8.30am - 9.30am</td>
<td>Registration opens</td>
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<tr>
<td>9.30am</td>
<td>Arrival Coffee/Tea &amp; Exhibition Opens</td>
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<tr>
<td>9.30am - 11.00am</td>
<td>Opening Ceremony and Gollow Lecture</td>
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<tr>
<td>9.30am - 9.35am</td>
<td>Surfers Paradise Room 2 &amp; 3</td>
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<tr>
<td>9.35am - 9.45am</td>
<td>Welcome by Katherine Brown - Chair of the Australasian Chapter of Sexual Health Medicine</td>
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<tr>
<td>9.45am - 9.50am</td>
<td>Welcome by Katherine Brown - Chair of the Australasian Chapter of Sexual Health Medicine</td>
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<td>9.50am - 9.55am</td>
<td>Opening address by Di Reilly MP, Member for Mudgeeraba</td>
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<tr>
<td>9.55am - 10.05am</td>
<td>Katherine Brown - Chair of the Australasian Chapter of Sexual Health Medicine</td>
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<td>10.05am - 10.50am</td>
<td>Ron Jones - Professor of Obstetrics &amp; Gynaecology at the University of Auckland</td>
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<tr>
<td>10.50am - 11.00am</td>
<td>Questions and Discussion</td>
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<tr>
<td>11.00am - 11.30am</td>
<td>Morning Tea &amp; Exhibition Viewing</td>
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<tr>
<td>11.30am - 12.00pm</td>
<td>Symposium: Sexual Aversion</td>
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<td>11.30am - 11.50am</td>
<td>Surfers Paradise Room 1</td>
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<td>11.50am - 12.00pm</td>
<td>Vaginismus, Vulvodynia and Pelvic Floor Muscle Activity</td>
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<td>12.00pm - 12.30pm</td>
<td>Lorraine Dennerstein - University of Melbourne, Australia</td>
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<td>Patricia Weerakoon - Senior Lecturer, Academic Coordinator of the Graduate Program in Sexual Health, University of Sydney, Australia</td>
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<td>11.30am - 12.00pm</td>
<td>Symposium: HIV and Women</td>
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<td>Virginia Furner - Albion Street Centre, Sydney, Australia</td>
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**Symposium: HIV and Women**

- **Surfers Paradise Room 2 & 3**
  - **Chairs:** Suzanne Garland and Maree O'Sullivan
  - **Speakers:**
    - **David Lewis:** National Institute of Communicable Diseases, South Africa
    - **Maree O'Sullivan:** African Experience
    - **Jayne Russell:** La Trobe University (ARCSHS)
    - **Virginia Furner:** Albion Street Centre, Sydney, Australia

**Symposium: Sexual Aversion**

- **Surfers Paradise Room 1**
  - **Chairs:** Jane Howard and Juliet Broadmore
  - **Speakers:**
    - **Ruth Sapsford:** Mater Public Hospital, Australia
    - **Lorraine Dennerstein:** University of Melbourne, Australia
    - **Patricia Weerakoon:** Senior Lecturer, Academic Coordinator of the Graduate Program in Sexual Health, University of Sydney, Australia
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<td>2.00pm -</td>
<td>Chlamydia - Novel Strategies 'Rocket Science'</td>
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<td>Chair: Ron Ballard and Suzanne Garland</td>
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<td>Garton - The Chlamydia Project; Improving Knowledge Of, And Testing</td>
<td>Surfers Paradise Room 2</td>
<td>Chair: Kit Fairley and Cheryl Palmer</td>
<td>Intimate Relationships</td>
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<td>Davis and Schmidt - 'Stamp Out Chlamydia' Project Bringing Chlamydia</td>
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<td>Chair: Di Rowling and Catriona Ooi</td>
<td>Spokes - Infectious Syphilis Elimination For Aboriginal People In NSW:</td>
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<td>2.45pm</td>
<td>Bialasiewicz - Development And Validation Of A Novel Gel-Based Urine</td>
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<td>Challenges And Opportunities</td>
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<td>Buhre Skinner - The Check Is In The Mail: A Novel Approach To Chlamydia</td>
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<td>Powell - Sexual Health Services &amp; HIV Prevention: Improving Intervention</td>
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<td>Kong - Sex And Sport: A Community Based Project Of Chlamydia Testing And</td>
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<td>Kang - Young People Get Clued Up About Chlamydia: An Internet Based</td>
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<td>Emerson - Gonorrhoea Infection In Sydney Women</td>
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<td>Sawsthewarkar - Is Helicobater Pylori A STI? - A Pilot Study</td>
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<td>MSM 'Mars'</td>
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<td>Chair: Stuart Aitken and Ian Denham</td>
<td>Barrington - Impact Of Triage On Patient Presentations At A Large Publicly</td>
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<td>Womens Health 'Venus'</td>
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<td>Chair: Janet Say and Henrietta Williams</td>
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<td>Jin - Anal Sexually Transmissible Infections As Risk Factors For HIV</td>
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<td>Hayes - More Than Just Anal Sex: The Potential For STI Transmission Among</td>
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<td>Men Visiting Sex On Premises Venues In Melbourne</td>
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<td>Partners Explain The Diverging Trends In Hiv Epidemic In Australia?</td>
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<td>Hillman - What Do Anal Cytology Results Mean?</td>
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<td>Harvey - Out Of The Spotlight :An Audit Of Five Years Of Implanon® Use In</td>
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<td>Prestage - Testing For Sexually Transmissible Infections Among Gay Men</td>
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<td>Natalie Edmiston - Registrar, Newcastle Sexual Health Clinic</td>
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<td>Penelope Lowe - Registrar, Parramatta Sexual Health Service, Sydney NSW</td>
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Symposium: 'Sticky Moments'

Surfers Paradise Room 1
Chair: Stuart Aitken

Symposium: 'New HIV Infections on the rise - why is it so and what can we do?'

Surfers Paradise Room 2 & 3
Chair: Levinia Crooks, Kit Fairley and John Kaldor
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<td>1.30pm -</td>
<td>Rebecca Gay - Australian HIV Data, Focusing on Differences Between States and STD Data</td>
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<td>Jeffrey Grigson - Changes In Sexual Practices Among MSM</td>
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<td>John Imrie - Changes In Sexual Practices Among MSM</td>
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<td>Garrett Prestage - Mapping MSM Populations - HIV Prevalence</td>
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<td>Matthew Law - HIV Treatment Differences/Estimates of HIV Incidence</td>
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<td>Presentation: 'Case Study: A Survivor of Sexual Assault'</td>
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<td>Presentation: 'Challenges faced by survivors of sexual assault'</td>
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<td>Presentation: 'Measuring the impact of sexual assault on health outcomes'</td>
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<td>Presentation: 'Supporting survivors: resources and support services'</td>
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<td>Presentation: 'Supporting survivors: the role of health care providers'</td>
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<tr>
<td>7.30am -</td>
<td>Registration</td>
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<tr>
<td>9.00am -</td>
<td>Arrival Coffee/Tea &amp; Exhibition Viewing</td>
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<tr>
<td>9.00am -</td>
<td>HPV 'The Black Hole'</td>
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<tr>
<td>10.30am -</td>
<td>Surfers Paradise Room 1 Chairs: Ron Jones and Jenny McCloskey</td>
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<tr>
<td>9.00am -</td>
<td>Chlamydia 'Asteroids'</td>
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<tr>
<td>10.30am -</td>
<td>Surfers Paradise Room 2 Chairs: Richard Hillman and Carolyn Shand</td>
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<tr>
<td>9.00am -</td>
<td>Sexuality and Attitudes 'Sexuality Supernova'</td>
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<tr>
<td>10.30am -</td>
<td>Surfers Paradise Room 3 Chairs: Rick Franklin and Rosey Cummings</td>
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<tr>
<td>9.00am -</td>
<td>Morrow - Patterns Of Treatment And Resource Utilisation In The Treatment Of Genital Warts</td>
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<td>9.15am -</td>
<td>In Australian Sexual Health Clinics</td>
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<td>9.30am -</td>
<td>Ung - The Australian Women's Health Survey: Assessing The Psychosocial Burden Of HPV</td>
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<td>9.45am -</td>
<td>Related Illness And Preventive Interventions</td>
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<td>10.00am -</td>
<td>Conway - Genital Warts And Associated Health Care Use In General Practice In Australia</td>
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<td>9.45am -</td>
<td>Rawlings - Capitalising On The Unique Opportunity Of The HPV Vaccine, For A</td>
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<td>10.00am -</td>
<td>Cervical Screening Program</td>
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<td>9.45am -</td>
<td>McNulty - Patient Delivered Partner Therapy For Chlamydial Infection: What Would Be</td>
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<td>10.00am -</td>
<td>Missed?</td>
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<td>10.00am -</td>
<td>Power - Australian Lesbian And Bisexual Women's Knowledge Of, And Attitudes Toward, The</td>
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<td>10.15am -</td>
<td>Human Papilloma Virus And The HPV Vaccine</td>
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<td>10.15am -</td>
<td>Skinner - High efficacy of a HPV-16/18 L1 virus-like particle (VLP) vaccine adjuvanted</td>
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<td>10.30am -</td>
<td>with AS04 against CIN2+ caused by HPV-16/18 infection in a broad population of young women</td>
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<tr>
<td>10.30am -</td>
<td>Morning Tea &amp; Exhibition Viewing</td>
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<tr>
<td>11.00am</td>
<td>Plenary: Testing, Testing</td>
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<td>11.30am</td>
<td>Surfers Paradise Room 2 &amp; 3</td>
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<tr>
<td>12.30pm</td>
<td>Chairs: Kit Fairley and Basil Donovan</td>
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<tr>
<td>11.00am -</td>
<td>Ron Ballard - Centers for Disease Control &amp; Prevention, USA</td>
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<td>11.30am</td>
<td>Point of Care, Testing Issues</td>
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<td>11.30am -</td>
<td>Suzanne Garland - Royal Women’s Hospital, Victoria, Australia</td>
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<td>12.00pm</td>
<td>STIs and Pregnancy</td>
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<td>12.00pm -</td>
<td>Sepehr Tabrizi - Royal Children’s Hospital, Victoria, Australia</td>
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<td>12.30pm -</td>
<td>Laboratory Contribution to Control of Chlamydia</td>
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<tr>
<td>12.30pm -</td>
<td>Lunch in Southport Room &amp; Exhibition Viewing</td>
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<td>1.30pm</td>
<td>Exhibition and Poster Viewing Close</td>
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<tr>
<td>1.30pm -</td>
<td>Sexual Health Conference Plenary and Closing: Prevention</td>
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<td>3.00pm</td>
<td>Conference Close</td>
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<tr>
<td>11.00am -</td>
<td>Angela Williams - Victorian Institute of Forensic Medicine, Australia</td>
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<tr>
<td>12.30pm</td>
<td>Is Sexual Assault Preventable?</td>
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<td>11.00am -</td>
<td>Ron Jones - Professor of Obstetrics &amp; Gynaecology at the University of Auckland</td>
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<tr>
<td>12.30pm</td>
<td>Is Vulval Cancer Preventable?</td>
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<td>12.30pm -</td>
<td>Basil Donovan - The Australian Collaboration in Chlamydia Enhanced Sentinel Surveillance (ACCESS) Project</td>
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<tr>
<td>12.30pm -</td>
<td>Prize Presentations by Katherine Brown - Chair of the Australasian Chapter of Sexual Health Medicine</td>
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<tr>
<td>12.30pm -</td>
<td>Closing Remarks by Katherine Brown - Chair of the Australasian Chapter of Sexual Health Medicine</td>
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<tr>
<td>12.30pm -</td>
<td>Presentation of next years’ conference by Jenny McCloskey - Committee Convenor of Australasian Sexual Health Conference 2008</td>
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Please review product information before prescribing.

REFERENCES: 1. Pozniak AL, et al. Tenofovir disoproxil fumarate, emtricitabine, and efavirenz versus fixed-dose zidovudine/lamivudine and efavirenz in antiretroviral-naive patients. Virologic, immunologic and morphologic changes: A 96-week analysis. J Acquir Immune Defic Syndr 2006;43:535–540. 2. Cassetti I, et al. The safety and efficacy of tenofovir DF in combination with lamivudine and efavirenz through 6 years in antiretroviral-naive HIV-1-infected patients. HIV Clin Trials 2007;8(3):164-172. 3. Martinez E, et al. Efficacy and safety of NRTI's switch to TDF + FTC (Truvada®) vs. ABC + 3TC (Kivexa®) in patients with virologic suppression receiving a 3TC containing HAART. 4th IAS Conference on HIV Pathogenesis, Treatment and Prevention incorporating the 19th ASHM Conference, July 2007, Sydney, Australia. 4. Australian Approved Truvada® Product Information. TRUVADA® (300 mg tenofovir disoproxil fumarate/200 mg emtricitabine) tablets. INDICATION – Treatment of HIV infected adults over the age of 18 years, in combination with other antiretroviral agents. DOSAGE AND ADMINISTRATION – one tablet daily, orally with food. Dosage adjustments required for patients with renal impairment (CrCl <50 mL/min). Not to be administered to children or adolescents. CONTRAINDICATIONS, PRECAUTIONS, ADVERSE REACTIONS – Hypersensitivity to constituents. Concomitant therapy with VIREAD® (tenofovir disoproxil fumarate), EMTRIVA® (emtricitabine) or lamivudine containing drugs. Lactic acidosis and severe hepatomegaly with steatosis. Renal impairment. Bone effects. Lipodystrophy. Post-treatment exacerbations of hepatitis in patients with HIV and hepatitis B virus co-infection. Triple nucleoside regimens. Immune reconstitution syndrome. Drug interactions with concomitant nephrotoxic agents, unboosted atazanavir and drugs that compete with active tubular secretion; co-administration with didanosine should be monitored closely for didanosine-associated adverse events; Not recommended to patients with CrCl <30 mL/min or requiring haemodialysis. Pregnancy and lactation. Additional reactions can include nausea, diarrhoea, vomiting, fatigue, dizziness, headache, pain (back, abdominal) fever, rash, skin discolouration, allergic reaction, hypophosphataemia, dyspnoea, increased amylase, pancreatitis, increased liver enzymes (AST, ALT, gamma GT), hepatitis, myopathy, osteomalacia, increased creatinine, renal insufficiency, renal failure, acute renal failure, Fanconi syndrome, proximal tubulopathy, nephrogenic diabetes insipidus, proteinuria, acute tubular necrosis, polyuria, nephritis, interstitial nephritis (including acute cases), anaemia. Creatinine clearance should be calculated prior to initiating therapy and, as clinically appropriate, during therapy. Close clinical observation by physicians experienced in the treatment of patients with HIV associated diseases recommended. Full Prescribing Information is available from Gilead Sciences Pty Ltd and should be reviewed before prescribing TRUVADA. Truvada®, Viread® and Emtriva® are Registered Trademarks of Gilead Sciences Inc.

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AUSTRALASIAN SEXUAL HEALTH CONFERENCE 2007
“VENUS & MARS AT JUPITERS”

Monday 8 – Wednesday 10 October 2007
CONRAD JUPITERS, GOLD COAST, QUEENSLAND, AUSTRALIA

ORAL PRESENTATION ABSTRACTS
MONDAY 8 OCTOBER 2007
MONDAY 8 OCTOBER 2007

Opening Ceremony and Gollow Lecture (9.30am – 11.00am)

GOLLOW LECTURE
SEX AND CANCER

RW Jones
National Women’s Hospital, Auckland, New Zealand

This Lecture will address the development of our knowledge relating to the influence of sexual and hormonal activity in the development of genital tract cancers. The contributions of a number of Australian physicians in this field will be acknowledged.
Symposium: Sexual Aversion
(11.30am – 1.00pm)

VAGINISMUS, VULVDONYIA AND PELVIC FLOOR MUSCLE ACTIVITY

Sapford R
Mater Public Hospital, Australia

The pelvic floor muscles form the base of the abdominal cylinder and work in synergy with other muscles around the cylinder – the abdominal muscles and the diaphragm. Activity in each muscle group affects the others. Co-ordinated recruitment of these muscle groups is necessary for generation and maintenance of intra-abdominal pressure, postural support of the trunk, and during functional tasks such as lifting, coughing and nose blowing. Co-ordinated release of these groups is required for micturition, while defaecation may need activity in some muscles and release in others. Vaginismus and vulvodynia both have a component of over activity of the pelvic floor muscles which impairs normal function, though this over activity may only occur at the time of attempted penetration. Some of the physiological factors that contribute to this overactivity come from outside the pelvic floor muscle complex itself and can be ameliorated by understanding and management of these muscle synergies. An EMG study of muscle activity of the abdominal and pelvic floor muscles during a simulated body posturing for female sexual arousal will help to explain how the pelvic floor muscle over activity in vaginismus arises. Treatment programmes that have been used to successfully address these problems will be explained.

NON CONSUMMATION

Dennerstein L
1Office for Gender and Health, Department of Psychiatry, The University of Melbourne, Parkville, Vic. Australia 3010.

This presentation will examine the relationship between women’s acceptance of their own anatomy and the clinical condition of non consummation of relationship. The lecturer will utilise case examples from 35 years of clinical experience in treating sexual dysfunction to describe women’s feelings about their own bodies, those of their partner and the sexual act. The resultant vaginismus, apareunia and duspareunia are well known but the aversive aspects also need to be addressed.

UNDERSTANDING VENUS: EXPLORING FEMALE DESIRE

Weerakoon
Senior Lecturer and Academic Coordinator of the Graduate Program in Sexual Health Faculty of Health Science
The University of Sydney

The female sexual response is highly variable and multifaceted and is a result of interplay of physiological, psychological and interpersonal factors. The advent of technology and non-invasive functional brain imaging has provided a map of the regions of the brain involved in sexual arousal and the neurochemistry that underlies the process. However, this increase in the understanding of the biological basis of female sexuality has only reinforced the role of interpersonal and cultural factor in the sexual response, specially the genesis of sexual desire. An acceptance of this by professionals, has led to the consensus for a more holistic biopsychosocial approach for the management of female sexual concerns.

The presentation will discuss the current research on the neural and hormonal basis for female desire and explore the role of sexual desire as a motivator and a force for sexual activity in the context of the prevailing models of the female sexual response.

There is a need for the recognition of the place and value of sexual desire in the female sexual response and an appreciation that whereas there is a biological drive, this is tempered by the motivational aspect (individual and relationship psychology) and the cultural and moral overlay of values and attitudes. This will in turn provide the milieu for understanding normal and dysfunctional sexual desire and assist us on the road to discovering a best practice model for the diagnosis and management of ‘female desire disorders’.

References:
Africa as a continent has been devastated by the acquired immunodeficiency syndrome epidemic caused by the human immunodeficiency virus (HIV). Women are more likely to acquire HIV/AIDS for a number of reasons and incidence studies show that younger women are particularly at risk of HIV acquisition. Biologically, they are more vulnerable and the acquisition of HIV can be influenced by hormonal contraceptives as well as sexually transmitted infections, which are often more asymptomatic than is the case for men. Women in Africa are also more vulnerable because of cultural issues; in some countries polygamy is accepted practice. Women are often economically disadvantaged and disempowered. It is often hard for them to insist on the use of condoms with husbands and regular partners. Physical and sexual abuse of women, including rape, remains a major problem on the continent, particularly in times of civil war. Many women are forced to work as sex workers or be involved in transactional sex in order to survive.

Most countries rely on anonymous antenatal surveys to generate HIV seroprevalence data for women of reproductive age. These data is often used as surrogate markers for HIV prevalence rates in men of a similar age. The seroprevalence of HIV among pregnant women differs remarkably around the continent, with the highest rates being seen in Southern Africa, as high as 30%, and much lower rates being seen in West Africa. These reasons underlying these differences are complex and not completely understood.

UNAIDS estimated in 2005 that 470,000 (87%) of the world’s 540,000 newly infected children (<15 years old) reside in Sub-Saharan Africa. Prevention of mother to child transmission (PMTCT) of HIV is thus a national priority in many Sub-Saharan African countries. Despite policies, treatment is sometimes not given at the clinic level for several reasons, and when it is, most commonly it is with single dose Nevirapine. Data from South Africa has shown that both mothers and infected babies rapidly acquire nevirapine resistance. It is likely that this will lead to early failure of first line antiretroviral (ARV) therapy among these mothers once they start their ARVs. In South Africa, for example, either efavirenz or nevirapine form the backbone of the first-line ARV regimens.

AIDS defining illnesses (ADIs) in women living in Africa are similar to those observed in men. Tuberculosis is the most common ADI but other life-threatening illnesses such as cryptococcal meningitis are relatively common compared to other parts of the world. Cervical cancer and cervical intra-epithelial neoplasia (CIN) lesions are more common in HIV-infected than in non-infected women. Most countries in Africa do not have cervical screening programmes and, even in richer countries such as South Africa, the national policy is to screen women three times in their life at 30, 40 and 50 years of age. Many HIV specialist centres, with additional donor funds, are now attempting to perform annual cervical screening, at least in South Africa.
COMMONALITIES, CONCERNS AND POTENTIALS: DYADIC PERSPECTIVES IN THE PSYCHOSOCIAL CARE OF WOMEN LIVING WITH HIV/AIDS IN AUSTRALIA

Russell, J

1Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, VIC, Australia

There are more women than ever living with HIV/AIDS in Australia and this relatively small heterogenous population has received scant research attention. Women living with HIV/AIDS, face many complex and compelling challenges in managing this stigmatised illness in their everyday lives. This study sought to gain an understanding of these women’s support needs. Semi-structured, in-depth interviews were conducted with two groups: women living with HIV/AIDS (Sydney and Melbourne, involved and not in advocacy); and HIV specialists (Sydney and Melbourne) treating women living with HIV/AIDS. There was a consensus view among both specialists and women that women: have limited knowledge of HIV/AIDS; have no collective or historical understanding of HIV/AIDS; are more likely to present late with HIV; experience diagnosis as extremely distressing; are not aware of the resources available including medical treatments; and are more likely to experience social isolation. Both groups recognised the need for psychological and social support. HIV specialists questioned the effectiveness of community based peer support, while women identified this as one of the most important forms of support. HIV specialists differed in their knowledge and views of CBOs, and this influenced their decisions on recommending these to their female patients. The unique nature of this stigmatised illness calls for the recognition of the contributions of all parties in efforts to address these support needs; the women living with HIV/AIDS, HIV specialists and community based organisations. Particularly in light of the potential for social isolation, inquiries into social structures that provide the opportunity to access social resources are arguably a future direction to advance knowledge in this area.
Chlamydia – Novel Strategies ‘Rocket Science (2.00pm – 3.30pm)

‘THE CHLAMYDIA PROJECT; IMPROVING KNOWLEDGE OF, AND TESTING RATES FOR CHLAMYDIA AMONG YOUNG PEOPLE IN A REMOTE ABORIGINAL SETTING

Dunn C 1, Garton L2, Lynch K 2
1 Nindilingarri Cultural Health Services (NCHS), Fitzroy Crossing, WA, Australia; 2 Kimberley Health Population Unit (KPHU), Broome, WA, Australia.

The Kimberley region has some of the highest rates of Chlamydia infection in Australia. NCHS obtained funding to initiate and establish a Chlamydia Project aimed at increasing screening rates amongst indigenous youth aged 15 to 30 in the Fitzroy Valley. Population for the Valley is approximately 3000, predominately Aboriginal, covering more than 40 remote communities and the town of Fitzroy Crossing. The community has a strong belief in traditional values therefore observation of cultural protocols is paramount, especially when working in the area of sexual health. This can present challenges when setting up a sexual health program that is culturally appropriate, accepted and sustainable.

The aim of the project is to encourage young people to attend for STI screening when they are asymptomatic. The project will also endeavour to increase awareness of Chlamydia and other sexual health issues relevant to the age group.

Methods used, include setting up screening clinics in town and remote communities, involving young people in making decisions about how the clinics are run, holding “Feel Good Nights” that promote discussion and information sharing about sexual health, peer education and encouraging young people to participate in resource production.

Anecdotally, results so far have shown a greater number of young people are accessing sexual health services and there is an increase in knowledge of Chlamydia and sexual health in general amongst the target population. This project will run until May 2008. This paper will present the progress of the project so far, and some of the highlights and challenges of setting up a sexual health program in a remote community setting.

STAMP OUT CHLAMYDIA’ PROJECT – BRINGING CHLAMYDIA SCREENING TO TERTIARY STUDENTS IN THE AUSTRALIAN CAPITAL TERRITORY

Davis BK1,2, Schmidt M2, O’Keefe E2, Currie M J1, Baynes AM1, Bavinton T1, McNiven M4, Bowden F J1,2,5
1 Academic Unit of Internal Medicine, The Canberra Hospital, PO Box 11, Woden, ACT 2605, Australia; 2 The Canberra Sexual Health Centre, The Canberra Hospital, PO Box 11, Woden, ACT 2605, Australia; 3 Sexual Health and Family Planning ACT, GPO Box 1317, ACT 2601, Australia; 4 ACT Pathology, The Canberra Hospital, PO Box 11, Woden, ACT 2605, Australia; 5 The Australian National University Medical School, Academic Unit of Internal Medicine, The Canberra Hospital, PO Box 11, Woden, ACT 2605, Australia.

Study’s objective
Stamp Out Chlamydia (SOC) is a pilot research project funded by the Commonwealth Department of Health & Aging to devise and implement a cost effective program for education and chlamydia screening for ACT tertiary students aged 16-26 years at The Australian National University (ANU), University of Canberra and Canberra Institutes of Technology, that may be suitable for national implementation.

Methodology
A collaborative clinical outreach project between Canberra Sexual Health Centre, Sexual Health and Family Planning ACT and ANU Medical School, whereby the SOC team attends student-initiated events on ACT tertiary campuses to educate and test young people, using self-obtained urine specimens.

Summary of Results
The majority of these outreach events were attended by two Registered Nurses and the Health Promotion Officer. To date they have attended 19 events including Orientation Week activities, BBQ’s, Easter Scavenger Hunt, Gay Pride Week events and sports events. Promoting the SOC project has been through word of mouth, SOC ‘Champions’, convenience and media advertising and a dedicated web site.

By May 2007 the SOC project had:
- Interfaced with 1512 tertiary students and offered them the opportunity to participate in the research
- Screened 445 for chlamydia
- Found a chlamydia prevalence of 1.8%
- Treated eight cases and their contacts
Of those screened:
Male 240
Female 205
Target group 412

Conclusion
ACT tertiary students accept this outreach approach. Of students approached, over a quarter agreed to have screening. The high profile of the SOC project is leading to an increased awareness of chlamydia. Many students are unaware of the high incidence and/or the consequences of chlamydia, if left untreated and report that they would not have attended mainstream services for screening. Ongoing data analysis will determine if this project is cost effective and feasible.

DEVELOPMENT AND VALIDATION OF A NOVEL GEL-BASED URINE TRANSPORT SYSTEM FOR USE IN CHLAMYDIA TRACHOMATIS PCR BASED DIAGNOSIS

Bialasiewicz
Queensland Paediatric Infectious Diseases Laboratory

Background: Chlamydia trachomatis infection rates have increased within Australia over the past several years, including persistently high incidences in known risk groups. The development of novel C. trachomatis detection methods which can be self-collected and mailed in a plain envelope presents significant opportunities for increasing access to urine testing across Australia, particularly those who are geographically or socially isolated and have limited or impeded access to mainstream health services.

Aim: The purpose of the study was to develop a urine transportation system which retains comparable sensitivity to standard sampling methods, is easy and safe to use by the average person within a home setting, and which complies with regulations concerning the transport of biological specimen through regular mail.

Results / Discussion: An expanding-matrix based method was developed in which a small amount of urine is applied to a dry mixture of a super absorbent polymer and nucleic acid stabiliser, yielding a dry gel. The gel can then be subsequently treated in the diagnostic laboratory to release the reconstituted urine, from which nucleic acid can be extracted using standard methods. Once extracted, the sample can be utilised in a nucleic acid amplification based C. trachomatis diagnostic assay. The clinical sensitivity of the gel-matrix was found to be comparable to that of standard urine transport methods. The applicability of the gel for use by the public in a home collection setting was deemed appropriate due to the non-toxic nature of the matrix materials, ease of use, and the basic packing and postage requirements. The dry gel form of the urine and packaging complied with Australia Post standard postage requirements. Results of the initial development and validation of the gel matrix will be presented.
THE CHECK IS IN THE MAIL: A NOVEL APPROACH TO CHLAMYDIA TRACHOMATIS TESTING USING SELF COLLECTED, MAILED SPECIMEN

Buhrer Skinner M 1,2, Muller R 1, Bialasiewicz S 3,4, Debattista J 5

1 Anton Breinl Centre for Public Health and Tropical Medicine, James Cook University, Townsville, QLD 4811, Australia
2 Chlamydia Testing Trial, Institute of Primary Health and Ambulatory Care, Queensland Health, North Ward Health Campus, PO Box 5224, Townsville QLD 4810, Australia
3 Queensland Paediatric Infectious Diseases Laboratory, Sir Albert Sakzewski Virus Research Centre, Royal Children’s Hospital, Herston QLD 4029, Australia
4 Clinical Medical Virology Centre, University of Queensland, Brisbane QLD 4000, Australia
5 Sexual Health & AIDS Service, North Side Health Service District, 270 Roma St, Brisbane QLD 4000, Australia.

Background: The progress in chlamydia testing / management seems to have stalled in Australia over the last years with persistent high prevalences observed in known risk groups. A novel approach is needed to lower the barriers to testing especially in those who are socially isolated and/or live in rural or remote locations.

Aim: To develop, implement and evaluate a novel approach to chlamydia testing in the form of a ‘self-collection testing kit’ that is easily accessible, confidential, free of charge, easy to use, and allows for home self-collection of specimens, their transportation by regular mail and the central management (notification, treatment and follow-up) of results.

Methods: The developed ‘kit’ consists of all necessary items and instructions to obtain a sample. A network of ‘kit’ distribution sites at locations frequented by the target population has been established in urban as well as rural and remote areas. The ‘kits’ can also be requested via an advertised website and a 1800 phone number. Specimens are returned via reply paid mail. A centralised system for the management of results and follow up of individuals has been developed. Test results are conveyed to participants by the method of their choice including email, SMS and phone. Treatment is organised via a network of health care providers in various locations.

Results / Discussion: First promising results and experiences from the implementation phase of this novel approach to chlamydia testing will be presented covering distribution and uptake of ‘kits’, return of specimens as well as management and follow up. If eventually proven successful, this approach to chlamydia testing will provide significant opportunities for increasing access to testing across Australia especially in rural and remote areas. An extension to gonorrhoea testing is possible.

This project is supported by the ‘National Chlamydia Pilot Program’ funding of innovative chlamydia projects.
SEX AND SPORT: A COMMUNITY BASED PROJECT OF CHLAMYDIA TESTING AND TREATMENT IN RURAL AND REGIONAL VICTORIA

Kong F1, Kyle-Link C2, Hocking J1,3, Hellard M1.
1Centre for Epidemiology and Population Health Research, The Burnet Institute, Melbourne, VIC, Australia; 2Women’s Health Loddon Mallee, Bendigo, VIC, Australia; 3Key Centre for Women’s Health in Society, University of Melbourne.

Chlamydia is the most common notifiable infectious disease in Australia with the number of notifications increasing 92% over the past 5 years. The “Sex and Sport” Project is piloting a community based chlamydia testing and treatment program reaching young people in a specific community setting, sporting clubs. This multifaceted approach utilises health education, population screening and collection of data on risk taking behaviour as the first steps in enhancing health and shaping future service provisions. The project’s primary aim is to assess the feasibility of an outreach testing and treatment program. Secondary aims are to measure the prevalence of chlamydia and assess sexual risk behaviour in this population.

Strong community collaborations and integration into local health services through the Primary Care Partnerships is important in the project’s sustainability; in particular key community members respected by sporting clubs needed to be identified, capacity developed to deliver effective health promotion messages and improve young people’s access to sexual health services. Additionally, local knowledge has guided overall program implementation and provide opportunities for capacity building to regionally based services. For example, poor access to sexual health services is being addressed by the participants being able to access services via telephone consultation with Melbourne Sexual Health Centre.

Approximately 1000 Victorians aged 16-25 years from the Loddon Mallee region of Victoria will be tested between June and September 2007.

This paper will report on the feasibility, challenges and possible solutions in establishing a community based outreach testing and treatment program.

YOUNG PEOPLE GET CLUED UP ABOUT CHLAMYDIA: AN INTERNET BASED RANDOMISED CONTROLLED TRIAL

Kang M1, Rochford A1, Mindel A2, Skinner SR3, Webb M4, Hillier L5 and Usherwood T1.
1Department of General Practice, University of Sydney, Sydney, NSW, Australia;
2Sexually Transmitted Infections Research Centre, University of Sydney, Sydney, NSW, Australia;
3School of Paediatrics and Child Health, University of Western Australia, Perth, WA, Australia, 4Inspire Foundation, Sydney, NSW, Australia, 5Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, VIC, Australia.

Young people (16 – 25 years) are a target group for the prevention of Chlamydia trachomatis in the Australian national STI strategy. This study is a randomized controlled trial of an innovative internet-based intervention which aims to increase Chlamydia testing and treatment among at risk young people living in Australia. Study participation is via a website developed in consultation with young people and linked to an evaluated health promotion website. Young people in the intervention group receive personalised, confidential emails from a nurse or doctor while those in the control group receive automated emails. Follow up at 6 months will measure self-reported Chlamydia testing and other outcomes.

By 5 June 2007, 359 young people of a target sample of 1,000 were enrolled (83% female). Mean age is 20 years (range 16 – 25). Participants reside across all states and territories. Thirty percent of participants in the intervention group are in active email dialogue with the research nurse, e.g. “The research and…site was…really good,…it’s kinda scared me into getting a test and just to get over the embarrassment... will the test be able to be part of just a normal appointment?” Zero participants in the control group have responded to the automated email. Baseline data and examples of the email interaction will be presented.
CAUGHT IN THE WEB: CYBERSEX AND ITS IMPACT ON INDIVIDUALS AND THEIR INTIMATE RELATIONSHIPS

Misso K.
1Senior Counsellor, Relationships Australia (Qld)
159 St.Paul’s Terrace Brisbane Q 4000, 2Sessional Lecturer, School of Psychology & Counselling, Queensland University of Technology, Carseldine Q 4034

With the current meteoric expansion in computer technology phonographic magazines and videos are fast being replaced by virtual intimacy and sex on the Internet. The affordability, accessibility and anonymity of the net offer a pseudo-intimacy less threatening and demanding than real life intimacy. The illusion of being in control, of constructing the relationship of your dreams can become quite addictive. This presentation will draw on current research and clinical data to illustrate how clients caught in the web find the compulsive behaviour patterns that emanate extremely destructive. With the passage of time such behaviour patterns can have a negative impact on an individual’s psychological health, social relationships, work performance and most significantly, intimate relationships. The latter is a new factor contributing to distress in and the breakdown of couple relationships. The presentation highlights several ‘warning signs’ of a downward spiral and offers clinicians therapeutic strategies for working with couples caught up in this potential maelstrom. The computer hailed as a communication marvel, which was to facilitate ‘connection’, is fast becoming an instrument of ‘disconnection’ for those who are naïve enough to ignore its darker side.

GENITAL HERPES ONLINE RISK SURVEY

Mindel A1, Christie E1, Chung C1, Berger T2 and the Australian Herpes Management Forum (AHMF)
1Sexually Transmitted Infections Research Centre (STIRC) and University of Sydney, Marian Villa, Westmead Hospital, Westmead NSW 2145, Australia
2Australian Herpes management Forum, c/- STIRC, Marian Villa, Westmead Hospital, Westmead NSW 2145, Australia

BACKGROUND
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 HSV-2. The majority of people infected with HSV-2 are asymptomatic. With increasing availability of web-based technology for use as an information and education tool, we established a web-based survey to determine risk for genital herpes and encourage people who maybe at risk to attend a health care professional for HSV testing.

METHODS
A web-based genital herpes risk assessment quiz was established on the AHMF web page. The quiz was based on epidemiological data derived from a national population-based survey and other epidemiological studies and consisted of 16 questions, each with a numerical weighting. Factors were weighted according to age, country of origin, gender, sexual history, condom use, symptoms suggestive of herpes and whether the individual was of Aboriginal or Torres Strait Islander (ATSI) origin. Scores were added up and individuals allocated a risk score of low, medium or high.

RESULTS
By the 24th May 2007, 2639 questionnaires had been completed, 52% were male and 48% female and 87% from Australia. 18% were classified as low risk for genital herpes, 46% as medium risk and 36% as high risk. Women had a higher mean risk score than men (p<0.001) and were less likely to report condom use than men (P< 0.001), however, men were more likely than women to have had sex with someone they knew had herpes (p=0.018). ATSI participants had a higher mean risk score than non-ATSI participants. Detailed analyses of risk scores and comparisons between groups will be presented.

CONCLUSIONS
On-line risk surveys are a useful way for individuals to determine their risk of genital herpes. Similar tools should be developed for other STIs.
RISKS, CHOICES AND CONSEQUENCES: INTERNATIONAL STUDENTS AND SEXUAL HEALTH PROMOTION

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International students are the 4th most revenue raising industry in Australia bringing in $6 billion in 2006. December 2006 reports show 383,818 international students were enrolled across Australia with 61,019 in Queensland. The vast majority of students come from Asian countries with a high prevalence of HIV/AIDS and STIs combined with minimal sexual health knowledge.

Through workshops and discussion groups with international students they have been identified as a high risk in relation to sexual health problems due to their lack of sexual health knowledge, their tendency to engage in risk behaviour without adequate knowledge of risks, consequences and protection mechanisms. As a result, sexual health issues are increasingly presenting to professionals working directly with international students and health services in claims related to pregnancy, abortion rates, sexual assault, rape and reports of international students from high risk countries found to be HIV+.

Further, international students reported receiving no information prior to arrival and on arrival of risk behaviour, safety issues, health or laws in Australia. In order to promote safe sex behaviour among international students we have formulated various strategies to raise awareness of international students, from print material on arrival, to information stalls at O-week, intermittent workshops for international students, student leaders and professionals working directly with international students and health services in claims related to pregnancy, abortion rates, sexual assault, rape and reports of international students from high risk countries found to be HIV+.

Our program findings demonstrate that the international student population is a high risk group facing sexual health issues where increased education and support must occur to prevent and reduce sexual health related problems.

A RANDOMIZED CONTROLLED TRIAL OF THE IMPACT OF EMAIL AND TEXT (SMS) MESSAGES ON THE SEXUAL HEALTH OF YOUNG PEOPLE

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Objective: to trial a novel method of sexual health promotion - sending email and mobile phone text messages (SMS) about safe sex and STI to promote reductions in STI behaviours and increases in STI knowledge and testing.

Methods: young people (aged 16–29) were recruited at a music festival in Melbourne. They completed a questionnaire about sexual risk behaviour and were randomised to either the intervention arm of the study (to receive messages) or a control group. Text messages were sent every 3-4 weeks for a twelve month period and included catchy STI prevention slogans. Emails were sent monthly and contained detailed information about STI topics and links to related websites. Participants completed follow-up questionnaires online after 3, 6 and 12 months. Clustered weighted estimating equations were used to compare outcomes of the two groups.

Results: 994 people completed at least one questionnaire (507 in the intervention group and 487 in the control group); at baseline 58% were female, the median age was 19 years and 82% had ever had sex. At 12 months, STI knowledge was higher among the intervention group for both males (OR 3.19, 95%CI 1.52, 6.69) and females (OR 2.36, 95%CI 1.27, 4.37). Females in the intervention group were also more likely to have discussed sexual health with a clinician (OR 2.92, 95%CI 1.66, 5.15) and to have had an STI test in the past 6 months (OR 2.51, 95%CI 1.11, 5.69). There were no significant differences in condom use between the groups. Respondents’ opinions of the SMS and emails were positive.

Conclusions: receiving regular sexual health-related SMS and email messages can improve knowledge in young people and health seeking behaviour in young women. SMS and email are low cost, widely available and convenient, which - when combined with their popularity among youth - means that these media have considerable potential for sexual health promotion.
PATIENTS’ PERSPECTIVES ON THE BEST WAYS TO TELL PARTNERS ABOUT CHLAMYDIA: HOW ACCEPTABLE ARE THE NEW TECHNOLOGIES?

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As part of a larger, combined qualitative-quantitative methods study of partner notification, 40 in-depth telephone interviews were conducted with patients diagnosed with Chlamydia from clinics in Victoria, ACT and Queensland to determine their usage and opinions of different methods partner notification. Overwhelmingly, personal methods such as telling partners face-to-face or over the phone were preferred to impersonal methods such as email, SMS and letter. Face-to-face was considered the “gold standard” in partner notification because it demonstrated courage, caring and respect. Phone contact, while considered insensitive and cowardly by some, was often used because it was quick, convenient and less confronting. Email was viewed as only being acceptable in certain circumstances, such as if the partner was overseas, because it was seen as impersonal and uncaring. SMS was considered the least acceptable method for telling partners with most interviewees seeing it as cold, disrespectful and “gutless”. However, interviewees who were fearful of their partner’s reaction or who had high numbers of casual partners were enthusiastic about an anonymous SMS facility. For both emails and SMS, interviewees were concerned that the message could be misunderstood, not taken seriously or shown to others. Letters, both from the patients or from their doctor, while not viewed as unfavourably as the newer technologies were less likely to be used. These findings suggest that people diagnosed with Chlamydia are reluctant to use the new technologies for partner notification, except in specific circumstances, and our efforts in developing partner notification resources may best be focused on giving patients the skills and confidence for personal interaction.

INCREASING ACCESS TO SEXUAL HEALTH ADVICE FOR HIGH RISK INDIVIDUALS THROUGH AN AUTOMATED, INTERNET BASED SERVICE

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Objective: It may be difficult for young people to know if they need testing for sexually transmitted infections and some primary care physicians may be unsure about what tests to order for patients with different risk profiles.

Our aim was to help overcome these barriers by implementing an automated, internet based service that allowed internet users to receive specific recommendations for STI screening based on their online responses to a series of questions relating to their recent sexual practices (“Check Your Risk” (CYR), available at: www.mshc.org.au). This study evaluated this service and compared the risk profile of individuals using CYR with that of patients attending a sexual health centre in the same city over the same time period.

Methods: An automated and individualised web based algorithm was developed using current recommendations for STI testing. The characteristics of individuals visiting CYR were compared to those attending the Melbourne Sexual Health Centre (MSHC) for the first time over the same 6 month period, from January to June 2006.

Results: There were 2492 (59% men, 41% women) who visited the CYR online service and 2735 (59% men, 41% women) who attended the MSHC over the period. 513 (22%) of the men visiting CYR and 467 (18%) of the men visiting MSHC reported sex with other men, with a median of 6 (SD 26.4) and 6 (SD 29.4) partners in the previous 12 months respectively (p=0.5). 43 (1.8%) of the women visiting CYR and 54 (2.1%) of the women visiting MSHC reported sex with other women, with a median of 1 (SD 9.3) and 1 (SD 2.1) partners in the previous 12 months respectively (p=0.05).

Among men reporting sex with women only, the median number of female sex partners in the preceding 12 months was 2 (SD 10.6) and 3 (SD 5.8) for those visiting CYR and MSHC respectively (p=0.8). For women reporting sex with men only, the median number of male partners was 2 (SD 11.1) and 2 (SD 4) for those visiting CYR and MSHC respectively (p=0.03).
Participants responded favourably to the CYR online service, with 70% rating it as ‘useful’ or ‘very useful’.

**Conclusions:** This internet based sexual risk assessment tool was accessed frequently by individuals with a high risk profile that was similar to those who attended the sexual health service in the same city. The CYR service cost A$4000 to set up. CYR effectively increased the outreach of the centre’s services substantially, via the internet and was given a positive rating by the majority of its users.
INFECTIOUS SYphilIS ELMination FOR ABORIGINAL PEOPLE IN NSW: CHALLENGES AND OPPORTUNITIES

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Elimination of syphilis within Aboriginal communities is one of the stated goals of the NSW Sexually Transmissible Infections Strategy 2006-2009. In 2007, a project was undertaken to inform strategy development to achieve the goal of elimination of infectious syphilis in Aboriginal communities.

Australian and international literature on elimination strategies for syphilis, STIs and other diseases was reviewed. Surveillance data were accessed through the National Notifiable Diseases Surveillance System and NSW Notifiable Disease Database and analysed to describe the current burden of disease. Key informants were consulted for advice on elimination strategies for infectious syphilis for Aboriginal people and possible barriers to the goal.

Infectious syphilis notifications for Aboriginal people have decreased significantly from 64% of all infectious syphilis cases in 1995 to 3% in 2006. For the rest of the population notifications have increased. Changes in male to female ratios and an increase in metropolitan notifications have been noted in recent years. Improvements in recording of Aboriginality information for infectious syphilis in NSW have allowed greater confidence in interpreting these trends. The role of accurate and complete surveillance information will play an important role in planning and directing the implementation of interventions to achieve the goal of syphilis elimination for Aboriginal people in NSW.

Challenges to the goal of elimination and the feasibility of a disease elimination strategy specific for Aboriginal people include issues of access to services for testing, diagnosis and treatment; cross-border mobility of Aboriginal people; prevalence of syphilis in the wider community; and continued access to accurate information. Lessons learned from international and Australian elimination strategies; burden of disease information; definition of elimination and target rates; challenges and strategies for achieving the goal of syphilis elimination and will be discussed.

SEXuAL HEALTH SERVICES & HIV PREvENtion: IMPROVING INTERVENTION OPPORTUNITIES

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Objective: This descriptive study was undertaken to determine the presence of key indicators which might alert clinicians that a Melbourne Sexual Health Centre (MSHC) client is at increased risk of HIV acquisition and, if so, lead to recommendations for changes to clinical practice.

Method: We identified and reviewed the most recent medical files of clients who received an HIV positive diagnosis and who had also received a negative result at MSHC within the preceding two years (n = 20). Quantitative epidemiological and demographic data were collected and analyzed using SPSS software. Qualitative data analysis of annotated entries both pre and post HIV diagnosis included transcription and examination for emergent themes.

Results: Quantitative data analysis revealed the following; all 20 clients were male and identified MSM behaviour. Median age at diagnosis was 34.5 years (95% CI:28.3-37.6 years). The median number of partners in the 3 months preceding HIV diagnosis was 4 (95%CI:3.4-9.6;p=0.005)) and in the preceding 12 months 23 (95% CI:11.4-61.4;p<0.05). 85% of men reported inconsistent condom use, and one reported no anal sex in the preceding 12 months. None reported a history of IDU and three men reported sex overseas in the preceding 12 months.

Qualitative analysis revealed some emergent themes which included histories of mental illness, drug and alcohol use, childhood abuse, HIV serodiscordant relationships and confusion surrounding sexual orientation.

Discussion: Clinicians have an obligation to assist clients, within their scope of practice, to remain HIV negative. Results from this study have implications for the method of identification of clients at risk and also for the utilization of intervention opportunities which impact on risk behaviour. The challenge for MSHC is to adapt our practice in order to maximize these opportunities.
GONORRHOEA INFECTION IN SYDNEY WOMEN

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Abstract
Background: Gonorrhoea is associated with undesirable reproductive health outcomes in women including pelvic inflammatory disease and tubal factor infertility. However there is low prevalence in the general community and some authors have suggested that only those women with risk factors should be tested. But can we predict who will have a positive gonorrhoea result?

Methods: A retrospective, case controlled, study was undertaken in an inner Sydney public Sexual Health clinic between January 2000 and December 2005. Cases were all women with culture proven cervical n.gonorrhoea infection in the time period. These were case matched with subsequent women with a negative gonorrhoea culture test. Variables examined included demographics, sex worker status, country of birth, injecting drug use (IDU) status, presence of symptoms and concurrent STIs.

Results: There were 40 women who were n.gonorrhoea culture positive during the study period and 27 cases and 23 controls reported any genital symptoms. The relative risk of having gonorrhoea if discharge was described was 1.75 (p<0.05). The cases had a high rate of concurrent STI including Chlamydia.

Conclusions: The only significant predictor of gonorrhoea in this group was the symptom of vaginal discharge. Thus in our clinic population behaviour, demographic data or cannot be used to determine who gets tested for gonorrhoea.

IS HELICOBACTER PYLORI A STI? – A PILOT STUDY

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BACKGROUND
Helicobacter pylori is responsible for chronic gastritis and peptic ulcer disease and is associated with an increased risk of developing stomach cancer. The seroprevalence of Helicobacter pylori in the Australian-born adult population is about 20% and increases with age. The exact mode of transmission of Helicobacter pylori infection remains unknown and it has been suggested that sexual transmission maybe important. This study is a preliminary investigation into a possible association between sexual risk factors and Helicobacter pylori infection.

SUBJECTS AND METHODS
All patients aged 18 and above, presenting to the Parramatta Sexual Health Clinic and were having blood taken for any other purpose, were eligible for the study. Blood samples were collected for Helicobacter pylori serology using an enzyme-linked immunosorbent assay to detect Helicobacter pylori IgG. Demographic information and data regarding sexual behaviour and risk factors for sexually transmitted infections was obtained. The sample size to detect a 15% difference between the study population and the general Australian population with 90% power was 105. To allow for minor variations we plan to recruit 125 participants.

RESULTS
To date, 65 patients (75.4% males) have been enrolled in the study and 10 (7 males and 3 females) (15.4%) were positive for Helicobacter pylori. One additional result was equivocal. 24.6% of the participants were born outside Australia and out of 8 who belonged to middle and low-income countries, three had positive serology. The full results of the study, including seroprevalence and the demographic and sexual risk factors, will be presented.
IMPACT OF TRIAGE ON PATIENT PRESENTATIONS AT A LARGE PUBLICLY FUNDED SEXUAL HEALTH SERVICE

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Introduction/Background
Increasing prevalence of sexually transmissible diseases in Australia has led health authorities to require publicly funded sexual health services to target services to those most in need. Nurse triage has previously been shown to improve efficiency of sexual health services. Nurse triage of all new patients telephoning SSHC for an appointment was implemented in 2004. A priority tool was developed to guide the process that delegated the types of clients and client presentations appropriate for the Centre.

A review was conducted of medical record data in the patient database to ascertain the percentage of patient presentations triaged into SSHC who did not fit the priority categories in the tool. This was conducted for a full year in 2006 and for comparison pre implementation of the triage system in 2001.

Results
In 2001 a total of 23% of 1422 new patients did not fit the criteria of patient presentations appropriate for the Centre. In 2006 this percentage more than halved to 10% of 1039 patient presentations.

Conclusions
Telephone triage has been effective in increasing the percentage of priority presentations at SSHC.

ELECTRONIC HEALTH RECORD SYSTEMS IN AUSTRALIA & NEW ZEALAND SH/HIV/HEP C/WOMEN’S HEALTH CLINICS 2006 – A PILOT PROJECT

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Objective: This pilot study examined the utility pattern of electronic health record & clinic management systems in the region.

Methods: An anonymous one-paged survey form was sent either by email or facsimile to 100 randomly selected public & private Sexual Health/ HIV/ Hep C/ Women’s Health/ GP (High Case Load ) listed in the Australasian Chapter of Sexual Health Medicine Register of Public SH Clinics 2006 and the ASHM Directory 2006-2007. Responses on the clinics activities & utility for 2006 were collated.

Results: Response rate = 20 % N=20 clinics Mean Occasion of service (OS) = 4,812 Median OS = 4,150 (Range 162- 20,000) 25% of clinics provided estimated figures only Mean No. tests done = 5,467 Median = 5,474 (Range 224- 20,000)
Nature of Clinics: SH 81.3% FP/Women’s Health 18.8% GP 6.3% Other 6.3%
Clinic Software: SHIP 50% Other 25% Nil 25%
Regular Reports: None 62.5% Daily 37.1% Weekly 6.4% Monthly 37.5% Quarterly 31.5% Annually 37.5%
Automatic Results download: Yes 43.8% No, plan to 25% No Plan 12.5%
Unsure 18.7%
Hours of training provided to staff on clinic software: mean 61.8 hrs median 1hr (Range 0- 500)
Funding allocated for clinic IT support in 2007: None 37.5% Unsure 56.3%
Yes 6.25% (Max $ 6000)
Funding allocated for IT support in next 3-5 yrs: None 100%

Discussion: Limitations of study: Small sample (100/355 clinics) and limited response rate (20%), the latter may indicate that issues of eHealth have not featured in the priority list of most clinics surveyed, as evident in the poor level of funding (> 90% none or unsure) and training (median 1hr for 2006) allocations. Others trends and issues include: low ratio of utility compared to the functionality of the softwares & technology available; competing interests of policy & privacy etc. will be discussed with recommendations proffered.
ANAL SEXUALLY TRANSMISSIBLE INFECTIONS AS RISK FACTORS FOR HIV SEROCONVERSION

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Objectives: Sexually transmitted infections (STIs) are believed to increase the risk of HIV acquisition, but few studies have focused on homosexual men. We examined sexual behaviour and common STIs as independent risk factors for HIV seroconversion in a community-based cohort of homosexual men in Sydney.

Methods: Between 2001 and 2004, 1,427 initially HIV-negative men were enrolled. They were tested annually for HIV, for gonorrhoea and chlamydia in the urethra and anus (strand displacement amplification, BDProbeTec), and for herpes simplex virus types 1 and 2 (HSV-1 and HSV-2) using type specific ELISA. Participants also reported diagnoses of STIs since their last interview. Detailed information on sexual risk behaviours was collected every 6 months.

Results: There were 49 HIV seroconversions through 2006, an incidence of 0.80 per 100PY. A higher number of episodes of insertive and receptive unprotected anal intercourse (UAI) with HIV positive or HIV status unknown partners was each significantly associated with HIV seroconversion. In multivariate analysis of behavioural risk factors, HIV seroconversion was significantly associated with a higher number of episodes of receptive UAI with a partner of unknown HIV status (p trend<0.001) or with a partner known to be HIV positive (p trend<0.001). After controlling for these sexual behaviours, a study diagnosis of anal gonorrhoea remained strongly related to HIV seroconversion (RR=7.41, 95% CI 1.75-31.75). Most cases of anal gonorrhoea diagnosed were asymptomatic. In addition, there was an independent association with anal warts (RR=3.43, 95% CI 1.43-8.19), and prevalent HSV-1 infection was of borderline significance (RR=2.78, 95% CI 0.99-7.80).

Conclusion: Certain anal STIs were associated with HIV seroconversion, even after adjustment for UAI. For some anal conditions, in particular gonorrhoea, infection was frequently asymptomatic. Screening for anal STIs should be investigated as a potential HIV prevention intervention.
MORE THAN JUST ANAL SEX: THE POTENTIAL FOR STI TRANSMISSION AMONG MEN VISITING SEX ON PREMISES VENUES IN MELBOURNE

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Objective
Sex On Premises Venues (SOPVs), where men have sex with other men, provide an environment where the transmission of sexually transmitted infections (STIs) is potentially enhanced. However, the extent to which SOPVs contribute to STI transmission is unknown. This study aimed to obtain detailed data on the types of sexual practices and frequency of these practices among men who have sex with men (MSM) visiting SOPVs in Melbourne, Australia.

Methods
In a cross-sectional study, MSM visiting 6 Melbourne SOPVs between December 2006 and February 2007 were asked to complete an exit survey on the types of sexual practices and frequency of such practices they had engaged in at that visit. Of 447 men approached, 150 (34%) participated in the study.

Results
The median age of participants was 42.5 years (range 20-79). Among participants who engaged in receptive oral sex (66%) and insertive oral sex (75%), the median number of such acts reported by each man during the visit was 2 (range 1-10) and 2 (range 1-10) respectively. Eleven men (7%) reported receptive oral sex with ejaculation into their mouth with a median of 1 act (range 1-3) per man.

Among participants who engaged in receptive anal sex (19%) and insertive anal sex (38%), the median number of such acts per man during the visit was 1 (range 1-4) and 1 (range 1-8) respectively. Eleven men (7%) reported unprotected insertive anal sex with a median of 1 act (range 1-4) per man; 4 (3%) reported unprotected receptive sex.

A substantial number of men who did not report any anal sex engaged in practices potentially capable of transmitting infections. Notably, 44 men (29%) reported unprotected rubbing or touching of their penis (“nudging”) onto another man’s anus without actual anal penetration with a total of 71 other men (median 1 act per man, range 1-10). When specifically asked, 17 (39%) of these men reported that they had not engaged in “anal sex”. In addition, 32 men (21%) reported being the recipients of “nudging” with 40 other men. Fourteen (44%) of these men reported not having had any “anal sex”. Oro-anal sex, whether “active” or “passive”, was reported by 57 (38%) of men, while 84 (56%) men reported anal penetration using fingers, whether receptive or insertive.

A significant minority (11%) of men reported that their ability to have safe sex was compromised by the use of drugs or alcohol. Of note, 58 (39%) men reported having a regular male partner, with whom 23 (40%) had unprotected anal sex. And 13 (9%) reported having a regular female partner, with whom 10 (77%) reportedly had unprotected vaginal or anal sex.

Conclusions
The potential for STI transmission between men visiting Melbourne SOPVs and to their partners outside these venues is high. The contribution of what might be perceived as “safer” sex practices to the transmission of STIs among MSM may have been underrecognised.
CAN UNPROTECTED ANAL INTERCOURSE WITH REGULAR AND CASUAL PARTNERS EXPLAIN THE DIVERGING TRENDS IN HIV EPIDEMIC IN AUSTRALIA?

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Introduction: Worldwide, increases in unprotected anal intercourse have been linked to the resurgence in HIV and STI in gay men. We assessed whether changes in UAI within regular and casual relationships may explain the diverging trends in HIV in three Australian states - NSW, Victoria and Queensland.

Methods: We used the data from the annual cross-sectional Gay Community Periodic Surveys conducted annually in Sydney since 1996 and in Melbourne and Queensland since 1998. A short self-administered questionnaire asks about HIV serostatus, sexual health testing and behaviors relevant to HIV epidemic. We present time trends in seroconcordance and unprotected sex with regular and casual partners.

Results: Currently, about one third of gay men report being in monogamous regular relationships, and this proportion has been slowly increasing everywhere. The self-reported UAI with regular partners (UAIR) was highest among men in seroconcordant positive relationships, lower among seroconcordant negative partners and lowest in non seroconcordant relationships. From 1998 to 2006, the rates of UAIR consistently increased by 10% in all three states and in all relationships by serostatus. The rates of UAI with casual partners (UAIC) were historically highest in NSW. From a peak in 2001, UAIC rates have consistently declined in NSW, but continuing increases were observed in Victoria and Queensland. Higher rates of nondisclosure of HIV were also observed in the context of UAIC in the latter two states.

Conclusion: Changes in unprotected sex with casual partners may be responsible for the slowing of HIV epidemic in NSW. Sustained investment in policies and programs are important in achieving behaviour change.

RISK TAKING AND SAFER SEX PRACTICES IN CASUAL RELATIONSHIPS BETWEEN MEN

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Introduction: Universal condom use in casual sex is unlikely. We explored whether gay men lower the risk of HIV transmission during unprotected anal intercourse with casual partners (UAIC) by disclosing HIV serostatus and engaging in lower risk practices such as strategic positioning and/or withdrawal.

Methods: We used data from the annual cross-sectional Sydney Gay Community Periodic Survey. A short self-administered questionnaire collects information about HIV serostatus of the respondents, sexual practices with other men and other HIV-relevant behaviours. We present the prevalence of and time trends in disclosure of serostatus and the use of strategic positioning and withdrawal with casual partners.

Results: In 2006, 2568 men reported having had a casual partner in the 6 months before the survey. Disclosure was higher among men engaging in UAIC (68.4%) compared to those who always used condoms (49.7%). This relationship was more apparent amongst HIV-positive than negative men, of whom 83.5% and 63.9%, respectively, reported any disclosure. Over time, HIV-positive and negative men have increasingly reported disclosing to ‘all’ of their casual partners (p<.01). HIV-positive men were less likely to report insertive-only positioning during UAIC (8.9%) compared to HIV-negative men (39.2%), with no changes emerging since over time. Significant increases were also noted in the proportion of HIV-positive men reporting withdrawal during insertive-UAIC (p<.001) and HIV-negative men reporting withdrawal during receptive-UAIC (p<.001).

Conclusion: In the context of UAIC, gay men appear to be employing a range of risk-reduction strategies. Increasing levels of disclosure and/or practices such as strategic positioning and withdrawal demonstrate the complexity of gay men’s construction of, and engagement with, risk associated with HIV transmission. A more thorough understanding of these practices is essential for ongoing education and prevention.
WHAT DO ANAL CYTOLOGY RESULTS MEAN?

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Background
Between 1970 and 2000 in Australia, anal cancer rates have increased over fourfold. Furthermore, the prevalence rate of anal cancer in MSM is approximately 35 cases/100,000, comparable to that of cervical cancer in women prior to the introduction of the national cervical screening program. These observations have led to calls for the introduction of targeted anal cytological screening program for MSMs. Our study examined the effectiveness of anal cytological testing in detecting histologically proven high grade anal intraepithelial neoplasia (HGAIN, also known as AIN2 & 3).

Methods
A retrospective case note review of people attending an anal dysplasia clinic from July 2002 to May 2007 was performed. Cytological results of anal swabs were compared to results of biopsies obtained through high resolution anoscopy.

Results
436 anal cytological results were identified. Of these, 5% were unsatisfactory, 51% showed low grade changes and 44% showed high grade changes. 185 cases were then paired with corresponding histological results. Analysing the data from the perspective of diagnosing histologically proven HGAIN, anal swab cytological abnormalities revealed a sensitivity of 54% and specificity of 90% for the most recent cytological test and 83% and 39% respectively, when analysed according to most serious cytological result ever.

Conclusions
Our sensitivities of 54-83% and specificities of 39-90% are consistent with those found with cervical cytology, but emphasize the need for caution in their interpretation. However, before any anal cytological screening programs are introduced, it is important to also establish that treatment of any high grade anal dysplasia detected by such screening is of value in preventing progression to cancer.

TESTING FOR SEXUALLY TRANSMISSIBLE INFECTIONS AMONG GAY MEN IN SYDNEY, AUSTRALIA

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Introduction: Recently, rates of sexually transmissible infections (STIs) have been increasing among gay men in Australia and elsewhere. We explored trends in STI testing among gay men in Sydney.

Methods: We used behavioural data from the six-monthly Sydney Gay Community Periodic Survey (SGCPS). Men are recruited through gay community venues, clinics and events in Sydney. Since 2003 men were asked whether they had received the following tests in the previous year: Anal swab, throat swab, penile swab, urine sample, and blood test for STIs other than HIV. Men recruited from clinics were excluded from the following analyses.

Results: In 2006, 3,145 completed questionnaires were received from non-clinic sites, with 40.9% of respondents reporting having received an anal swab, 45.4% a throat swab, 34.6% a penile swab, 52.7% a urine sample, and 56.1% a blood test for STIs other than HIV. The majority (67.2%) reported at least one test for STIs, with 25.5% having received all five forms of STI test. Although there was no increase during 2003-2006 in having any STI tests, the proportion of men having received all five types of test increased. The largest increase was in the proportion reporting anal swabs: From 23.8% in 2003 to 40.9% in 2006. Among men reporting unprotected anal intercourse with casual partners (UAIC), as well as among men with more than ten casual partners in the previous six months, rates of STI testing were higher but the time trends were similar.

Conclusion: The majority of men report STI testing in the previous year, and this testing has become more comprehensive, with men receiving a broader range of STI tests over time. Men at higher risk for STIs tested at increased rates.
Trichomonas vaginalis (TV) diagnosis rates have decreased considerably in some countries during the last two decades. It is unclear why TV has decreased only in some countries. This study investigated the relationships between: 1) TV diagnosis rates among women attending the Melbourne Sexual Health Centre (MSHC), and among Pap smears screened by Victorian Cytology Services (VCS); 2) the use of nitroimidazoles in Australia and; 3) gonorrhoea notification data for Victoria to assess changes in sexual behaviour.

TV diagnosis rates among women attending MSHC rose from under 5% in the 1940’s, to 20% to 30% in the 1960’s and then declined 5% to 10% during the 1970’s. From 1980 onwards, TV diagnosis rates fell progressively to below 1% by 1991, with 0.1% in 2004. A similar pattern was seen in TV at VCS, but with lower absolute percentages. Metronidazole was introduced into Australia in 1961 and tinidazole in 1976 and by 1987 there were 400,000 nitroimidazole prescriptions per year. Pap smear screening in Victoria began in 1965, only including 20% of women per year (aged 15 to 69) by the mid 1980’s. Post 1980’s, screening rose until 2000, stabilising at 35% of women per year. Gonorrhoea notification rates peaked during times TV was experiencing its greatest falls.

The initial decline of TV seen in Victoria was associated with the introduction of effective antibiotics. The further decline to less than 1% was seen when Pap smear screening participation increased during the 1990’s.
WHAT WOMEN WANT WHEN FACED WITH AN UNPLANNED PREGNANCY

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Objective
To collect data in regards to:
- women's experience of/desire for emotional support and information when faced with an unplanned pregnancy;
- women's desire for counselling to support their decision-making, and the kind of counselling they want.

Methodology
- 6,593 women received an email invitation to complete the online survey.
- 2,003 responded.
- 1,022 had experienced an unplanned pregnancy, therefore qualifying.
- Participating women were of reproductive age, drawn nationally.
- Key findings published in November 2006.

Summary of results
- At any given time amongst a sample of women of reproductive age, just over half (51%) have experienced an unplanned pregnancy.
- 75% of women did not wish to speak to a counsellor before making a decision on how to proceed with an unplanned pregnancy.
- Parenting was the most (56%) and adoption the least (2%) popular choice for resolving an unplanned pregnancy.
- 81% of women said it was important that a pregnancy counsellor refer for all three options – abortion, adoption and parenting.

Conclusion
- Unplanned pregnancy is a key health issue for Australian women.
- While pregnancy counselling should be available to women, it would be mistaken to see it as desired or required in all circumstances and it should be regulated.
- There is a need for increased resources to be directed towards lowering contraceptive failure rates, and greater access to sexual health services.

PATTERNS OF CONTRACEPTIVE USE AFTER REPRODUCTIVE EVENTS: FINDINGS FROM THE AUSTRALIAN LONGITUDINAL STUDY OF WOMEN’S HEALTH

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This paper examines changes in young women's contraceptive use over nine years in relation to a range of reproductive life events using longitudinal data from the Australian Longitudinal Study on Women's Health (ALSWH).

Little previous research has examined changes in young women's contraceptive use after significant reproductive or health life events. Some research has examined the reasons that women might discontinue contraceptive use in general and there has been some work investigating contraceptive use after the birth of a child and after the termination of a pregnancy. However other events may also cause a woman to re-evaluate her contraception, for example, the diagnosis of an STD, or having an abnormal pap test.

The Australian Longitudinal Study on Women's Health is a broad-ranging project which examines relationships between many biological, physiological, social and lifestyle factors and women's physical health, emotional well-being, and use of and satisfaction with health services. Women were selected from the Medicare database which includes all citizens and permanent residents using stratified random sampling, with systematic over-sampling of women from rural and remote areas.

This paper presents data from 6,716 women who completed a self-report survey in 1996 when they were aged 18-23, and again in 1999, 2002 and 2005. Multinomial analysis is used to explore patterns of contraceptive use before and after events related to pregnancy and birth (pregnancy, live birth, miscarriage and termination of pregnancy) and health (diagnosis with a sexually-transmitted infection and abnormal Pap test) and the factors associated with changes in contraceptive use. The ALSWH provides an exciting opportunity to examine patterns of contraceptive use over time among women of reproductive age.
OUT OF THE SPOTLIGHT: AN AUDIT OF FIVE YEARS OF IMPLANON® USE IN QUEENSLAND

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The progestogen contraceptive implant –Implanon® was launched into the Australian marketplace in May 2001, with intense marketing and extensive training programs for doctors. However, negative media focused on removal problems and unexpected pregnancies, followed by increased medical indemnity requirements for providers, resulted in restricted access for Australian women as many GPs ceased providing insertions.

To date there is no published data on the use of this contraceptive implant in Australia. To identify trends in usage, continuation rates, side effects and acceptability of this method, a retrospective chart audit of clients attending Family Planning Queensland (FPQ) clinics for implant insertion and/or removal over a 5 year period was conducted. The audit examined 1800 implant users from the two busiest FPQ clinics, one in a regional setting.

Preliminary results from the audit indicate:-
• All age groups across the reproductive years are represented in the group.
• The major reason for removal is unacceptable bleeding patterns.
• Many women have the device removed because they no longer require contraception.
• There have been no pregnancies identified with implants.
• The last 2 years have seen significant numbers of women presenting for implant replacement, with these women providing valuable information on factors contributing to longer term acceptability of the method.

This presentation will provide an analysis of the audit findings, particularly in relation to duration of use and implications for client acceptability of this contraceptive method. The information about Implanon® use in a clinical setting will be used to make recommendations on improvements in the appropriate selection and counselling of women considering this contraceptive method.

VULVOVAGINAL CANDIDIASIS IN AUSTRALIA: LET’S TAKE A LOOK ‘DOWN UNDER’

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Objectives: To determine: 1) The accuracy in patient self-diagnosis and medical diagnosis of vulvovaginal candidiasis (VVC) in Western Australia; 2) The contributing factors for self-diagnosing rather than seeking a medical diagnosis.

Methods: A cross-sectional cohort community-based study, over a 13-month period, was conducted. All women wishing to purchase a topical antifungal product for their personal treatment of presumed VVC, from participating community pharmacies within a nominated division of general practice in Perth, Western Australia, were invited to participate in the study. Participants completed a detailed questionnaire prior to their immediate referral for evaluation and examination by an experienced medical practitioner, and underwent a range of laboratory tests to determine the cause of their symptoms. Chi-square testing for association was performed for univariate comparisons with that of culture proven VVC.

Results: Ninety-four symptomatic women aged between 19 to 79 years were recruited. Of the 88 women who completed all aspects of the study, 41 (47%) were confirmed to have VVC by culture. The remaining 47 (53%) women either had another infectious cause (10 [11%]: urinary tract infection [4]; bacterial vaginosis [2]; chlamydia [2]; or genital herpes [2]) or their symptoms were not secondary to an infection (37 [42%]). Sixty-three percent of presumptive diagnoses made by medical practitioners were concordant with laboratory proven VVC. The women avoided seeking medical advice for a number of reasons.

Conclusions: Over half of the study population self-diagnosed VVC incorrectly. The proportion of correct presumptive diagnoses made by medical practitioners was only slightly greater. Diagnosis based on presenting signs and symptoms alone could result in an incorrect diagnosis and a proportion of STIs being missed. Improving the management of VVC will be dependent on addressing factors influencing women’s reluctance to seek medical advice and in addressing the current diagnostic processes. Over-the-counter antifungals, whilst convenient, may well compromise women’s health.
MONITORING HIV TRANSMISSION AMONG MEN SEEN AT METROPOLITAN SEXUAL HEALTH CLINICS IN AUSTRALIA, 1996 – 2005

McDonald A and Kaldor JM, for the Collaborative Group on Sentinel Surveillance in Sexual Health Clinics, NCHECR, Sydney NSW 2010 Australia

National surveillance for newly diagnosed HIV infection indicates an increasing trend in Queensland, South Australia and Victoria but not in New South Wales. It was not clear if trends in newly diagnosed HIV infection were due to different patterns of HIV antibody testing. We report the pattern of HIV antibody testing among people seen through a network of sexual health clinics in Australia.

Six public metropolitan sexual health clinics (Sydney Sexual Health Centre (SSHC), South West Sexual Health Centre (SSWSHC), NSW; Brisbane Sexual Health Clinic (BSHC), Gold Coast Sexual Health Clinic (GCSHC), QLD; Clinic 275, SA; Melbourne Sexual Health Centre (MSHC), VIC) provide annual tabulations of the number of people seen, the number tested for HIV antibody, and the number with newly diagnosed HIV infection, broken down by sex, exposure category and testing history.

The number of men seen at the clinics ranged from 17,138 in 1996 to 19,184 in 2005. Among men seen, the percentage who were tested for HIV declined from 62% in 1996 to 50% in 2001 and increased to 56% in 2005. HIV prevalence remained stable in 1996 – 2005 at 0.5% and was highest at SSHC (0.7% - 1.1%) and among homosexually active men (1.8% in 1996 and 1.6% in 2005). The percentage of men retested within 12 months of a negative test increased from 41% in 1996 to 44% in 2005. At SSHC, retesting among homosexually active men declined from 56% in 1996 to 44% in 2001 and increased to 58% by 2005. At Clinic 275 and MSHC, 50-60% and around 50% of homosexually active men were retested in 1996 – 2005 and in 2004-2005, respectively. HIV infection was newly diagnosed in 0.4% (8) in 1996 and in 0.8% (26) in 2005.

While HIV antibody testing patterns vary between the clinics, incidence of newly diagnosed HIV infection has remained low.
MARCHISHA NZ: TOWARDS AN EVIDENCE BASE TO INFORM HIV PREVENTION INTERVENTIONS IN NEW ZEALANDS MIGRANT AFRICAN COMMUNITIES

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The second social group most affected by HIV in New Zealand is that of the migrant African communities. As is the case in many resource-rich countries, the number of new HIV diagnoses assumed to have occurred through heterosexual sex has now caught up with those new diagnoses assumed to have occurred through men who have sex with men (MSM). While there is good behavioural surveillance of HIV-related knowledge, attitudes and behaviour (KAB) in New Zealand’s MSM population (the GAPSS Surveys), there is very little data available on African migrant communities to provide an evidence base with which informed decisions can be made regarding HIV primary and secondary prevention interventions within these communities.

The Mayisha I and II Projects in the UK have been successful in developing community based research collaborations that have resulted in valuable HIV-related KAB data being obtained from their migrant African communities. Such a model of working is now being developed within New Zealand.

This paper reviews the UK Mayisha models and how such behavioural surveillance data is being utilised by HIV prevention stakeholders in the UK. It then describes how the model is being modified and developed within the New Zealand context.

AN INCREASE IN HIV CASES REPORTING HETEROSEXUAL EXPOSURE IN WESTERN AUSTRALIA

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Introduction:
In Australia, men who have sex with men (MSM) constitute the majority of newly diagnosed HIV cases. After a decline in the late 1990’s, several Australian states have reported increases in HIV mainly attributed to MSM. There has also been an increase in HIV in Western Australia (WA), however recently, a larger proportion have been attributed to people who acquired the infection through heterosexual contact.

Objective:
This paper describes the epidemiology of HIV in WA from 2000 to 2006, focusing on the increase in cases with heterosexual exposure.

Methods:
In WA, notification of HIV cases is mandatory for doctors and laboratories. Information collected includes basic demographics and probable exposure. Descriptive analysis was carried out on de-identified HIV notification data from 2000 to 2006.

Results:
An annual average of 49 HIV cases were notified in 2000-2004. However, in 2005 and 2006, this increased to 64 and 72 cases respectively. The increase was mainly among non-Aboriginal males and females reporting heterosexual contact. The number of non-Aboriginal males who reported heterosexual contact increased from an average of 9 cases in 2000-2004 to an average of 20 cases in 2005-2006. The number of non-Aboriginal female cases reporting heterosexual exposure increased from an average of seven cases in 2000-2004 to 9 and 14 cases notified in 2005 and 2006 respectively.

The majority of non-Aboriginal males reporting heterosexual exposure in 2005-2006 acquired their infection overseas (84%). Of these, 71% reported Asia as the place of acquisition.
Of the non-Aboriginal females reporting heterosexual exposure in 2005-2006, 52 % were acquired overseas.
The number of Aboriginal cases remained stable between 2000-2006 fluctuating between two and 11 cases and continued to be mainly heterosexually acquired within WA.

Conclusion
There has been an increase in the number of male and female HIV cases reporting heterosexual exposure in WA. A large proportion reported acquiring their infection overseas highlighting the need to raise awareness among people who travel, work in countries with high rates of HIV.
CIRCUMCISION AND RISK OF HIV SEROCONVERSION IN THE HIM COHORT OF HOMOSEXUAL MEN IN SYDNEY

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Objectives: We examined circumcision as a risk factor for HIV seroconversion in a community-based cohort of homosexual men in Sydney.

Methods: Between 2001 and 2004, 1,427 initially HIV-negative men were enrolled. Circumcision status was self-reported at baseline, and self-report was validated by clinical examination during study visits in a sub-sample of approximately 300 participants. All participants were tested annually for HIV and offered testing for other sexually transmitted infections (STIs). Detailed information on sexual risk behaviours was collected every 6 months.

Results: At baseline, 66% of participants reported being circumcised; mostly as infants. The proportion circumcised ranged from 83% in those aged 45 or more to only 50% in those aged less than 25 (P < 0.0001). There were 49 HIV seroconversions through 2006, an incidence of 0.80 per 100 person years (PY). Anorectal gonorrhoea and anal warts were independent risk factors for HIV infection. Overall, being circumcised was not related to HIV infection (relative risk (RR) 1.07, 95% CI 0.56-2.06). After controlling for non-concordant unprotected anal intercourse (UAI), anorectal STIs and age, there remained no association with circumcision (RR = 0.88, 95% CI 0.45-1.74). Only nine of the 49 seroconversions occurred among men who reported no receptive UAI, an incidence of 0.35 per 100PY. In this group, circumcision was also not associated with HIV seroconversion (RR = 0.99, 95% CI 0.25-3.96).

Conclusion: Overall, circumcision status was not associated with HIV seroconversion. In addition, analyses limited to those men who reported no receptive UAI, who are more likely to have been infected through insertive sex, suggest that circumcision may not reduce HIV risk even for insertive anal intercourse. Other preventive strategies are required to reduce HIV incidence in homosexual men.

PILOT OF NON-INVASIVE (ORAL FLUID) TESTING FOR HIV WITHIN A COMMUNITY SETTING

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An anonymous HIV surveillance study was conducted to determine the prevalence of HIV amongst patrons attending gay recreational venues, the level of undiagnosed HIV infection and to identify sexual risk behaviour associated with HIV positive, HIV negative and unknown serostatus.

427 men who have sex with men were recruited over a period of one week in various sex on premises venues and gay bars within the inner city of Brisbane. Oral fluid testing for HIV antibodies was undertaken using the Orasure collection system and assay. Each participant was invited to complete a brief behaviour questionnaire and submit an oral fluid specimen. Participants were also asked their HIV status. Surveys and specimens were linked using an anonymous numerical code. Surveys were analysed using Epi-Info. Oral swabs were tested for the presence of HIV antibodies and any reactive specimens were confirmed using an Orasure western Blot. Confirmed serology results were linked to reported sexual behaviours, testing patterns and HIV status. The results of this study – sexual and testing behaviour correlated with serostatus- and implications for HIV prevention programs will be presented. As well as that, discussions will be held regarding the community response to the project.
AUSTRALASIAN SEXUAL HEALTH CONFERENCE 2007
“VENUS & MARS AT JUPITERS”

Monday 8 – Wednesday 10 October 2007
CONRAD JUPITERS, GOLD COAST, QUEENSLAND, AUSTRALIA

ORAL PRESENTATION ABSTRACTS
TUESDAY 9 OCTOBER 2007
MEASURING TRENDS IN STI SYNDROME AETIOLOGIES AND ANTIBIOTIC RESISTANCE PATTERNS: THE SOUTH AFRICAN EXPERIENCE

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The World Health Organization’s Global strategy for the prevention and control of sexually transmitted infections (STIs): 2006–2015 highlighted the need for STI surveillance as a cornerstone for national programmes. Yet, in many countries of the world, little or no surveillance exists and, when it does, it is often clinical in nature. Much of the world’s resource-poor areas use the syndromic management approach, which includes a recommendation for periodic surveillance of antimicrobial resistance in Neisseria gonorrhoeae. It is also important to perform aetiological surveillance, to assess the common causes of the main STI syndromes, such as genital ulceration (GUS), male urethritis syndrome (MUS) and the vaginal discharge syndrome (VDS). This allows observation of trends and ensures that the drugs used in the syndromic management flow chart as still valid.

South Africa started to build a national microbiological and clinical surveillance programme in 2004. Prior to that, microbiological data came from surveillance among particular core groups, such as miners, that could not be extrapolated to the general population. 30 sentinel sites (primary healthcare facilities) were set up in each of the country’s nine provinces for the purpose of enhanced clinical surveillance. Data were collected on all the main syndromes in terms of episodes per year. At the same time, microbiological surveillance was initiated in the following provinces: the Northern Cape, Mpumalanga, the Western Cape and Gauteng. Plans are to conduct further surveillance in the Free State and possibly the Eastern Cape later in 2007.

Within each province, one primary health care facility was chosen on the criteria of a large STO caseload and proximity to the laboratory doing the initial culturing of N. gonorrhoeae. Consecutive patients were recruited using informed consent and anonymous specimens collected. Patients were treated syndromically in the normal manner according to national STI management guidelines. Gonococcal isolates, obtained from men with urethral discharge, were tested for ciprofloxacin and ceftriaxone resistance using E tests. In addition, swabs were collected from MUS patients and VDS patients for multiplex polymerase chain reaction (M-PCR) based testing for the following four pathogens: N. gonorrhoeae, Chlamydia trachomatis, Trichomonas vaginalis and Mycoplasma genitalium. Ulcer swabs were also tested by M-PCR for herpes simplex virus (HSV), Haemophilus ducreyi and Treponema pallidum. A separate PCR was used to test the extracted DNA for C. trachomatis L1-L3. Serum was taken from all participants and tested for syphilis (RPR plus TPPA), HSV-2 and HIV antibodies.

Key findings have confirmed the decline of chancroid to below 1% of genital ulcers and the predominance of genital herpes as the major cause of genital ulceration in South Africa. Gonorrhoea continues to be the major cause of urethritis in men and prevalence far exceeds Chlamydial infection. Approximately 10% of men with MUS are also infected/colonized with T. vaginalis. Only about one third of VDS cases appear to be caused by sexually transmitted pathogens. HIV infection rates exceed those recorded in the annual antenatal surveys and are highest among genital ulcer patients (70%). RPR seropositivity in non-ulcer patients is around 5% and antibodies to HSV-2 occur in about 50-60% of patients overall. The surveillance has also demonstrated alarming rises in the prevalence of ciprofloxacin resistant gonorrhoea since 2004.
TITLE TBC
Ballard R
Centers for Disease Control & Prevention, USA
This paper will describe the sexual function of postmenopausal women in their seventh decade and contrast this with their sexual function some 13 years earlier when the women were premenopausal.

The presentation uses data obtained in the Melbourne Women's Midlife Health project, a longitudinal population-based study of women's health. Australian-born women aged 45-55 and resident in Melbourne were eligible for the initial telephone interview. All those who were still menstruating and not taking the oral contraceptive pill were invited to take part in a longitudinal study.

At follow-up, a similar proportion of the women had a sexual partner at mean ages of 51 (81%) and 63 (83%). A marked decline in sexual function was evident. The percentage of partnered women who became sexually inactive increased from 17 to 23%, the percentage who had sex less than once a week increased from 15% to 42%, while the percentage having sex more than once a week declined from 20% to 4%.

The overall score on the SPEQ significantly declined but only 19% of these women were significantly distressed about this. When specific domains of sexual function were examined, women using hormone therapy at L13 have significantly higher libido and greater responsiveness (Sexual Response) than postmenopausal women not using HT. There was no significant difference with respect to dyspareunia, frequency of intercourse, partner problems or partner feelings. Sexual Response was significantly affected by prior function, feelings for partner, change in partnership, estradiol level and mood as well as aging. The circulating level of estradiol is highly significantly linked to Sexual Response. Thus both chronologic and reproductive aging have negative effects on sexual function and estradiol therapy may be needed.

Sexuality in older adults especially the sexual behavior of older women has been shrouded in discreet silence distaste and ignorance (Oppenheimer, 2002). Recent literature however has demythologised sexuality and revealed that men and women continue to be sexually active well into old age. A recent study from US reported in the New England Journal of Medicine (Lindau et al, 2007) reports that 73% of those 57-64 age, 53% of those 65-74 years of age and 26% of those 74-85 years of age reported to being sexually active (defined as any mutually voluntary activity with another person that involves sexual contact, whether or not intercourse or orgasm occurs). In all groups, sexual activity for men was higher. It is interesting that 35% of all women and 13% of all men interviewed said “sex was not at all important” It is recognized that leading an active and fulfilling sexual life is related to physical health, ability to function sexually, availability of a partner and perceptions of self esteem and body image (Lindau, 2007, Clarke, 2006). Overlying all of these is the personal knowledge, attitude and perceptions of the role of sexuality and sexual behaviors in wellbeing.

With the ‘Baby Boomer’ generation coming of age as ‘Older Adults’, this presentation will explore whether the discourses of positive ageing have created the sexy ageless consumer as a personally and socially responsible citizen. Is the availability and apparent popularity of adult on-line dating for relationships; gyms and health fads for the healthy body; drugs and devices (sex toys such as the Eros clitoral device, and ben-wa balls); cosmetic treatments (Clarke, 2006) and now surgical procedures for the body beautiful (Goodman et al, 2007) indicative of a need for assistance in sexuality? Or a use of the ‘Baby Boomer’ demographic bulge in the population as a marketing target?

References:
INNOVATION AND DESIGN: IMPROVING CONTACT TRACING IN SEXUAL HEALTH CLINICS

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Contact tracing (CT) is an integral part of sexually transmitted infection (STI) management. Although routinely conducted in most sexual health clinics (SHCs), the methods used may vary. To improve CT required novel approaches.

First we audited the outcomes of current contact tracing methods. A major finding of this audit was that while CT was routinely recommended, outcomes were poorly recorded. We developed a sticker to be placed in the charts of clients with a traceable STI. This indicated the number of contacts requiring notification, and how many had been notified and treated at our clinic. This enabled a standardised approach to CT records and improved ability to audit outcomes. It also focused clinicians on the need to ensure follow up of CT and to offer assistance when CT had not been done.

Next, a brochure was developed to give to clients when diagnosed with a traceable STI. This brochure mentioned the reasons for contacting partners, dispelled some myths that have been found in previous studies about telling partners and provided ideas about how to tell partners.

In conjunction with this a SMS was developed, that could be sent to index cases’ mobile phones, allowing them to forward the SMS to partners. This was seen as an ideal method for young people who frequently had mobile numbers of past partners but little other contact details. It was also able to be simple and quick.

The next step will be reauditing the CT outcomes once the SMS and brochure are in established use.

A CASE REPORT: PLASMA CELL VULVITIS TREATED WITH TOPICAL MISOPROSTOL

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Introduction:
Plasma cell vulvitis (PCV) is an uncommon, benign, chronic, inflammatory disorder of the vulva, characterised by erythematous, erosive lesions, often resulting in pain, irritation, dyspareunia and discharge. The aetiology is thought to be autoimmune and coexisting systemic autoimmune disease is common. Treatment can be difficult and usual first line therapy is topical corticosteroid, but other immunosuppressive agents and topical antibiotics are used. What little is published on this condition often concerns cases that have not responded to conventional therapy. This is the second report of topical misoprostol used for treatment of refractory PCV.

History:
A 36 year old woman presented in 2005 with superficial dyspareunia, vulval itch and non-healing vulval erosions. She has Crohn’s disease, mostly confined to the small bowel, managed with methotrexate and mesalazine. Examination revealed three tender, well defined, erythematous, eroded areas distributed in a ring-like pattern around the vestibule and histopathology from the edge of a lesion favoured PCV.

Management:
Treatment with topical Diprosone OV ointment and 1% clotrimazole cream twice daily led to initial reduction in discomfort and partial healing of erosions, but response was short lived and she relapsed despite continued treatment. Topical clindamycin 2% cream was added to this regimen and again she initially improved, but response was partial and transient.

Based on a single report in the literature of successful treatment with topical misoprostol in 3 cases of refractory PCV, a trial of topically applied 0.01% misoprostol compounded in white petrolatum was begun. Four weeks after starting treatment she reported marked improvement in symptoms and lesions had almost healed. Follow up is continuing.

Conclusion:
Topical misoprostol is a potential treatment option for PCV refractory to other therapy.
TREPONEMA PALLIDUM PCR APPLICATION AND DIAGNOSTIC VALUE IN 2 CASES OF PRIMARY SYPHILIS

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Epidemics of infectious syphilis have been ongoing in large cities in industrialised countries since the turn of the millennium. These epidemics have almost exclusively involved homosexually active men, with a disproportionately high rate among HIV infected individuals. Genital ulcerative disease, including syphilis, has a strong correlation with onward transmission of viral and bacterial sexually transmitted infections.

Due to the lack of a culture system for Treponema pallidum, the causative organism of syphilis, other direct test methods are needed in the evaluation of skin lesions possibly due to syphilis. Dark ground microscopy was once commonly used by sexual health clinicians, but skills in this method have waned in recent years. Polymerase chain reaction (PCR) assays are being increasingly used in the diagnosis of infectious syphilis.

We describe the use of a nucleic acid amplification assay for Treponema pallidum, which targets the 47 kilodalton gene, in the diagnosis of primary syphilis in 2 patients with genital lesions. The first patient was an HIV infected man who presented with an ulcer typical of a chancre but who denied any recent risk behaviour. The second was an HIV negative homosexually active man with an atypical genital lesion. In both cases, Treponema pallidum PCR was positive and serology was consistent with the diagnosis of primary syphilis.

Conclusion/Recommendation:
Appropriately validated Treponema pallidum nucleic acid amplification assays could replace dark ground microscopy and direct fluorescent antigen tests as a direct test for early infectious syphilis. It could be particularly useful in individuals who have treponemal skin lesions of atypical appearance.

SYPHILIS SCREENING PROFILE AT SEXUAL HEALTH CLINIC, ST GEORGE HOSPITAL & SUTHERLAND HOSPITAL

Tran H, Konecny P, Carmody C

A retrospective analysis was conducted to describe the cases of Syphilis identified and managed at Short Street Centre and The Sutherland Sexual Health Centre, in South Eastern Sydney and Illawarra Area, from January 2000 to June 2007. Syphilis serology is routinely offered as part of an STI screen to new and follow-up patients as appropriate. Information on the diagnoses, demographic and other variables was extracted from the clinical database Sexual Health Information Program (SHIP) and analysed in SPSS v11. Information on age, gender, relationship status, country of birth, presenting symptoms, stage of Syphilis, type of treatment and subsequent RPR levels were confirmed from patient records. An analysis of the relative frequency of the stages of Syphilis from over 130 patients will be presented and their relationship to a number of demographic and behavioural factors.
THE MANAGEMENT OF MEN WITH ACUTE CHLAMYDIA-NEGATIVE NON-GONOCOCCAL URETHRITIS: A LACK OF CONSENSUS AMONG AUSTRALIAN SEXUAL HEALTH PHYSICIANS

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Objective
In clinical practice, chlamydia-negative non-gonococcal urethritis (NGU) is a common but poorly understood condition. The purpose of this study was to determine how Australian sexual health physicians manage men with this condition.

Methods
In July 2006, a survey was mailed to all members of the Australasian Chapter of Sexual Health Medicine.

Results
Of 166 surveys mailed out, 111 (67%) were returned completed. The majority of sexual health physicians (73%, n=81) indicated that they believed that female partners of men with acute chlamydia-negative NGU were at risk of adverse reproductive health outcomes. However, only 19% (n=21) routinely tested men with acute NGU for pathogens other than Neisseria gonorrhoeae and Chlamydia trachomatis. Most commonly, this was for M. genitalium (n=16). While 68% of respondents believed that M. genitalium was a cause of acute NGU, only 27% had access to testing for this organism. Other pathogens that were sometimes tested for included herpes simplex virus, Trichomonas vaginalis and adenovirus. Over half of sexual health physicians indicated that they would usually initiate notification of female sexual partners of men presenting with acute NGU, even before confirmatory test results were available.

Conclusion
There are substantial differences in how acute, chlamydia-negative NGU is managed by Australian sexual health physicians. In part, these may relate to differences in beliefs around which pathogens are responsible for this condition and the availability of testing for particular pathogens. Notification of female partners is commonplace, even though the underlying cause of urethritis in affected men appears to be poorly defined.
AUSTRALASIAN SEXUAL HEALTH CONFERENCE 2007
"VENUS & MARS AT JUPITERS"

Monday 8 – Wednesday 10 October 2007
CONRAD JUPITERS, GOLD COAST, QUEENSLAND, AUSTRALIA

ORAL PRESENTATION ABSTRACTS
WEDNESDAY 10 OCTOBER 2007
The Australian Women's Health Survey: Assessing the Psychosocial Burden of HPV Related Illness and Preventive Interventions

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There is increasing recognition of the psychosocial impact of cervical cytology screening programs as well as of the treatment of screening-detected human papillomavirus (HPV) - related disease. The HPV Impact Profile (HIP) includes 29 items with standard response categories representing nine psychosocial impact domains: "worries and concerns, emotional impact, sexual impact, self image, health perception, cognition, partner and social relations, interaction with doctors and sleep." Higher scores (0–100) are associated with higher disease burden. The HIP and other generic quality of life instruments such as the Sheehan Disability Scale were administered to women who had experienced and were aware of an HPV related diagnosis in the past 3 months (total N= 333): 103 women with normal Pap test results (N. Pap), 111 with abnormal Pap tests (58 low grade squamous intraepithelial lesions (LSIL) and 53 high grade SIL (HSIL)), 80 women with biopsy confirmed cervical intraepithelial neoplasia (CIN) (36 CIN1 and 44 CIN 2/3) and 39 women with external genital warts (EGW). In univariate analysis, estimated HIP scores (95% CI) were lower for N.Pap than for all other groups (p<0.0001). N. Pap: 25.8 (22.6–29.0); LSIL: 38.8 (34.6–43.1); HSIL: 41.7 (37.2–46.2); CIN1: 41.7 (36.3–47.1); CIN 2/3: 46.6 (41.6–51.5) (p=0.013 vs LSIL); EGW: 44.6 (39.4–49.8). The effect was maintained after adjusting for age, race and occupation. On the Sheehan scale, CIN 2/3 and EGW demonstrated increased interference with work and social activities. Results demonstrate: a) HPV infection and disease are associated with significantly increased psychosocial...
burden, beyond that of the Pap test experience; b) The HIP instrument can adequately distinguish between different HPV conditions; c) Despite their non life threatening nature, the psychosocial impact of genital warts is similar to that of potentially life threatening high grade cervical lesions.

GENITAL WARTS AND ASSOCIATED HEALTH CARE USE IN GENERAL PRACTICE IN AUSTRALIA

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The introduction of the quadrivalent vaccine (HPV types 6, 11, 16, 18), GARDASIL, in the National HPV Vaccination program has the potential to eliminate a substantial proportion of the health burden of external genital warts (EGW), currently the most common sexually transmitted viral disease in Australia. Approximately 60% of cases of EGW are managed in general practice. In this study both new and existing EGW cases were identified in the BEACH (Bettering the Evaluation and Care of Health) database from April 2000 – September 2006. Extrapolating to the Australian population, there are approximately 34,000 new cases of EGW each year managed through general practice, accounting for 96,000 GP visits. Incidence extrapolated from new cases showed a peak in females in the age groups 15 – 19 and 20 – 24 years (5.6 and 6.6 per 1,000 annually respectively) and a later peak in males in the age group 20 – 24 and 25 – 29 years (4.8 and 5.7 per 1,000 respectively). Ablative therapies were the most common form of treatment applied at 33 – 40% visits for females and 30 – 64% visits for males (new and repeat visits respectively). Topical medications were prescribed in ~ 14% of cases. Assigning average costs, the direct health care costs, including GP visits, medications, other treatments and referrals, are at least ~ $290 per case.

This study confirms the considerable individual and clinical burden of this common disease.

CAPITALISING ON THE UNIQUE OPPORTUNITY OF THE HPV VACCINE, FOR A CERVICAL SCREENING PROGRAM

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The medical advancement of the human papilloma virus (HPV) vaccine and it’s swift addition to the National Immunisation Program, caused a sudden surge in the public’s awareness and interest in HPV. The challenge for PapScreen Victoria, a state based cervical screening program, was to react quickly and strategically to ensure that this new knowledge did not prevent women from having Pap tests.

PapScreen pre-empted that the vaccine would have a huge impact on the current program, and undertook an educational journey to identify issues. The program sought expert opinions, formulated new partnerships in the immunisation sector and examined the current research.

The program identified that its role was to inform women about HPV and the importance to continue screening in this new era of HPV vaccination. In the prevention of cervical cancer, there was also a role to inform health professionals, parents and young women about the benefits of the vaccine. The challenge was capitalising on the unique opportunity that the vaccine created.

Developing and implementing strategies quickly was paramount in the program’s success on capitalising this interest. Across three main areas - community, communications and research - the program implemented a range of strategies, including new resources, media opportunities, formative research and education, among others. PapScreen’s aim was to remain the prime source of information for the prevention of cervical cancer in Victoria.

The success of these strategies has been profound and immunisation messages are now included in all program messages across a range of sectors. The program was able to capitalise on this unique occasion by being flexible, proactive and strategically adaptable to the public health environment.
AUSTRALIAN LESBIAN AND BISEXUAL WOMEN’S KNOWLEDGE OF, AND ATTITUDES TOWARD, THE HUMAN PAPILLOMA VIRUS AND THE HPV VACCINE

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Lesbians and bisexual women are known to be at risk for sexual transmission of the human papilloma virus (HPV), and yet internationally have low levels of awareness of this risk and are less likely to access regular cervical screening. The level of awareness of HPV amongst this group of women is unknown in Australia. This study used a ‘self-reporting’ questionnaire, completed by over 300 lesbian and bisexual women and a comparison group of heterosexual women, to determine lesbian and bisexual women’s levels of knowledge about HPV and their attitudes toward the newly available HPV vaccine, compared to those of heterosexual women. Alongside this, a series of in-depth interviews with lesbian and bisexual women was used to explore their sources of knowledge about HPV and pap testing, and their preferred methods of receiving health promotion on this topic. The study confirmed the hypothesis that a high number of lesbians perceive female-to-female sex to be of low or no risk for HPV transmission. This has implications for lesbian and bisexual women’s attitudes toward the HPV vaccine, as they may consider it to be unnecessary for women not engaging in heterosexual sex. Despite low perceived risk, lesbian and bisexual women reported a similar rate of abnormal pap tests to heterosexual women. There were also equivalent or higher levels of risk factors for cervical abnormality amongst lesbian and bisexual women compared with heterosexual women, including smoking, infrequent Pap screening, lifetime history of sex with men, and infrequent use of safer sex. The study also revealed that mainstream sexual health promotion resources for women generally do not specifically address STI risk for female-to-female sex and are therefore often not seen by lesbians to be relevant to them. The need for more explicit sexual health promotion resources for lesbian and bisexual women was raised.

HIGH EFFICACY OF A HPV-16/18 L1 VIRUS-LIKE PARTICLE (VLP) VACCINE ADJUVANTED WITH AS04 AGAINST CIN2+ CAUSED BY HPV-16/18 INFECTION IN A BROAD POPULATION OF YOUNG WOMEN

Skinner SR¹, Garland SM², Denham I, O’Sullivan M, Waddell R, Mindel A³ on behalf of the HPV PATRICIA study group
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Objectives: Previous studies with the HPV-16/18 L1 VLP AS04 vaccine have shown 100% efficacy against HPV 16/18 associated persistent infection and CIN in women with no previous exposure to oncogenic HPV. This interim analysis of a phase III, randomized, controlled trial assessed vaccine efficacy against HPV 16/18 associated CIN2+ and persistent infection with oncogenic HPV types in a broad population of women.

Methods: Healthy women, aged 15-25 years, with ≤6 sexual partners and no previous colposcopy were eligible and were randomly allocated to 3 doses of HPV or hepatitis A (control) vaccine at 0,1,6 months. Serum antibodies for HPV 16/18 were assessed by ELISA. HPV DNA was detected by PCR on cervical cytology and biopsy. Vaccine efficacy was assessed in women who received at least one vaccine dose, had normal or low-grade cytology and were HPV 16/18 sero- and DNA negative at entry. Additional analyses were undertaken to assign causality where multiple HPV types were present. Immunogenicity was evaluated in a subset of women and safety was assessed in the entire vaccinated cohort.

Results: 18729 women from Asia Pacific (34%), Europe (34%), North (16.5%) and Latin America (14.9%) were enrolled. 18525 were included in the cohort for vaccine efficacy analyses. Mean age was 20 years and mean follow up 15 months from dose 1. Most HPV 16/18 infections were detected prior to dose 3 in this analysis. Of 23 CIN2+ lesions associated with HPV 16/18, 14 contained multiple oncogenic HPV types: three showed no preceding infection or E4 gene expression for the relevant HPV vaccine type. Vaccine efficacy according to HPV DNA detected in the lesion was 90.4% (95% CI, 53.4-99.3); after additional analyses for causality assignment, efficacy was 100% (95% CI: 74.2-100). Cross-protection against 6-months infection with HPV-45, -31, -52; and broad protection against 12-month persistent non-16/18 oncogenic HPV infection was also demonstrated. Seroconversion was 99.5% after dose 2 and 3. Safety profiles were comparable between groups.

Conclusions: In a broad cohort of women, high vaccine efficacy was observed against CIN2+ caused by HPV-16/18.
Chlamydia 'Asteroids' (9.00am – 10.30am)

GENOTYPING OF UROGENITAL CHLAMYDIA TRACHOMATIS IN REGIONAL NEW SOUTH WALES, AUSTRALIA

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Background: Chlamydia Trachomatis is one of the most common sexually transmitted infections in Australia and world wide. This study was undertaken to map the frequency of Chlamydia genotypes in regional New South Wales (NSW), Australia, to explore the potential utility of genotype analysis in defining local sexual networks, and to investigate whether patterns of genotype frequency are correlated with demographic factors, including age and gender.

Methods: We studied 204 urine samples infected with Chlamydia trachomatis, as determined by PCR analysis using the COBAS Amplicor system. Samples were collected from wide geographic area of regional New South Wales (Hunter, New England, Northern Rivers, South Eastern New South Wales). Sequencing and genotyping were performed after nested PCR of the omp1 gene.

Results: Genotype E was found in 42.6% of infections, with genotypes F (23.5%) and G (16.7%) other common causes of infection. Mixed infection occurred in only 3 cases. There was no significant difference in genotype frequency based on gender or geographic location. There was a significant difference in gender frequency based on patient age, with older patients significantly more likely to demonstrate infection with genotype G (mean age (years) 23.7 +/- 7.29sd, E: 21.7 +/- 5.7 sd; G: 28.9; sd10.18; p=0.022).

Conclusions: There was no significant difference in genotype frequency in the various regions of New South Wales, suggesting genotype analysis is of limited use in defining sexual networks in regional NSW. The finding of a higher frequency of genotype G in older patients raises the possibility that genotypic variation may be driven by immune responses to genotypes that occur more frequently at a younger age. These results may have implications for the future design of a chlamydial vaccine.

TAKING THE SEX OUT OF STI SCREENING! VIEWS OF GPS AND YOUNG WOMEN ON IMPLEMENTING CHLAMYDIA SCREENING IN AUSTRALIA

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In-depth face to face interviews were carried out with a randomly selected sample of 20 General Practitioners (GPs) and 24 young women from across Victoria. We aimed to determine the attitudes of GPs and young women to chlamydia screening, what systems and education would be required to support chlamydia screening in general practice in Australia and in particular to explore how young women feel about being asked to test for chlamydia when they attend a GP for any reason.

Both GPs and young women accept age-based screening for chlamydia and screening during a sexual health related consultation in general practice. Both feel that a large scale public education program, encompassing the high prevalence of chlamydial infection in young people in Australia, the asymptomatic nature of infection and the potential consequences if untreated, will be essential in ensuring the success of a chlamydia screening program in Australia. For the women, trust in their GP, was a major factor in the acceptability of chlamydia screening. They also felt chlamydia screening should be offered to all young women rather than targeted at “high risk” women based on sexual history and they particularly emphasised the importance of normalising chlamydia screening. Women were clear that they did not want to be asked to provide a sexual history as part of being asked to have a chlamydia test. This finding has not been widely published in the literature and is worthy of comment. There is considerable evidence suggesting that GPs also regard sexual history really an important precursor to a chlamydia test? Our study suggests maybe not.
CHLAMYDIA SCREENING OF ANTENATAL WOMEN IN MELBOURNE BETWEEN 16-25 YEARS


Objective
Routine chlamydia screening of pregnant women is not widely practiced in Australia and limited data are available on the prevalence of infection in this population. This cross-sectional study sought to determine the prevalence of genital chlamydial infection among pregnant women aged 16-25 attending antenatal clinics in Melbourne.

Methods
Consecutive women attending 4 major maternity services covering northern, western, eastern and south-eastern Melbourne were approached between October 2006 and May 2007. Of 931 eligible women, 882 (95%) were approached and 845 (96%) agreed to participate. Participants completed a questionnaire which was translated into Chinese, Vietnamese and Arabic, and provided first-void urine which was tested for Chlamydia trachomatis using polymerase chain reaction.

Results
Eighteen percent of women had a preferred language other than English. Of the 826 tests which were non-assessable, 30 were positive representing a prevalence rate of 3.6% (95% CI: 2.5-5.1%). However, among women aged 16-20, 14 of 203 women were infected, representing a prevalence rate of 6.9% (95% CI: 3.8-11.3%). All infected women received treatment with azithromycin and all who had repeat chlamydia tests to date have been negative.

Conclusion
In this study of a wide cross-section of pregnant Melbourne women, chlamydial infection was common, particularly among teenagers. Screening was highly acceptable, with the great majority of women approached agreeing to be screened.

PATIENT DELIVERED PARTNER THERAPY FOR CHLAMYDIAL INFECTION: WHAT WOULD BE MISSED?

McNulty AM, Teh MF, Freedman EF.

The number of contacts of STIs who are tested and treated is generally low. Patient delivered partner therapy (PDPT) has been proposed in order to increase the number of sexual partners of the index case that are treated. PDPT does not require the contact to be clinically assessed and tested. We sought to determine whether PDPT for chlamydial infection would result in missed diagnoses of other STIs or of the complications of chlamydial infection.

The Sydney Sexual Health Centre database was accessed to identify patients who presented as contacts of chlamydia and chlamydia associated conditions and to determine whether other STIs were diagnosed at the time of presentation. Those who were contacts of more than one bacterial STI or HIV were excluded. In the 3 years from June 2003 to June 2006, 626 individuals presented as contacts of chlamydia, NGU or PID. Of these, 212 (34%) tested positive for Chlamydia trachomatis by PCR. Of the 442 heterosexual patients, 36% had chlamydial infection diagnosed. Of the 184 men who had sex with men (MSM), 29% had chlamydial infection diagnosed. Of the heterosexuals who presented as contacts, 13 were diagnosed with other bacterial STIs or complications of chlamydia. Of these, 2 women and 2 men had gonococcal infection (0.9%), 1 woman had syphils of unknown duration, 6 women (3%) were diagnosed with PID and 2 men (0.8%) with epididymitis. Of the MSM, 9 (5%), were newly diagnosed with HIV infection, 15 (8%) with gonococcal infection and none with syphilis.

PDPT would result in a missed opportunity to diagnose other STIs in MSM. In heterosexuals a small number of cases of PID and epididymitis would be inadequately treated and a small number of gonococcal infections would be missed.
THE RIGHT THING TO DO: PATIENTS’ VIEWS AND EXPERIENCES OF TELLING PARTNERS ABOUT CHLAMYDIA

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Partner notification for patients diagnosed with chlamydia is recommended to assist in controlling the increasing incidence of this often asymptomatic but treatable infection. Few studies, however, have ascertained the views on partner notification from those who are often expected to perform it – the individuals who have been diagnosed with chlamydia. As part of a larger combined qualitative-quantitative methods study of partner notification, 40 in-depth telephone interviews were conducted with people diagnosed with chlamydia from clinics in Victoria, ACT and Queensland. Reactions to chlamydia diagnosis, as well as reasons for, and feelings about, telling their sexual partners about this infection were explored. Common reactions to initial diagnosis were surprise, shock and shame, as well as relief about being able to put a name to symptoms. Many spoke of relief on learning the condition was treatable. Both men and women commonly saw partner notification as a social duty, and cited concerns about their own health and the health of others as a reason for telling partners and ex-partners about the diagnosis. An infrequent reason offered for partner notification was to confront a partner to clarify fidelity. Reasons for not contacting a partner were typically fear of reaction, or a lack of contact details. Although participants reported sexual partners exhibiting a variety of reactions when told of the diagnosis, results showed that for almost everyone, the experience of notifying their partner was better than they had expected. Views about taking antibiotics to the partner varied according to the currency of the relationship, with some feeling it could be offered as appeasement, and others feeling it might be seen as intrusive. Overall, the findings from this study suggest that partner notification by people diagnosed with chlamydia is achievable, with many of these results likely to be transferable to other settings.

GP PERSPECTIVES ON PARTNER NOTIFICATION FOR CHLAMYDIA

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As part of a larger, combined qualitative-quantitative study of partner notification, 40 semi-structured in-depth telephone interviews were conducted with General Practitioners (GPs), from Victoria, ACT and Queensland, who had diagnosed at least one case of chlamydia in the last year. Rural doctors and those who had experience working with Aboriginal patients were over-sampled to ensure their views were represented in the study. The interviews explored GPs’ current practices with regard to partner notification for chlamydia, barriers they perceived to partner notification for chlamydia in the general practice setting and what resources/incentives they felt would improve partner notification for chlamydia. The GPs in our study primarily ask the index patient to carry out partner notification themselves. It was relatively rare for GPs to have experience of notifying partners on the patient’s behalf. Half of the GPs report that they only encourage notification of the patient’s current/immediate past partners. There was considerable confusion amongst the GPs interviewed as to the role of government partner notification officers. Many thought that support from a government agency would allow partner notification to occur more effectively. Some were under the impression that this process is automatically activated when they “notify” that they have diagnosed someone with chlamydia. Some of the main barriers perceived include confusion about issues of privacy and confidentiality with regard to partner notification and the sense that there is a lack of clarity as to what is expected of them in terms of partner notification for chlamydia. Most GPs feel that access to decision support tools and clear guidelines would be helpful. Financial incentives for doing partner notification were seen as particularly important to fund allied health workers’ time rather than to pay GPs themselves e.g. for practice nurses and Aboriginal health workers. GPs were enthusiastic about computer based resources to aid in partner notification.
SEXYUAL COMPETENCE AT FIRST SEXUAL INTERCOURSE: FACTORS ASSOCIATED WITH SEXUAL COMPETENCE IN A SAMPLE OF NEW ZEALAND TERTIARY STUDENTS

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It has been proposed that the manner in which people experience their first sexual intercourse has implications for the development of subsequent sexual health. Sexual competence, as utilized by the UK NATSAL 2000 Study, was defined as being willing and autonomous, lacking regret, not being intoxicated, and using a reliable method of contraception.

This study explored the construct in an opportunistic sample of 247 students at Otago University and Otago Polytechnic in 2006. Participants were aged between 17 and 21, and completed a self-report questionnaire. Data suggested that, of the 85% who reported having had sexual intercourse, the mean age of first sex was 16 years old. Seventy percent had not decided to have sex or discussed its occurrence with their partners prior to the event. Sexually competent first sexual intercourse was more likely with females than males, was more likely to occur the older they were at the time, was associated with more positive affective responses, and was associated with higher levels of sexual and emotional satisfaction.

The manner in which sexual competence at first sexual intercourse was associated with subsequent sexual satisfaction and sexual health will be explored.

The implications of these findings will also be discussed in terms of how sexual health promotion interventions should be developed, with particular focus on the age and circumstances under which young adults first experience sexual relationships.

A FEMINIST EXPLORATION OF WOMEN’S EXPERIENCES OF HAVING A SEXUALLY TRANSMITTED INFECTION

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Background and Objectives: Sexually transmitted infections (STIs) affect millions of people worldwide and are capable of causing significant physical and psychological harm to individuals and communities. Although STIs can affect any sexually active individual they have more severe consequences for women compared to men, and are capable of causing infant death, infertility, and reproductive cancer. Despite the increasing prevalence of STIs, issues associated with the mental health consequences of these infections remain largely unexplored. However the negative impact on self-esteem and the stigma associated with STIs have been identified as important factors affecting the psychological wellbeing of individuals. This study aims to explore women’s experiences and perceptions of having an STI from a feminist perspective. This paper will present initial findings.

Methodology: This study utilised a feminist methodology. Data was obtained through qualitative open-ended interviews with the women participants either in person or online and all data was subjected to feminist narrative analysis.

Results and Conclusion: Data collection and analysis is in progress at the time of abstract submission. It is anticipated that preliminary results will be presented at this sexual health conference. Initial analysis has revealed that stigma, condom negotiation, self-blame, and acceptance/empowerment are major themes within the women participants’ stories. This research will contribute to the existing body of literature and provide information to facilitate appropriate care provided by healthcare personnel through gaining insights and understanding into the needs of these women.
DOES CIRCUMCISION MAKE A DIFFERENCE TO THE SEXUAL EXPERIENCE OF GAY MEN? FINDINGS FROM THE HEALTH IN MEN (HIM) COHORT

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The relevance of circumcision in preventing HIV male-to-male sex transmission is poorly understood, in particular because any potential effect could be obscured by sexual practice as a mediating or confounding factor.

Using data from the Health in Men (HIM) cohort of 1,426 HIV-negative homosexually active men in Sydney, we compared the sexual practices and sexual experiences of circumcised and uncircumcised men.

Overall 66% of men (n=939) in the cohort were circumcised. After adjusting for age and ethnicity, we found no difference between circumcised and uncircumcised men in anal sexual practices, difficulty using condoms, or sexual difficulties (e.g. loss of libido). Among the circumcised men, we compared those circumcised at infancy (n=854) with those circumcised after infancy (n=81). The majority cited phimosis (i.e., an inability to fully retract the foreskin) and parents’ decision as the main reasons for circumcision after infancy. After adjusting for age and ethnicity, men circumcised after infancy were more likely to practice receptive anal sex (88% versus 75%, p<.05) and to experience premature ejaculation (15% versus 23%, p<.05) than those circumcised at infancy.

Our data suggest that overall circumcision status does not affect HIV-negative gay men’s anal sexual practices, experience of condom use or likelihood of sexual difficulties. However, there is some suggestion of differences between circumcised men depending on the age at circumcision.

CIRCUMCISION STATUS AND RISK OF SEXUALLY TRANSMITTED INFECTIONS IN THE HIM COHORT OF HOMOSEXUAL MEN IN SYDNEY, AUSTRALIA

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1National Centre in HIV Epidemiology and Clinical Research, University of New South Wales; 2Sexual Health Service, Sydney South Area Health Service; 3Sydney Sexual Health Centre, Sydney Hospital, Sydney; 4National Centre in HIV Social Research, University of New South Wales

Objectives: To examine circumcision status as an independent risk factor for prevalent and incident sexually transmitted infections (STIs) in the community-based Health in Men (HIM) cohort of homosexual men.

Methods: Between 2001 and 2004, 1,427 initially HIV-negative men were enrolled. Circumcision status was self-reported at baseline and was validated by clinical examination in a sub-sample of participants. All participants were tested annually for HIV and offered testing for other STIs including nucleic acid amplification tests (NAAT) for urethral gonorrhoea and chlamydia, and serology for syphilis and herpes simplex virus (HSV). Demographic information and past history of STIs was collected at baseline and detailed information on sexual risk behaviours was collected every 6 months. At annual face-to-face visits, participants reported diagnoses of STIs made in the previous 12 months.

Results: At baseline, 66% of participants reported being circumcised; mostly as infants. Uptake of STI testing was high with over 90% of participants tested each year. On multivariate analysis, controlling for age and sexual risk behaviour, circumcision was not associated with baseline seropositivity to syphilis (p=0.34), HSV1 (p=0.33) or HSV2 (p=0.92), nor with a history of self-reported genital warts (p=0.18). There was also no association with incident bacterial urethral infections (p=0.67 & p=0.89 for gonorrhoea and chlamydia, respectively), self-reported incident genital warts (p=0.35), incident HSV1 (p=0.70) or incident HSV2 (p=0.36). However, circumcision was associated with a significantly reduced risk of incident syphilis after controlling for age, number of casual partners in the previous 6 months and unprotected anal intercourse according to partners’ HIV status (HR=0.35, 95% CI 0.14-0.87, p=0.024).

Conclusion: Circumcised men had a reduced risk of incident syphilis in this cohort. Although most STIs were not associated with circumcision, these data suggest that circumcision may have an effect on syphilis acquisition in homosexual men.
MÉNAGE A TRIOS: SEXUAL HEALTH, SEXUAL ASSAULT AND FORENSIC MEDICINE

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Objectives: Small jurisdictions often require clinicians to work in more than one speciality. The aim of this paper is to explore the commonalities between sexual health, sexual assault and forensic medicine that make this possible.

Methods: Exploration of (1) common attributes of clinicians who provide these services, (2) characteristics the client groups, (3) administrative aspects and (4) gains for participating clinicians.

Results: Clinicians in all three specialties practice within a public health model of care, have a good understanding of confidentiality, sexual wellbeing, other intimate concerns and social justice issues. They have experience working with non-medical groups and are experienced in teaching students and non-clinicians.

Clients attending all three of services are commonly victims, vulnerable, marginalised, poor and less able to access traditional medical services. They commonly exhibit high-risk behaviours pertaining to sex and drug and alcohol use.

Administrative systems commonly found in sexual health centres such as independently held and secured files and coded filing systems and protocols and practices concerning confidentiality and appropriate interactions with other services allow clinical forensic medicine to be easily incorporated.

Clinicians gain from participating in these services by refreshing and developing specialist skills in the management of simple injuries, acute drug and alcohol withdrawal and in the law (forensic evidence collection, minors and custody issues).

Conclusions: The similarities between the practise of sexual health, sexual assault and forensic medicine make the transition between the specialties smooth and relatively easy. Indeed the practice of one enhances the other two for clients and clinicians alike.

HIPPOCRATES APPRENTICES ON EARTH: MEDICAL STUDENTS EXPERIENCES AND CONSENT FOR VAGINAL EXAMINATIONS OF ANAESTHETISED PATIENTS.

Broadmore J A1, Hutton J D1, Langdana F1, Parkin C J F1
1Department of Obstetrics and Gynaecology, School of Medicine and Health Sciences (SM&HS), University of Otago (OU), Wellington, PO Box 7343, Wellington 6242, New Zealand.

Vaginal examinations (VEs) are an essential sexual health examination skill. Reports of students having difficulties getting experience with VEs are matched by reports of patients being examined without consent.

This study prospectively researched what happens when medical students seek consent for VEs of anaesthetised patients.

There was a 78% student response rate from the 66 2005 5th year medical students at WSM&HS, OU to a 19 item questionnaire about their experience at gynaecology operating sessions. Chi-squared test determined result significance.

141/184 patients were asked if the student could attend the operation. Consultants asked on the student’s behalf for male more than female students (p>0.0010). Male students asked patients within 2 hours of operations. Some female students asked 5 or more hours beforehand; a significant gender difference (p>0.0001).

Four patients declined student attendance at their operation.

When asked 99/114 patients (86.8% SD 3.4%) gave permission for the student conducting a VE, with no statistical gender difference.

VEs were done on 76 patients who had consented, and 6 where consent was not obtained, or was uncertain. Eleven students did no examinations.

The examination was rated highly valuable for student learning by 73% students regardless of gender or age.

The implications of these findings for teaching sexual health skills are discussed. Strategies are proposed that could improve the outcomes for patients and students, and help ensure a skilled sexual health care workforce in the future.
SEXUALLY TRANSMITTED INFECTIONS [STIs] AND PREGNANCY

Garland S
Director of Microbiological Research and Director of Clinical Microbiology and Infectious Diseases, Royal Women’s Hospital, Victoria, Australia; Professor, Department of Obstetrics & Gynaecology, University of Melbourne

Routine antenatal screening tests currently recommended in Australasia and endorsed by the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) include rubella, varicella-zoster, group b streptococcus [GBS], asymptomatic bacteriuria, as well as the following STIs: Treponema pallidum (syphilis), Human immunodeficiency virus (HIV), Hepatitis B virus (HBsAg), Chlamydia trachomatis (adolescent pregnancies) and offer of hepatitis C virus (HCV).

Infections can infect the foetus or neonate by various routes (intrauterine, intrapartum and/or postnatal) and cause potentially serious disease. Such infections in the mother may be mild or commonly subclinical, yet can result in miscarriage, preterm birth, foetal damage, or even death, depending on the pathogen and stage of pregnancy. Consequently, diagnoses should be made definitively by instituting appropriate laboratory tests to ensure effective treatment and follow-up of the woman and her infant, as well as her contact(s). Specific treatment of the mother, where applicable, can prevent most of the impact on the fetus and newborn. The principles for the use and choice of screening tests are (1) if maternal infection occurs, there is a significant risk of fetal or neonatal infection and damage, or other adverse pregnancy outcome; (2) there are sensitive, specific, and inexpensive screening and confirmatory tests; (3) there is a safe, effective intervention and/or treatment regimen which can reduce morbidity and mortality in the fetus and/or the mother.
LABORATORY CONTRIBUTION FOR CONTROL OF CHLAMYDIA

Tabrizi S
Department of Microbiology and Infectious Diseases, The Royal Women’s Hospital, Carlton, Victoria, Australia and Department of Obstetrics and Gynaecology, University of Melbourne, Parkville, Victoria.

Infection with *Chlamydia trachomatis* may present a wide spectrum of clinical symptoms in patients. Diagnosis based on presenting symptoms however may be of limited value in asymptomatic patients. Therefore, laboratory tests are utilized; in particular nucleic acid amplification technology (NAAT) based assays. In the recent years, NAAT testing has improved diagnosis of chlamydia to a great degree. The increased sensitivity of NAAT assays has also allowed for better detection of chlamydia in extragenital samples, diagnosis of lymphogranuloma venereum and has made the use of non-invasive self-collected samples possible. Chlamydia genotyping and sequence based comparisons are also increasingly being used in investigation of types present in the population as well as providing possibility of differentiating a new infection from re-infection. Such methods continue to play a major role not only in patient diagnosis but also in epidemiology and public health.
A NEW SPIN ON “FOOTY TRAINING” – TAKING SEXUAL ASSAULT TALKS TO THE AFL

IS SEXUAL ASSAULT PREVENTABLE?

Williams A
Victorian Institute of Forensic Medicine, Australia

RESPECTFUL BEHAVIOURS: PEOPLE IN SPORT – Adult Sexual Assault – was a presentation that was developed by Dr Angela Williams and Patrick Tidmarsh in conjunction with the Statewide Steering Committee to Reduce Sexual Assault, (established by the Chief Commissioner of Police in Victoria, Christine Nixon), to address the issue of sexual assault in the broader community. The education package was the first element to be implemented of a broader policy to be announced later this year.

The package was designed to best educate men in our community whilst identifying specific needs of AFL elite players. It aimed to air the topics of sexual assault, violence against women and respectful behaviours. The education package was delivered to every club from May through to August 2005.

Education of our community on these issues is extremely important and essential to cultural change. This discussion will address one effective way of educating our community as it looks more specifically at educating men on these topics.

Style and content of education package

What the education package covers
Identifiable risk factors and scenarios
Assessments and evaluations
WHERE TO FROM HERE?

IS VULVAL CANCER PREVENTABLE?

Jones RW, Auckland, New Zealand

Cancer Research UK has recently produced their latest CancerStats on vulval and vaginal cancers1. Vulval cancer is relatively uncommon, being ranked 18 in incidence among women in the UK (thyroid and liver are ranked 19 and 20 below it) with just over 1000 women diagnosed each year, and approximately one woman dying each day.

Of concern is the increasing incidence over the last 25 years, especially in women under the age of 50 where the proportion of cases rose from 6% in 1975 to 12% in 2003. A similar trend has been reported from the USA, where between 1973 and 2000 invasive vulval cancer increased by 20%. If similar trends were reported in cervical or breast cancer there would be cries of concern, but this latest report about vulval cancer has been largely ignored.

The recent Vulval Health Awareness Campaign (www.vhac.org) aimed to educate women about the significance of vulval symptoms, and the importance of seeking professional advice. Women frequently attribute symptoms to infections such as “thrush” and some are reluctant to be examined. Many doctors lack confidence to examine the vulva and some do not appreciate the significance of visible lesions.

There are two forms of vulval squamous cell carcinoma. The first is associated with “high risk” human papilloma virus (HPV) infection and smoking, and the second with chronic vulval dermatoses, especially lichen sclerosus. Both forms are preceded by vulval intraepithelial neoplasia (VIN), but the type associated with HPV is termed “VIN, usual type”, while that with dermatoses is termed “differentiated VIN”.

In recent decades there has been a striking increase in the incidence of HPV-related VIN and cancer, particularly in younger women2,3. The natural history of VIN is contentious. The histological association of VIN with cancer4, the integration of HPV 16 & 18 into the genome of vulval epidermis in women with cancer5 and clinical reports of the outcome in women with untreated VIN over 30 years of age all point to its significant invasive potential6. However, unlike cervical intraepithelial neoplasia (CIN) where the natural history is expressed in decades, the mean interval between the diagnosis of VIN and invasion in untreated cases is 4 years and almost always within 8 years6.
Most women who present with VIN experience localised pruritus, or “lumps” (which may be confused with condylomata). About one third will have a preceding history of HPV-related lower genital tract neoplasia (usually CIN) or condylomata. The majority of women with VIN are smokers and this should be discouraged. The clinical features are heterogeneous and biopsy is required for diagnosis. In the longer term a well-organised vaccination programme will reduce the risk of VIN. In the meantime, conservative local excision will remain the gold standard for treatment.

The more common form of vulval cancer is found in older women arising in a background of lichen sclerosus (LS) and differentiated VIN. The associations between LS and vulval cancer are based on the epithelial changes adjacent to the cancer. Individual patients with LS who have progressed to cancer and large series of LS cases where the incidence of cancer is 3-5%. The prevalence of LS is uncertain but may be as high as 1 in 30 among elderly women. The risk of developing vulval cancer in LS appears to increase with age and with clinical evidence of localised hyperkeratosis, although young women cannot be excluded because there are cancers reported in women with LS aged less than 40 years.

There are now well-established guidelines on the use of potent topical corticosteroids (e.g. clobetasol) in the treatment of LS and evidence to suggest that such steroid therapy will prevent development of vulval cancer. Most women with LS can be successfully managed in primary care, but there are circumstances when referral to a specialist clinic is advised. This includes those women who require potent steroid application three or more times a week or greater than 30 mg of steroid cream per 6 months. Women previously treated for usual (HPV-related) or differentiated type VIN and/or vulval cancer should be seen by a specialist clinic, and those with clinical evidence of localised skin thickening or hyperkeratosis require biopsy. Women with lichen sclerosis plus differentiated VIN are best treated by surgical excision.

Unfortunately, the majority of vulval cases occurring in a background of lichen sclerosus present to secondary care with undiagnosed or untreated LS. To make any impact we must encourage these women to present earlier to primary care when they first become symptomatic (e.g. by promoting Vulval Health Awareness among all women) and by including vulval inspection when women attend for their cervical smears taken in the primary care setting. Increasing awareness among professionals about the significance of LS and VIN might help to prevent further increases in the numbers of vulval cancers.

References
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Australasian Sexual Health Conference 2007
Venus & Mars at Jupiters
8-10 October 07
Conrad Jupiters - Gold Coast

Poster Abstracts
P1
WHY NOT ALREADY? YOUNG ANTENATES’ VIEWS OF CHLAMYDIA SCREENING AS PART OF ROUTINE CARE

Bilardi JE1, De Guingand D1, Temple-Smith MJ2, Fairly CK3,4,5, Garland S6, Tabrizi S6, Hocking J6, Grover S6, Wallace E6, Pirotta M3, Gurrin L9, Carter R7, Chen MY1,2

1Sexual Health Unit, School of Population Health, The University of Melbourne; 2Melbourne Sexual Health Centre; 3Department of General Practice, The University of Melbourne; 4Department of Microbiology and Infectious Diseases, Royal Women’s Hospital; 5Department of Obstetrics and Gynaecology, Mercy Hospital for Women/ The University of Melbourne; 6Department of Obstetrics and Gynaecology, Mercy Hospital for Women/ The University of Melbourne; 7Health Economics Unit, School of Health and Social Development, Deakin University; 8Key Centre for Women’s Health in Society, School of Population Health, The University of Melbourne; 9Centre for Molecular, Environmental, Genetic and Analytic (MEGA) Epidemiology, School of Population Health, The University of Melbourne

Very little data is available on the acceptability of chlamydia screening among antenatal women. Antenatal women aged 16-25 years, recruited from 4 antenatal services in Melbourne as part of a larger prevalence study, were interviewed using a semi-structured questionnaire for their views on chlamydia screening. Of 85 women approached, 84 agreed to an interview. All had already been screened for chlamydia using urine specimens and had received the test results; 21 women had received a positive result.

Women had low levels of awareness of chlamydia before the test, retained relatively little knowledge after the test and commonly had misconceptions around chlamydia transmission, testing and the sequela. Women indicated a high level of acceptance of, and support for chlamydia screening, expressing their willingness to undertake whatever care was necessary to ensure the health of their baby. There was a strong preference for urine testing over other methods of specimen collection. Women questioned why testing was not already conducted alongside other antenatal STI screening tests, particularly in view of the risks chlamydia poses to the baby. Women who tested positive for chlamydia had mixed reactions to their result, however, most felt relief and gratitude at having had chlamydia detected, and reported high levels of partner support.

The findings from this study suggest that chlamydia screening is highly acceptable among young pregnant women and strong support exists within this group for a program of targeted chlamydia screening of antenatal women in Australia.

P2
SUPPORTING EQUITABLE RESOURCE ALLOCATION FOR SEXUAL HEALTH SERVICES - IMPLEMENTATION OF THE NSW HIV/AIDS AND SEXUAL HEALTH AMBULATORY CARE MINIMUM DATA SET

Brotherton A
NSW Health

The NSW HIV/AIDS and Sexual Health Ambulatory Care Minimum Data Set (MDS) was developed in order to

- Support the development of a revised HIV/AIDS and STI Resource Distribution Formula (RDF), to incorporate standardised ambulatory morbidity data
- Inform an equitable allocation of resources based on the characteristics of caseload of services in addition to population measures
- Address the lack of ambulatory care data identified in the NSW HIV/AIDS Care and Treatment Services Needs Assessment (2004)
- Provide data on STI service provision to support the introduction of an STI needs index within the RDF

Ambulatory STI and HIV service data has intrinsic value to service providers and planners in informing program development and assessing the extent to which strategic goals are being achieved.

The MDS comprises nine items – five patient profile indicators and four activity related indicators – to minimise data collection burden on services. The data set defines 15 principal services covering STI treatment, detection and management.

Data collection commenced in July 2005. Data from 103 establishments across NSW is collected and collated on a quarterly basis.
Key challenges include ensuring consistency of interpretation and reporting practices across diverse service delivery models; addressing database compatibility issues; and aligning service categories with clinical practice.

Consistency analyses suggest a robust data set with acceptable levels of consistency in counting practices between Area Health Services, and between “like” services. Analyses have also identified a range of IT and data management issues which have been addressed by services.

This paper will provide an overview of state-wide STI treatment and management data, outline key implementation challenges and discuss the application of MDS data to the revision of the RDF as well as possibilities for augmentation to provide a comprehensive data set to support service planning, benchmarking and monitoring of strategic goals.

P3
KNOWLEDGE, SKILLS OR ATTITUDE: WHICH IS THE MOST IMPORTANT TO CLIENTS?

Brown KM1 and Hillman RJ2

1South East Sydney Illawarra Area Health Service, Warrawong, NSW; 2Sexually Transmitted Infections Research Centre, University of Sydney Westmead, NSW

A number of UK authors have identified the preferred characteristics of sexual health service staff, as reported by health service clients, however, there is limited information available about the Australian experience. This study set out to determine what aspects of care were considered most important, on a personal level, for Australians attending a regional sexual health service.

100 clients attending a regional sexual health service were randomly selected and invited to complete a four page questionnaire. The questionnaire consisted of a one page demographic sheet and three pages of questions regarding a sexual health worker’s knowledge, skills and attitudes. Participants were asked to rate these attributes using a Lickert scale from 1-5, from the least important to the most important to them personally. At the conclusion of the questionnaire, participants were asked to rank the three most important factors in determining their satisfaction with a practitioner in sexual health care. The surveys were analysed using SPSS.

The following were ranked within the top three most important characteristics: accuracy of diagnosis (43 clients), confidentiality (38 clients), making the person feel comfortable (30 clients), being non-judgmental (29 clients), knowledge about STIs (27 clients) and respect for the client as a person (21 clients). Three of the top six characteristics most highly ranked were related to attitude, two to knowledge and one to skill.

Whilst the need to make an accurate diagnosis was valued by clients, confidentiality, the ability to ensure client comfort and a non-judgemental approach were also highly regarded. The importance of such skills & attitudes, must be emphasised by clinical supervisors and those developing educational programs in sexual health.
P4 NON-ATTENDANCE RATES AND WAIT TIMES IN AN URBAN SEXUAL HEALTH CLINIC

Burton L.1 and Freedman E.1,2

1 Sydney Sexual Health Centre, South East Sydney Illawarra Health GPO 1614 Sydney 2000; 2 School of Public Health and Community Medicine, University of New South Wales, Kensington, NSW, Australia

Sydney Sexual Health Centre (SSHC) currently allocates approximately half the available clinical time to appointments and the other half to unbooked patients. To determine if changes to service delivery were needed an investigation of non-attendance rates and wait times for booked appointments was conducted.

A total of 23 calendar days were surveyed in March 2006. Waiting time was calculated at the same time daily and non-attendances were recorded at close of business daily. Where possible, medical records were reviewed to: extrapolate the visit reason; determine factors related to non-attendance; and determine any subsequent action taken by the patient to access the clinic.

There were 1596 clinic attendances, 772 unbooked and 824 booked appointments, during the study period. 150 patients did not attend for their booked appointments giving an overall mean non-attendance rate of 18.2%. The nursing unit had both the longest mean wait time (6.22 days) and the highest mean non-attendance rate (23.6%). The counselling unit had the shortest mean wait time (0.39 days) and a non-attendance rate of 16.5%. The medical unit had a mean wait time of 2.17 days and the lowest non-attendance rate (14.6%).

Of the files available for review (119/150), 90% documented the type of appointment missed. Appointments for vaccination (18.4%), counselling (18.4%) and results (14.3%) were most commonly missed.

In 44% of files the reason for non-attendance could be identified. 16 (13.5%) patients had chaotic clinic attendance history and 26 (22%) had previously failed to attend.

In the preceding week and the following week 56% (67) and 39% (47) respectively had clinic contact via an appointment, phone or triage. Five patients who re-booked failed to re-attend.

Non-attendance was correlated with longer wait times for an appointment, which may indicate the patient forgot to attend. However non-attendance could also reflect the perceived lesser importance associated with the reason for the visit. SSHC plans to introduce an SMS reminder system for all booked appointments to see if this improves attendance rates.

P5 A DECADE OF HIV PERFORMANCE INDICATORS (POST-HAART) IN A REGIONAL SEXUAL HEALTH CLINIC 1995-2005

Chuah J., Fankhauser W., Page M., Gold Coast Sexual Health Clinic, 2019 Gold Coast Highway, Miami, Queensland, 4220.

Dickson B, CaraData, Parkwood, Queensland 4214. Glenday K*., National Centre for HIV Epidemiology & Clinical Research (NCHER), UNSW, Darlinghurst 2010, *on behalf of AHOD Steering Committee and participating centres.

Objective: This study examined the patterns of a minimal set of trend performance indicators from a medium-size, regional sexual health (SH) clinic, the Gold Coast Sexual Health Clinic (GCSHC) in comparison to a representative “national” trend (AHOD) during the same period (when available).

Methods: Between 01 January 1995 and 31 December 2005, epidemiological and utility data were collected at the GCSHC, using the Sexual Health Information Program (SHIP V7.2). The data were collated and expressed in graphs and tables formats, in direct comparison to the Australian HIV Observation Database (AHOD), representing the “national” standard, covering the period of 01 January 1999 till 31 December 2005.

Results:

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Discussion: There has been a decreasing trend in HIV performance at GCSHC, compared to AHOD in recent years, albeit not statistically significant. The reason(s) for the negative trends remained unclear. Some possible impacts may include: State policy and funding changes, resulting in diminished roles in support & care in many ‘traditional’ non-government organizations (NGO), community complacency, workforce constraints etc. This study also re-iterated the key roles of SHIP and SH clinics in the surveillance and provision of ambulatory care in HIV management in Australia, since the introduction of HAART in 1995-6. However, other HIV performance indicators may be needed to reflect the increased complexity: degree of adherence; reasons for starting, changing and ceasing treatment; frequency & nature of adverse events and hospitalization etc. Standardization of these potential indicators are equally complex, but some national (AHOD) and international cohorts (TAHOD, IeDEA etc.) have initiated standardization and QA processes, which are yet to be embraced by the HIV/SH network in Australia.

P6
NON-OCCUPATIONAL POST EXPOSURE PROPHYLAXIS IN AN URBAN SEXUAL HEALTH SETTING

Clark FC, Aitken SD
Gold Coast Sexual Health Service, 2019 Gold Coast Highway, Miami, QLD 4220, Australia

Non-occupational Post Exposure Prophylaxis (NPEP) became available in Queensland in January 2001. Since that time there have been 95 episodes of care relating to NPEP at the Gold Coast Sexual Health Service (GCSHS).

This poster examines the demographics of those patients attending GCSHS for NPEP.

Records of GCSHS were retrospectively analysed. Cases of NPEP were identified by interrogating Sexual Health Information Program (SHIP) and Pharmacy Records.

This poster examines the age, gender, exposure risks and follow-up rates of presenting patients. The drug regimens prescribed are also described, including number and type of agents, change of regimen and site of regimen initiation.

This poster highlights the changing nature of NPEP prescribing habits over time. It also demonstrates the poor rates of patient compliance with the current recommendations for follow-up.
P7
ADENOVIRUS: IMPLICATIONS FOR THE INVESTIGATION OF PERSISTENT URETHRITIS

Couldwell DL, Lowe P, Sawleshwarkar S, McPhie K
1Parramatta Sexual Health Clinic, 162 Marsden Street, Parramatta, NSW 2150; 2Sexually Transmitted Infections Research Centre, Westmead Hospital, NSW, 2145. 3Centre for Infectious Diseases and Microbiology Laboratory Services, Institute of Clinical Pathology and Medical Research (ICPMR), Westmead, NSW, 2145.

Adenovirus has been associated with a small proportion of cases of nongonococcal urethritis in Australian men, and is a recognised cause of persistent urethritis. However, the investigation of persistent urethral symptoms has not routinely included testing for adenovirus. A case of persistent urethritis where infection with adenovirus was incidentally detected by viral culture for herpes simplex virus (HSV) will be presented.

In the sexual health clinic context, viral culture is often performed to isolate HSV, but the characteristic episodic nature of symptomatic HSV disease means that viral culture for HSV may not be a routine investigatory tool in cases of persistent NGU. As HSV is a relatively quick growing virus, cytopathic effect (CPE) is usually observed after about 3 days, and specimens are incubated for up to 7 days. On the other hand, adenovirus is a slow growing virus and usually produces CPE in viral culture from 7 to 10 days. Therefore, viral culture for HSV may not detect infection with adenovirus unless culture for this organism is specifically requested. In addition, PCR is being increasingly used for diagnosis of HSV, further reducing the chance of recognising infection with adenovirus.

Prolonged viral culture or PCR for adenovirus should be performed in cases of persistent urethritis.

P8
ARE YOU IN? ARE YOU OUT? DOES TRIAGE HELP?

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What is the most effective way to manage rising occasions of service, rising rates of sexually transmissible infections (STI) combined with limited resources? This is the question that faces many sexual health services today especially with the recent significant increase in notifications of STIs including HIV. The challenge is how to provide best practice services with optimal client outcomes while faced with these ongoing and emerging issues.

Due to ever increasing occasions of service and complexity of case presentations at Brisbane Sexual Health Clinic (BSHC) an internal audit of client services was undertaken in 2006. Evaluation of findings demonstrated that client outcomes and staff satisfaction were being negatively influenced due to client waiting times and appointment lists outside acceptable parameters, increasing walk-in client demands and limited resources to address the needs of core groups.

As a result of this audit and evidence that triage improves client access to services while providing priority for core client groups, a walk-in triage system was introduced in May 2006. This included the development of a purpose build electronic appointment database that enables the tracking of client pathways and quality monitoring of the triage process.

Has triage improved clinical efficiency? Has client satisfaction improved? Has the change impacted on staff attitudes? Have we increased access to service for core groups? This paper will present the results of evaluation after 12 months of implementing the new triage system.
P9 PROVISION OF CARE TO HIV POSITIVE PEOPLE IN NSW CORRECTIONAL CENTRES

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Justice Health (JH) is responsible for provision of health services to people in NSW prisons and juvenile detention centers. Approximately 18,000 people annually benefit from the organisation’s services. The fulltime population is currently around 9,600 adults and 340 adolescents. Twenty seven percent of adults stay less than eight days, 17% eight to 30 days, and 56% longer than 30 days with only 10% longer than six months. Recidivism is high at about 69%. Sixty-five percent of adolescents stay less than one week.

Health care is provided to patients in 80 centres located throughout the state, in metropolitan, regional and rural locations. This includes people in custodial settings and in court, community and post release settings.

There can be up to 40 people known to have HIV in custody at any one time. These people have complex health needs relating to co-infections, mental health and drug and alcohol issues. They are also a group of people who may not generally access health care regularly in the community.

Indigenous people are over-represented in prisons. Up to 10% of known HIV positive people identify as Aboriginal. Other complexities include HIV positive pregnant women and late presentations, including those from overseas countries with no English language skills.

Patients are managed by a team of experienced sexual/public health nurses in collaboration with specialist sexual health/immunology services. Providing these patients with optimal care presents many challenges. Potential movement of patients around the state makes follow up for specialist services, routine monitoring and management complex. Maintaining patient confidentiality also poses a significant challenge, for health care workers and for patients. Clearly, HIV is a significant health issue for patients and JH as a service provider.

This presentation will identify the challenges to service delivery, demonstrate JH’s response and describe the provision of service to HIV positive people.

P10 A NEW SYSTEM TO MONITOR C. TRACHOMATIS PREVALENCE IN YOUTH

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On behalf of the Victorian Primary Care Network for Sentinel Surveillance on BBVs and STIs

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Objective: Victoria, like other parts of the country, has seen Chlamydia trachomatis notifications increase markedly each year in conjunction with increased testing. The interpretation of this trend in notifications has been limited as there has been no mechanism to monitor prevalence. We describe the results from a new clinic-based system to monitor C. trachomatis prevalence and sexual risk behaviour of heterosexual youth in Victoria.

Methodology: The system was implemented in March 2006 at 12 primary health care sites servicing high risk clients; seven with large youth caseloads. Clinicians used a questionnaire to gather demographic and sexual risk behaviour data on all individuals routinely tested for C. trachomatis. Questionnaires were linked with test results.

Results: In the first nine months: 3745 questionnaires were completed; 2210 (59%) in females and 1535 (41%) in males. Among females; 54% were aged 16 to 24 years, 86% were asymptomatic on presentation, 61% reported inconsistent condom use in the past 12 months with casual partners and 38% had a new sexual partner in the past three months. Among males; 30% were aged 16 to 24 years, 62% were asymptomatic on presentation, 65% reported inconsistent condom use in the past 12 months with casual partners and 56% had a new sexual partner in the past three months. Among 16-24 year olds, the C. trachomatis prevalence was 5.4%, 95% CI 4.2-6.8 (females) and 10%, 95% CI 7.4-13.1 (males).

Conclusion: This new system provides a unique opportunity to monitor C. trachomatis prevalence and sexual risk behaviour without the input of extensive resources. It will be a valuable mechanism to inform and evaluate public health strategies designed to control C. trachomatis infections.
P11
BLOOD-BORNE VIRUS (BBV) AND SEXUALLY TRANSMISSABLE (STI) PREVENTION STRATEGIES IN A LOCAL COMMUNITY: AN INNOVATIVE APPROACH

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The City of Wyndham in the western metropolitan region of Melbourne is the fastest growing municipality in Victoria. The population includes high numbers of people from both low socio-economic background and Non-English speaking backgrounds. In 2004 FPV decided to assist in overcoming some of the access issues young people in the municipality faced by providing a sexual health clinic and nurse community education program. The service is co-located in a purpose built youth resource centre with other agencies and provides a “one stop shop” model. This unique and innovative project is very successful and has established sustainable structures and partnerships through close collaboration with key stakeholders including local youth services networks, school, alternative education centres, and key staff within the Department of Human Services. Some of the major achievements are:
1. An accessible sexual health service for young people
2. Increased awareness about the issues around sexuality and health
3. A supportive network of service providers including increased knowledge of service providers
4. A series of replicable products (the use of plays, education sessions)
5. The seXfactor ©FPV2005 I and II (2005 and 2006) projects using creative methods of raising awareness about sexual health issues, especially to those outside the mainstream school setting, through: the development of a series of short monologues and the use of drama to 112 Year 10 or equivalent students; and in the following year using professional comedienes and a play developed from the 2005 students to convey condom use and safer sex messages to 130 girls. The seXfactor III (2007) encompasses working with Year 9 boys regarding building safe, healthy and happy relationships and to increase awareness of sexual assault and violence. This presentation outlines the processes and key considerations around establishing such a program and will explain evaluation outcomes of some of the discrete initiatives.

P12
NON – CHLAMYDIAL NON-GONOCOCCAL URETHRITIS – MANAGEMENT AND FOLLOWUP DILEMMAS

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AIM
To audit the management of non chlamydial non gonococcal urethritis (NCNGU) for 2006.

METHOD
A clinic database search for cases of non-specific urethritis was conducted. Charts were reviewed and cases subsequently diagnosed with chlamydia or gonorrhoea at the visit were excluded. One person reviewed the charts for diagnosis, microscopy, treatment, contact tracing and follow up.

RESULTS
There were 38 recorded of cases of ncngu. The mean age of cases was 28.8years (sd 10.8), all were male, 15.8% identified as msm. Microscopy was performed in 60.5% of cases and PMNLs were detected in 36.8% of all cases (63.6% of cases where microscopy was performed). Treatment was with azithromycin in 63.2% of cases, doxycycline in 28.9% of cases, tinidazole in one case (2.6%) and no treatment was given in one case. Patients with PMNLs on microscopy were significantly more likely to be treated with azithromycin than those without PMNLs on microscopy or with no microscopy done (93.8% vs 50.0%, p<0.01, χ2 test). Contact tracing (CT) was recommended in 17 cases (55.3%) with confirmation of partner treated in 7 cases. There was no significant difference in contact tracing recommendation between those with PMNLs on microscopy and those without or microscopy not done (56.3% vs 36.4%, p >0.2, χ2 test). Clinical follow up at the clinic occurred in 25 cases. 80% (95%CI 60.9%-91.1%) of those followed up had resolution of symptoms, with the remainder having a recurrence or failure of resolution.

DISCUSSION
NSU management should include antibiotic cover for possible undetected Chlamydia. Azithromycin was more likely to be used if PMNLs were detected. Chlamydia treatment occurred in all but two cases, with one of the two cases having had adequate treatment previously. New Australian CT guidelines recommend CT M. genitalium but not for NSU. We would recommend CT current or most recent partners in all cases of NCNGU.
A DELAYED HYPERSENSITIVITY REACTION TO ENFUVIRIDTE AFTER RECHALLENGE

Emerson CR, Post JJ, Workman C

Objectives: To highlight delayed hypersensitivity reaction as an important possible side effect of enfuvirtide treatment.

Methods and Results: A heavily pre-treated 52 yr old male, with CD4 lymphopenia (9%), was commenced on a salvage regimen containing enfuvirtide, darunavir/ritonavir, MK-0518, tenofovir DF, lamivudine and etravirine. Prophylactic trimethoprim/sulfamethoxazole (TMP-STX) was commenced simultaneously. Injection site reactions (ISRs), measuring 2-4cm diameter, occurred with some doses of enfuvirtide. Ten days after commencement of treatment he developed a maculopapular rash on the chest and abdomen without any systemic features. Both enfuvirtide and TMP-STX were discontinued with complete resolution of the rash in 24 hours. TMP STX was considered the most likely agent and the patient was rechallenged with enfuvirtide 5 days later in a hospital setting. Prior to rechallenge there were 2 ISRs remaining. Enfuvirtide was self administered and the patient was discharged after 3 hours with no reaction. The rash reappeared involving the whole body (see photo) 5 hours post dose and was associated with fever (temperature 38.4), nausea and a pre syncopal episode. This reaction resolved 12 hours post dose however two ISRs from previous dosing became more inflamed (see photos).

Conclusion: Hypersensitivity to enfuvirtide occurs in less than 1% of patients. Previous hypersensitivity reactions after enfuvirtide rechallenge have occurred within minutes post dose. In this case the reaction was delayed to greater than 4 hours post dose. It may be important to consider overnight admission if rechallenging with this drug after a possible hypersensitivity reaction.

SEXUAL HEALTH CARE FOR SEX WORKERS

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Background
The Australian STI Prevention Framework identifies sex workers as a priority group. The Hunter New England Sexual Health Unit, based at the Royal Newcastle hospital provides free sexual health care to sex industry workers.

Objective
To assess current service delivery and barriers to accessing sexual health care by registered brothel based sex industry workers in the Hunter New England area.

Method
An on site survey of 36 sex industry workers was conducted.

Results
Clinical guidelines for sexual health care of this priority group were not being met. The majority of participants were receiving their sexual health care from GPs. A number of important barriers to accessing the specialist sexual health service were identified.

Conclusion
This study highlights the important role that GPs play in providing sexual health care to sex industry workers. It provides the impetus for future research, education and strategies to improve health service delivery to this important group.
P15
WORKING GIRLS IN MELBOURNE BROTHELS

Groves J

RhED (Resourcing health and education in the sex industry) provides information, health education, counselling/support, referral and advocacy to people who work in the sex industry in Victoria. Prostitution in Victoria is legislated by The Prostitution Control Act (1994). The Prostitution Control Act focuses on regulation of the sex industry. This includes licensing procedures and occupational health and safety. One of the priority areas is safe sex practices and prevention of blood borne viruses.

In order to deliver services to the people who work in the sex industry it is essential that RhED is able to understand the profile of sex workers. As the Prostitution Control Act has been enacted for the last twelve years, RhED undertook a survey to explore the changing profile of women working in the industry.

A semi structured face-to-face, confidential survey with 100 women from the industry, with both day and night shift was undertaken. The survey was conducted for the purpose of developing up to date baseline information on what the needs and issues are of women working in legal brothels.

This presentation presents the demographic information on women working in brothels, their knowledge of sexual health, their reasons for entering, staying and if they were considering leaving the industry, what, if anything, would prevent them.

The importance of gathering this information supports the planning and resource development of RhED and informs Victorian government and policy makers by identifying areas where legislation and support could be improved. In conclusion, it is hoped, that the information educates the wider community to remove stigma and barriers.

P16
RECENT TRENDS IN HIV DIAGNOSES IN VICTORIA

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Background: After a decade of steady decline, the annual number of new HIV diagnoses in Victoria has increased over the past seven years. We describe the characteristics of reported cases of infection and explore trends in the epidemiology over time.

Methods: The Burnet Institute manages HIV surveillance on behalf of the Victorian Department of Human Services (DHS). New HIV diagnoses reported by doctors and laboratories to DHS were analysed by time and according to specific surveillance variables.

Results: Between 1996 and 2006 there were 2,129 new HIV diagnoses reported in Victoria, the majority (n=1512, 71%) of which were associated with men who have sex with men (MSM). The annual number of new diagnoses decreased each year over the period 1993 to 1999, from 173 to 132 (23%), and then increased between 2000 and 2006, from 188 to 263 (43%). These trends were similar when the analysis was restricted to diagnoses in MSM only. Among MSM, there was a shift in the median age over time from 32 years in 1996 to 38 years in 2006. Overall, 18% of cases (n=390) were reported as heterosexually acquired with 53% of these cases either being from high-prevalence regions (sub-Saharan Africa or South-East Asia) or having sexual contact with partners from these regions.

Conclusion: The recent increase in annual HIV diagnoses in Victoria is largely due to increased diagnoses among MSM. Sexual behaviour trends from the Melbourne Gay Community Periodic Survey provide some explanations for these changes. The findings will guide upcoming intervention strategies in Victoria.
P17 A NEW APPROACH TO MONITORING HIV EPIDEMIOLOGY AMONG MEN WHO HAVE SEX WITH MEN IN VICTORIA

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Background: Over the past seven years there has been a marked rise in annual HIV diagnoses in Victoria, with about 70% of cases associated with male to male sex. We describe a new clinic-based system for monitoring HIV epidemiology among men who have sex with men (MSM) in Victoria.

Methods: The program was implemented in April 2006 at five large medical clinics with a high case load of MSM, responsible for 50% of annual HIV diagnoses in Victoria. Using a questionnaire, doctors collected HIV testing history, demographic and sexual risk behaviour information from all clients undergoing voluntary HIV testing. Questionnaires were linked with HIV test results.

Results: A total of 2762 questionnaires were completed among MSM; 32% were aged 30 to 39 years, 46% reported a negative HIV test in the 12 months prior to their current test; 74% had a casual sexual partner/s in the last six months and 34% of these men reported inconsistent condoms use with their casual partner/s; 63% had a regular sexual partner/s in the past six months (14% of partners were HIV positive) and 54% of these men reported inconsistent condom use with their regular partner/s. The overall HIV prevalence among MSM surveyed and tested was 1.9% (95% CI 1.4-2.5).

Conclusions: This new system has provided a unique opportunity to monitor HIV testing, prevalence and sexual behaviour among HIV negative tested for HIV. The findings will be compared to pilot study results from 2004 and 2005 and also in the context of trends in HIV diagnoses in Victoria. A range of HIV prevention strategies for MSM are likely to be implemented in Victoria in 2007 and the system described here will be a valuable mechanism to evaluate these strategies.

P18 CHLAMYDIA REDUCTION – TOO EASY! AN OUTREACH SCREENING PROJECT IN LINE WITH THE NATIONAL AND NSW STI STRATEGIES

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Objective
Genital Chlamydia is increasingly common among people 16 to 29, and this group produced 85% of Chlamydia notifications in 2005 (679 cases) on the NSW north coast in 2005, making it just ‘too easy’ to catch Chlamydia. Fortunately, it’s also ‘too easy’ to screen for Chlamydia and ‘too easy’ to treat. The ‘Chlamydia – Too Easy’ project aimed to increase screening of young people in the Hastings Macleay region of the NSW north coast. However, increasing opportunistic screening is only part of the solution. Also needed are:
• Training and support for health care workers
• Access to testing and treatment
• Health promotion and sex education
• Promotion and availability of condoms

The project
• Educated young people through information sessions at Kempsey, Wauchope and Port Macquarie TAFE Colleges followed by on-campus screening days.
• Identified high risk sexual behaviours and sought information about barriers to accessing services for sexual health.
• Promoted our newly established sexual health clinic
• Educated GPs and practice nurses about opportunistic testing in this age group.
Results

- One positive was statistically in line with current incidence in our population.
- Excellent opportunity to discuss safe sex and STI screening
- Presence of medical students helped breakdown barriers
- Identified attitudes around safe sex, STIs and HIV among young people.
- Revealed people are making good use of GPs for STI screening
- Revealed issues for young people around accessing services.

Discussion

Students responded positively to the screening opportunity. However, we also attracted many worried well, especially older people, and too few indigenous students, especially males. The program has prompted more young people to ask for Chlamydia screening. Area public health data show 332 cases reported between 1 January to 30 April 2007, 62% above the average (205) during the same period 2000-2005. Outreach is ongoing. This year we are focusing on youth via sporting clubs and the 45+ ‘newly single’ cohort in this sea-change, retirement area with promotional beer coasters placed in pubs and clubs.

P19

AWARENESS AND USE OF VOLUNTARY COUNSELLING AND TESTING: A COMPARISON BETWEEN THE 2002 AND 2005 NATIONAL HIV HOUSEHOLD SURVEY IN SOUTH AFRICA

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Objectives: This paper compares awareness and use of voluntary counselling and testing among adults aged 15 years and older who responded to a national HIV household survey in 2002 and 2005. Methods: A probability sample of over 8 000 adults aged 15 years and older and over 16 000 were interviewed as part of a national HIV household survey conducted in South Africa in 2002 and 2005 respectively. A questionnaire was administered gathering information including the following: demographic details (age, sex, marital status, level of education, race); HIV-related knowledge and attitudes; risk perception; and voluntary counselling and testing (VCT). All participants were requested to provide specimens for HIV antibody testing. Awareness and use of voluntary counselling and testing was analysed by sex and age differentials, type of residence, race group, education level and marital status. Contingency table chi-square tests were performed and all analyses used p < .05 as the criterion for significance testing. Results: Awareness of VCT was high in both surveys. However, only 19.8% of people who knew about VCT services made use of the services in 2002, as compared to 30.5% in 2005. Awareness of serostatus among HIV-positive individuals increased from 23.1% in 2002 to 36.5% in 2005. The elderly and rural communities continue to have lower levels of utilization of VCT as well as lower levels of perceived access to VCT in both surveys. Conclusions: The analysis showed that there has been an increase in testing among respondents aged 15 years and older. Efforts should be made to increase use of VCT among the elderly and in the rural areas.
EFFECTS OF ERECTION HARDNESS ON SEXUAL SATISFACTION:
ANALYSIS OF AUSTRALIAN DATA FROM THE GLOBAL BETTER SEX SURVEY

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Background: Clinical trials have demonstrated positive correlations between hard (grade 4) erections and sexual satisfaction. However, the relationship between erectile hardness and sexual satisfaction requires further study within the broader population.

Objectives: The primary objective was to investigate the relationship between erection hardness and sexual satisfaction in Australian men. Secondary objectives included examining the effects of erection hardness on love and romance and overall health, and comparing Australian male data with international male and Australian female data.

Methods: Data were obtained from the Global Better Sex Survey. This 2005 telephone survey involved 12,500 randomly selected men and women from 27 countries in the Americas, Asia, Oceania, Europe, Middle East and Africa. Respondents had to have had sexual intercourse at least once in the previous year. Australian male data are presented with comparative data in brackets [international male; Australian female data].

Results: Of the 125 male and 125 female Australian respondents, most were married and aged between 40-59 years. Only 25% of men [38%; 28%] were very satisfied with erection hardness. Among the 106 men [5641; 104] who had sex within the last four weeks, 65% [65%; 57%] of those who were very satisfied with erection hardness were also very satisfied with their sex life. In contrast, only 38% [60%; 45%] of those who were satisfied or less than satisfied with erection hardness were very satisfied with their sex life. Erection hardness was also associated with satisfaction with love and romance and overall health; these relationships were apparent for international men and Australian women.

Conclusion: Only 25% of Australian men surveyed were very satisfied with erection hardness. Similar to their international peers and Australian women, Australian men who were very satisfied with erection hardness were more likely to be very satisfied with their sex life, love and romance, and overall health.

SEXUAL HEALTH AND THE DEFENCE FORCES

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This presentation discusses findings revealed in the literature review that has been undertaken as a component of “a study of Chlamydia trachomatis: sexual risk behaviour, infection and prevention in the Australian Defence Force”.

A prevalence study of C. trachomatis infection in the Australian Defence Force has not previously been undertaken and this study will be the first to ask personnel in the ADF about their sexual behaviour and risk of STIs. Three sites have been selected for the study and a target to recruit 1000 personnel into the study has been set. The self administered survey asks for demographic information and sexual risk behaviour information. This includes: information place and type of last sexual activity; information about partners involved in sexual activity and information about risk taking behaviour. The outcomes of this study will be used to develop evidence based policies and procedures for the Australian Defence Force for monitoring prevalence of C. trachomatis infection in the ADF and for future training of health personnel in sexual health screening and information gathering. These will take the form of recommended ADF health directives and constitute a formal outcome of this project.

The literature review associated with this study has examined the history and epidemiology of Sexually Transmissible Infections (STIs) in the Australian Defence Forces and overseas Defence Forces; the effect of untreated C. trachomatis infection in Defence Forces; risk behaviours for STIs in Defence Forces; and Sexual Health Policies and Directives in Defence Forces in Australia and Overseas. The findings of this literature review will be discussed in the presentation.
p22
looking for stis in urine: multiplex pcr- reverse line blot assay- the next "big thing"?

mckechnie ml, couldwell d, kong f, hillman r, sintchenko v, gidding h, freedman e, gilbert gl

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men commonly present to sexual health services with urethral symptoms, but causative organisms are often not identified. a wide range of microorganisms has been implicated, but existing technologies limit their routine identification.

multiplex polymerase chain reaction-based reverse line blot (mPCR-RLB) assay allows rapid detection of multiple organisms in low concentrations. as part of an ongoing study at two sexual health clinics, we developed a mPCR-RLB assay to detect the following 14 microorganisms in urine: chlamydia trachomatis, neisseria gonorrhoeae, mycoplasma genitalium, ureaplasma urealyticum, ureaplasma parvum, trichomonas vaginalis, mycoplasma hominis, gardnerella vaginalis, herpes simplex virus types 1 and 2, adenovirus, neisseria meningitidis, haemophilus influenzae, and streptococcus pneumoniae.

development and validation of this method will be described. preliminary results, for the first 126 men enrolled, with and without urethral symptoms, revealed that c. trachomatis was detected in 7 (5.5%), n. gonorrhoeae in 3 (2.4%), h. influenzae in 4 (3.2%), hsv-1 in 2 (1.6%) and m. genitalium, adenovirus, n. meningitidis, s. pneumoniae, t. vaginalis, and g. vaginalis in one each. neither m. hominis nor hsv-2 were found in any specimens. in one man both c. trachomatis and n. gonorrhoeae were detected. ureaplasma results are not yet available.

mPCR-RLB is a patient-friendly way to rapidly identify a wide range of microorganisms from urine using a single laboratory method. further understanding of the epidemiology of these organisms will help in selecting future testing methods, treatment and partner management.

p23
using music to promote access to sexual health services, and advanced clinical nursing roles

muscardin dm, elmes ja

funds obtained from a successful new south wales (nsw) innovative scholarship, were used to assess and highlight local sexual health nursing skills in relation to consumer needs, and to develop an ‘upbeat’ music compact disc (CD). aimed at under 25year olds, the CD will provide information on prevention, transmission and screening of sexually transmitted infection’s & blood borne viruses whilst also promoting access to services.

local research, radio interviews and networking over the 12 month timeframe provided community education and promoted the benefits of screening to the community, particularly those likely to be affected by the high current rates of chlamydia.

this innovative project will use the music medium to deliver health messages. it will also provide insight into review and utilisation of nursing roles and skills whilst highlighting the benefits of the nurse practitioner role within sexual health services.

the CD will be played during the presentation.
MEANINGS OF MOTHERHOOD: WOMEN WHO USE DRUGS AND THEIR CONTRACEPTIVE BEHAVIOURS

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Health practitioners have recently noted a rise in the number of pregnant women presenting with drug problems. Women who use drugs are commonly found to practice low levels of contraception and experience high levels of unplanned pregnancy. Social discourse about contraception and motherhood among women who use drugs is predominately focused on dangers posed to children (both born and unborn). Drug using mothers are frequently depicted as the archetypal ‘bad’ mother. This extends to the medical sphere where there is evidence that women can be judged on social rather than medical grounds in relation to contraception and reproduction. These attitudes are closely linked to social views of the biological and social role of mothering, producing normative ideals and moral judgements about which women should avoid pregnancy.

Relatively little is known about the experiences of birth control, pregnancy and motherhood among women who use drugs. Available research suggests that drug using women expect to adopt the traditional caring roles for their children and share many of the same concerns, fears and hopes as other women.

Drawing on interviews with women living with Hepatitis C who inject drugs this paper will discuss how the social roles of child bearer and mother remain inextricably intertwined with contraceptive behaviours. A contraceptive history was taken from each of the women and have been analysed for personal, social and contextual meanings of birth control across a lifespan. These women’s experiences reflect a juggling of the dilemmas and contradictions of sexuality, fertility and motherhood. Despite their depiction as chaotic and careless, motherhood played a central role in the majority of participant’s reproductive health behaviours. The importance of fertility among this group should be used to encourage their improved sexual health and taken as a chance to expand women’s understanding of their reproductive body.

CHLAMYDIA CO-INFECTION RATES IN MEN WHO HAVE SEX WITH MEN PRESENTING WITH GONOCOCCAL URETHRITIS

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Australian and international guidelines for the management of gonococcal urethritis in men generally suggest presumptive treatment of possible Chlamydia co-infection. Opportunistic treatment for Chlamydia is considered good practice because of high co-infection rates in certain regions and the concern about patients not attending for follow up. This audit aims to describe the management of urethral gonorrhoea in men who have sex with men (MSM) in a metropolitan primary care practice, to determine the rate of Chlamydia co-infection and to establish whether empirical treatment of Chlamydia is appropriate in this clinical context. A retrospective case note review was performed on all men attending the Centre Clinic between 1st January, 2003 and 31st December, 2005 who were diagnosed with urethral gonorrhoea and who were symptomatic. During the study period, there were 72 cases of symptomatic gonococcal urethritis. All patients were MSM. 90% (65 of 72) of cases were given treatment for both gonorrhoea and Chlamydia. 30% (19 of 63) of gonorrhoea infections were found to be ciprofloxacin-resistant. Of the 72 cases of urethral gonorrhoea, 6 also had urethral Chlamydia (co-infection rate of 8%). More than 50% of symptomatic patients re-attended the clinic within one month. In MSM presenting with urethral gonorrhoea in this metropolitan area, the co-infection rate of Chlamydia was lower than anticipated and re-attendance was very high, so the use of empirical treatment for Chlamydia was not justified.
P26
TO SCREEN OR NOT TO SCREEN THAT IS THE QUESTION: DO GP’S AND YOUNG WOMEN SHARE THE SAME ATTITUDES AND VIEWS ABOUT CHLAMYDIA SCREENING?

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In-depth face to face interviews were carried out with a randomly selected sample of 20 General Practitioners (GPs) and 24 young women from across Victoria. We aimed to determine the attitudes of GPs and young women to Chlamydia screening, what systems and education would be required to support Chlamydia screening in general practice in Australia and, in particular, to explore how young women feel about being asked to test for Chlamydia when they attend a GP for any reason.

GPs and young women agreed that young women aged 16-24 should be screened for Chlamydia but young women did not believe that only sexually active young women should be offered screening. Both GPs and young women agreed that Chlamydia screening should be introduced at sexual health consultations but young women felt it was important that Chlamydia should be normalised and not stigmatised. Young women preferred testing by urine sample whereas GPs were more likely to suggest testing during a Pap test. Both GPs and young women agreed that being offered screening by a female GP was preferred. GPs felt that the most significant barrier to screening for them was the time taken to counsel a women who has a positive result, however, young women wanted time and support from their GPs if they tested positive for Chlamydia.

The issues on which GPs and young women did not agree need to be explored further if Chlamydia screening is to be implemented successfully in Australia.

P27
DEVELOPMENT OF NURSE-LED CLINICS IN WOMEN’S/SEXUAL HEALTH 2005-2007

Powell L. A.

Countsie Manukau District Health Board (CMDHB) – South Auckland New Zealand is a large geographical area in the largest city of New Zealand. The population of CMDHB is 400,000 (Manukau City Council website) and continues to grow at a significant rate. Residential and commercial developments are burgeoning and approx 50% of the population are in their teenage years.

This population presents a diverse group of issues related to sexual and reproductive health. Coupled with this are cultural beliefs around sexual and reproductive behaviours around the use of contraception including barrier methods amongst some cultural and religious groups.

The New Zealand Sexual and Reproductive Health Strategy 2002 commissioned by the Ministry of Health and the Youth Health-Health Issues Report 2007 aim to identify and address these issues and to improve access to contraception, and STI assessment and treatments to continue to reduce the inequalities particularly to Maori and Pacific peoples.

There are high levels of teenage pregnancy, high rates of Chlamydia and Gonorrhoea, and high rates of unwanted pregnancy with many choosing to terminate their pregnancies. These are compounded by significant socio-economic, cultural, issues impacting on people’s ability to control their fertility to reduce the unwanted/ unplanned pregnancies and to negotiate safer sex to reduce STI transmission and the potentially devastating sequelae of infertility and ectopic pregnancy. It is noted that Maori and Pacific patients are over- represented in the data.

The writer will present the project undertaken in March- December 2005 at CMDHB to understand and work towards improving these health statistics. She will also outline the nurse-led initiatives developed to continue the work and improve partnerships between secondary and primary care in South Auckland, New Zealand.
P28 HIGH GRADE ANAL INTRAEPITHELIAL NEOPLASIA – A GROWING PROBLEM?

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Background
Rates of anal carcinoma appear to be increasing in the developed world, particularly among HIV infected homosexual/bisexual men. High Grade Anal Intraepithelial Neoplasia (HGAIN, also known as AIN 2 & 3) is regarded by many as a precursor of invasive anal carcinoma. Using the analogy of CIN, it has been suggested that early diagnosis and treatment of HGAIN may reduce the incidence of anal cancer. Little is known about the epidemiology and natural history of anal neoplasia. We therefore sought to investigate the characteristics of people presenting with HGAIN.

Methods
The pathology databases at the participating sites were examined over the period 1995 to 2006. Histologically established cases of HGAIN were identified and a retrospective analysis of medical files was performed.

Results
A total of 161 cases were identified, with the number of cases rising from 4/yr in 1995 to 26/yr in 2005. 153 of the 161 (95%) were males, with a mean age of 47 years. Of the 123 patients who had been tested for HIV, 105 (85%) were HIV positive. Of the 55 cases in which the most recent CD4 count was known, the mean was 391 cells/µl (range 20 to 1161 cells/µl). Of the 57 cases in which the CD4 nadir count was known, the mean CD4 nadir was 207 cells/µl (range 1 to 744 cells/µl).

CONCLUSION
In our centres, the number of cases of HGAIN appears to be increasing over time, paralleling the rise in cases of anal carcinoma. Most patients were relatively young HIV positive men, with only modest evidence of immunosuppression. Increased awareness of the possibility of HGAIN amongst clinicians is important to enable early detection and management, and may form part of the response to the growing cases of anal cancer.

P29 A SUSTAINABLE HEALTH PROMOTION MODEL – ENGAGING TEACHERS AND THE COMMUNITY HEALTH SECTOR IN SEXUALITY EDUCATION INTERVENTIONS

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This presentation will examine a health promotion model used in rural Victoria to increase the capacity of a cluster of primary schools to implement sustainable health and sexuality programs. The model was independently evaluated by Deakin University with very favourable outcomes. In 2006 it was replicated in a further two cluster areas.

The presenters will outline the model used including:
- the findings of the initial Needs Analysis
- an outline of the 2 day professional development session which was conducted to increase capacity of local teachers to deliver sexual health interventions in schools
- the importance of linkages with the local community health centre
- what worked and what didn’t work as well
- linkages to the Health Promotion Continuum framework
- findings from the Evaluation Report of the professional development and
- recommendations for future programs

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Aim:
This retrospective audit investigated the method of referral to sexual health services for 16-25 year old clients at Brisbane Sexual Health Clinic (BSHC) who were diagnosed with a positive result of Chlamydia trachomatis (Ct) in the time periods in 1995-1998 and 2004-2007.

Methods:
The inquiry searched the BSHC database records for asymptomatic and symptomatic Ct positive 16-25 year old clients at BSHC in the two time periods 1995-1998 and 2004-2007. Clients self nominated methods of referral during registration by indicating on the Client Registration Form modes of access in the section titled “How did you hear about this service?” Options for selection included Phone Book, Dr Referral, Partner, Friend (not partner), previous visit, Other Health Agency, Newspaper, and Contacted by Clinic, TV/Radio, Men’s Club, Information Booth, Cinema Ad, Pamphlet, Internet and Other.

Results:
In the time period 1995-1998, 101 (83 male and 18 female) symptomatic Ct positive 16-25 year old clients were identified. “Friend (not partner)” totalled 24 (38%) of clients reporting that this was how they had accessed clinic services.
Ct positive asymptomatic clients accessing services in the period 1995-1998 totalled 192 (94 male and 98 female).
Results indicated “Friend (not partner)” a total of 70 (38%) nominated this method of awareness of services.
Nil clients accessed “Internet website” to source information about BSHC services during this time period.
Comparatively, during the 2004-2007 time periods of the 191 (167 male and 24 female) symptomatic 16-25 year old clinic attendees with a positive result “Internet website” was recorded by 34 (12%). “Friend (not partner)” was indicated by 25 (8%) of clinic attendees to be an information access point. This contrasts with asymptomatic clinic attendees during this period who nominated “Friend not partner” as the most frequent access point with 117 (39%).

Conclusion:
Increasing use of technology i.e. Internet websites and Texting are useful sources of information to assist clients.
The audit also highlights that “Friend (not partner)” peer support is an important feature of re-accessing the clinic.
P31
SWINGS AND ROUNDBOUTS – A SNAP SHOT OF PEOPLE LIVING WITH HIV/AIDS AGING AND THEIR PSYCHOSOCIAL ISSUES BEING EXPERIENCED IN AN AUSTRALIAN RURAL AREA

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Objectives: To create an understanding of the issues that People Living with HIV/AIDS (PLWHA) are beginning to experience as they come of age and are faced with life decisions they may now need to make to increase their supports – either in their own home or in a Nursing Home.

Methods: There is very little empirical research documented regarding the aging population of PLWHAs and the psychosocial issues they may encounter. Anecdotal evidence and case presentation material has been used to collate this information. Due to the issues of confidentiality for people living with HIV/AIDS in rural areas and the small populations in those areas a high degree of care has been taken so that these people are not identifiable.

Results: Psychosocial issues experienced by PLWHAs in an Australian rural area are varied. PLWHA’s often have complex needs such as AIDS related dementia cognitive impairment resulting from aneurysm, stroke, heart attack and/or other adverse reactions from HAART. Stigma and discrimination is still happening. Partners family and friends supporting and caring for PLWHAs reported difficulties in accessing services and supports. Anecdotal evidence from aged care teams have found it difficult to place a person in care with an infectious disease due to some nursing homes finding it difficult to implement universal precautions or are reluctant to have to deal with the perceived complications. However, some nursing homes are requesting training to enable them to meet the needs of PLWHAs and assist them in equity of access.

Conclusions: This is a snap shot of what is happening in rural Australian. The sad picture is rural nursing homes are not ready for the increase of PLWHAs accessing services. Some nursing homes are acknowledging they need the skills base. Additional research needs to be conducted to see how extensive the problem is rurally and throughout Australia.

P32
USING A MATHEMATICAL MODEL TO DETERMINE FREEZING TIME OF WARTS UNDER DIFFERENT CRYOTHERAPY METHODS

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A mathematical model that determines the optimum freezing time of papular skin lesions of various sizes is applied to a variety of cryotherapy methods. These methods include liquid nitrogen spray and nitrous oxide cooled probes. The model uses the fundamental heat conduction equations coupled with possible phase change in the tissue to track the temperature throughout the legion and adjacent skin. This can be used to estimate the freezing time of papular lesions of various size and predict damage to surrounding tissue.

The optimal placement of the cold source and application time is discussed.
P33
RISK REDUCTION PRACTICES AMONG GAY MEN IN REGULAR RELATIONSHIPS

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Introduction: Universal condom use by gay men in regular relationships is unlikely. We explored safer sex practices employed by gay men to reduce the risk of HIV transmission in the context of unprotected anal intercourse with regular partners (UAIR).

Methods: We used behavioural data from the Sydney Gay Community Periodic Survey (SGCPS), a cross-sectional survey of gay men which annually recruits participants in various venues in Sydney. A short self-administered questionnaire collects information about HIV serostatus of the respondents and their primary regular partners, sexual practices within relationships and other behaviours. We present the prevalence of and time trends in monogamous HIV negative relationships, and the use of strategic positioning and withdrawal.

Results: In 2006, 2,261 men were in regular relationships with the risk of HIV transmission (not concordant HIV positive); 1,229 (54%) of them reported some UAIR (66% of men in seroconcordant HIV negative relationships, 40% in serodiscordant relationships). Among men in seroconcordant HIV negative relationships, the majority (55%) stayed monogamous, there was no obvious preference for strategic positioning, and 59% reported using withdrawal before ejaculation. Among men in not seroconcordant relationships, only one third remained monogamous, 31% reported preference for insertive only positioning (compared to 13% receptive only and the rest practicing both), and 59% reported using withdrawal. More than two-thirds of men in all relationships practiced at least one of these safer sex practices, and this proportion increased during 1996-2006.

Conclusion: Substantial proportion of men in regular relationships with the risk of HIV transmission practice UAIR, but majority of these men balance risk by using safer sex practices. Understanding of these practices may help better tailor HIV prevention strategies.

P34
ATTITUDES TO CHLAMYDIA SCREENING IN GENERAL PRACTICE AMONG UNIVERSITY STUDENTS: A PILOT STUDY

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Chlamydia screening in general practice is one of the key elements of the national STI strategy. Sexually active young people are a target group for Chlamydia screening but face several barriers accessing primary health care. Overseas research has found that young people generally have favourable attitudes towards opportunistic screening for Chlamydia during visits to their general practitioner (GP). The aims of this pilot study were to explore the attitudes of university students (16 – 25 years) towards opportunistic screening in primary health care, preferences for the settings in which screening might be offered and preferred method of testing. The sampling frame was 1st year undergraduate students from three faculties (Arts, Science and Education) at a university in Sydney. One class from each faculty was selected on the basis of convenience. A questionnaire was administered under examination conditions and collected demographic information, sexual history, Chlamydia knowledge, attitudes towards Chlamydia screening and preferred setting for screening and method of Chlamydia testing. One hundred and eighty-five questionnaires were returned (78% female), with a participation rate of 89 – 94%. Arts students were younger, more likely to be sexually active and to report having little or no knowledge of Chlamydia. Science students and males were significantly less likely to have had sexual intercourse. Thirty of 110 sexually active students (27%) reported having had a Chlamydia test. Seventy-six percent of students said they were comfortable with routine testing for Chlamydia by their GP. Reasons for not being comfortable included “don’t think I’m at risk” (13%), “it should be a choice” (13%), and “not comfortable discussing sexual matters” (8%). Seventy-two percent preferred their GP as the setting to have a Chlamydia test and 17% nominated a sexual health clinic. These findings have implications for the introduction of a Chlamydia screening program in general practice in Australia.
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PRELIMINARY ANNOUNCEMENT

2008 NSW
Scientific Meeting

Friday 29 February 2008
(the day before Mardi Gras!)
Citigate Central Sydney, NSW, Australia

For more information contact:
The Australasian Chapter of Sexual Health Medicine
145 Macquarie Street
SYDNEY NSW 2000
T: (61 2) 9256 9643
F: (61 2) 9256 9693
Email: sexualhealthmed@racp.edu.au
PRELIMINARY ANNOUNCEMENT

Monday 15 to Wednesday 17 September 2008

PERTH CONVENTION CENTRE, WESTERN AUSTRALIA

(The conference will be held back-to-back with the 20th Annual ASHM Conference, 17 - 20 September 2008)

Some of the proposed presentations:
- HPV/STIs/HIV
- Syphilis
- Chlamydia
- Public Health
- Vulvodynia

For more information contact:
The Conference Secretariat on
Tel: 61 2 8204 0770
Email: info@sexualhealthconference.com.au
www.sexualhealthconference.com.au
Convened by the Australasian Chapter of Sexual Health Medicine

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Tel: 61 2 9256 9643
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