Dear Colleagues,

It is our pleasure to welcome you to Perth for the Australasian Sexual Health Conference, to be held from Monday 15 to Wednesday 17 September 2008. The theme of the conference is ‘Diamonds and Pearls’.

Some of the proposed presentations this year include HPV/STIs/HIV, Syphilis, Chlamydia, Public Health and Vulvodynia. The international and local speakers are experts in their field, and their presentations will both educate and entertain. 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 Wednesday 17 September and will be in conjunction with the ASHM Conference delegates. The theme of the dinner is ‘Diamonds are Forever’, and it promises to be a night of good food, entertainment and full of sparkle.

The conference venue is Perth Convention and Exhibition Centre located within Perth city centre. Perth city centre lies on the banks of the peaceful waters of the Swan River, 20 kilometres inland from the Indian Ocean on the west coast of Australia. For spectacular panoramic views of Perth and the Swan River, it is worth visiting Kings Park and Botanic Garden and taking advantage of the many lookouts and vantage points available to the public. You can also enjoy a relaxing picnic in one of the many recreation areas of the park. The Swan River also provides an excellent scenic backdrop while dining in Perth. Many restaurants have impressive river views, so you can enjoy delicious meals while taking in the surrounding landscape. Perth city centre also offers a wealth of shopping opportunities.

We look forward to meeting you in Perth and thank you for your attendance at the 2008 Sexual Health Conference.

Dr Jenny McCloskey
Convenor
Royal Perth Hospital, Western Australia

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Scientific & Advisory Organising Committee

**Convenor: Jenny McCloskey**  
Royal Perth Hospital, WA

**Katrina Allen**  
SHine SA

**Fraser Drummond**  
Sydney Sexual Health Centre, NSW

**Christine Dykstra**  
Department of Health, WA

**Donna Keeley**  
Fremantle Hospital, WA

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

**Lewis Marshall**  
Fremantle Hospital, WA

**Rene Reddingius**  
Communicable Disease Control Directorate, Department of Health, WA

**David Smith**  
North Coast Area Health Service, NSW

**Richard Teague**  
Melbourne Sexual Health Centre, VIC

**Henrietta Williams**  
The University of Melbourne, VIC

**Professional Conference Organisers**  
Daliah Szwarc, Nadine Giatras, Nicole Robertson  
Australasian Society for HIV Medicine  
LMB 5057, Darlinghurst NSW 1300  
Phone: 61 2 8204 0770  
Fax: 61 2 9212 4670
Supporting the care of patients with HIV in Australia and NZ
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.
Anyone can get herpes.

Herpes doesn’t only affect one type of person. In fact, herpes is so common that you can catch it even if you’ve only had a few sexual partners. So if you have recurring symptoms like redness or itching anywhere inside your underwear, next time they appear see a doctor. For more information visit thefacts.com.au
PROGRAM AT A GLANCE
<table>
<thead>
<tr>
<th>Time</th>
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<tr>
<td>7.30am</td>
<td>Registration opens</td>
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<tr>
<td>8.30am - 9.30am</td>
<td>Arrival Coffee/Tea and Exhibition Opening in Pavilion 1</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>11.00am - 11.30am</td>
<td>Morning Tea in Exhibition and Poster Area in Pavilion 1</td>
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<tr>
<td>11.30am - 1.00pm</td>
<td>Plenary 2 - Pearls to Think About</td>
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<td>1.00pm - 2.00pm</td>
<td>Lunch in Exhibition and Poster Area in Pavilion 1</td>
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<td>2.00pm - 3.30pm</td>
<td>Symposium - Aboriginal Health: Mining For Gold</td>
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<td>Meeting Room 1, 2</td>
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<td>Proffered Papers - Epidemiology: Bangles</td>
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<td>Meeting Room 3</td>
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<td>Proffered Papers - Systems: Baubles</td>
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<td>Riverview 4</td>
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<td>Proffered Papers - Chlamydia: Beads</td>
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<td>Meeting Room 6</td>
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<td>3.30pm - 4.00pm</td>
<td>Afternoon Tea in Exhibition and Poster Area in Pavilion 1</td>
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<td>4.00pm - 5.30pm</td>
<td>Proffered Papers - Aboriginal Health: Prospecting for Diamonds</td>
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<td>Meeting Room 1, 2</td>
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<td>Proffered Papers - Clinical: Precious Pearls</td>
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<td>Meeting Room 3</td>
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<td>Proffered Papers - Public Health: Cultured Pearls</td>
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<td>Riverview 4</td>
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<td>Proffered Papers - Education: Keshi Pearls</td>
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<td>Meeting Room 6</td>
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<tr>
<td>5.30pm - 7.00pm</td>
<td>Welcome Reception in Exhibition and Poster Area, Pavilion 1, Perth Convention Centre</td>
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<td>Sponsored by Novartis</td>
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<tr>
<td>7.00pm</td>
<td>AChSHM Trainee Dinner</td>
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<tr>
<td>7:30am - 9:00am</td>
<td>Registration Opens</td>
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<tr>
<td>7:30am - 9:00am</td>
<td>Trainee Update Breakfast Session</td>
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<td>Riverview 4</td>
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<td>8:00am - 9:00am</td>
<td>Arrival Coffee/Tea in Exhibition and Poster Area in Pavilion 1</td>
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<tr>
<td>9:00am - 10:45am</td>
<td>Plenary 3 - Elusive STIs</td>
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<td>Meeting Room 1,2,3</td>
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<tr>
<td>10:45am - 11:15am</td>
<td>Morning Tea in Exhibition and Poster Area in Pavilion 1</td>
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<tr>
<td>11:15am - 12:15pm</td>
<td>Plenary 4 Debate: The Great Debate: To Screen or Not to Screen?</td>
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<td>Meeting Room 1,2,3</td>
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<tr>
<td>12:15pm - 1:30pm</td>
<td>Lunch in Exhibition and Poster Area in Pavilion 1</td>
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<tr>
<td>12:30pm - 1:15pm</td>
<td>Syphilis Symposium in Meeting Room 8; Lunch will be provided there for attendees</td>
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<td>Meeting Room 1,2,3</td>
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<tr>
<td>1:30pm - 3:00pm</td>
<td>Symposium: Gynaes are a Girl's Best Friend</td>
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<td>Meeting Room 1,2</td>
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<tr>
<td>1:30pm - 3:00pm</td>
<td>Symposium: Sticky Moments</td>
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<td>Riverview 4</td>
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<tr>
<td>1:30pm - 3:00pm</td>
<td>Proffered Papers - Social Research: Champagne Diamonds</td>
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<td>Meeting Room 3</td>
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<tr>
<td>3:00pm - 3:30pm</td>
<td>Afternoon Tea in Exhibition and Poster Area in Pavilion 1</td>
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<tr>
<td>3:30pm</td>
<td>Exhibition Closes for ASHM Conference Exhibition set up</td>
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<tr>
<td>3:30pm - 4:30pm</td>
<td>Trainee Session: Diamonds in the Rough. Presented by Chapter Trainees</td>
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<td>All Delegates are invited to attend. Jan Edwards Prize awarded to the best oral presentation</td>
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<td>Meeting Room 3</td>
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<tr>
<td>4:30pm - 4:45pm</td>
<td>Break</td>
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<tr>
<td>4:45pm - 5:45pm</td>
<td>Annual Chapter Meeting</td>
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<td>Meeting Room 3</td>
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<tr>
<td>5:45pm</td>
<td>ASHNA Nurses Meeting</td>
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<td>Meeting Room 11</td>
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**WEDNESDAY 17 SEPTEMBER**

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<tr>
<td>7.30am</td>
<td>Registration Opens</td>
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<tr>
<td>8.00am - 9.00am</td>
<td>Arrival Coffee/Tea in Pavilion 1</td>
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<tr>
<td>9.00am - 10.30am</td>
<td>Sexual Health Plenary 5: A Mixed Bag of Jewels</td>
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<td>Meeting Room 1,2,3</td>
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<tr>
<td>8.30am - 10.30am</td>
<td>ASHM Opening Ceremony</td>
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<td>Riverside Theatre/Auditorium</td>
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<td>10.30am - 11.00am</td>
<td>Morning Tea in Exhibition &amp; Poster Area in Pavilion 1</td>
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<td>11.00am - 12.30pm</td>
<td>Sexual Health Plenary 6: Drugs and Sex</td>
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<td>ASHM Session: Women Risk HIV - International</td>
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<td>ASHM Session: ACH2 Bench to Bed 1</td>
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<td>Meeting Room 8</td>
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<tr>
<td>12.30pm - 1.30pm</td>
<td>Lunch in Exhibition &amp; Poster Area in Pavilion 1</td>
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<tr>
<td>12.45pm - 1.15pm</td>
<td>Launch of the Annual Surveillance Report and the Annual Report of Trends in Behaviour from the National Centre in HIV Epidemiology and Clinical Research</td>
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<td>Meeting Room 8</td>
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<td>1.30pm - 3.00pm</td>
<td>Sexual Health Plenary 7: Out of Sight Out of Mind</td>
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<td>ASHM Session: IDU - Domestic</td>
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<td>Riverside Theatre/Auditorium</td>
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<td></td>
<td>ASHM Session: ACH2 Bench to Bed 2</td>
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<td>Meeting Room 8</td>
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<tr>
<td>3.30pm - 3.30pm</td>
<td>Afternoon Tea in Exhibition &amp; Poster Area in Pavilion 1</td>
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<tr>
<td>3.30pm - 5.00pm</td>
<td>Sexual Health Conference Closing</td>
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<td>Meeting Room 1,2,3</td>
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<td>ASHM Session: Virology/Immunology</td>
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<td>ASHM Session: Economics and Policy</td>
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<td>Meeting Room 8</td>
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<tr>
<td>5.15pm - 6.15pm</td>
<td>ASHM Session: Circumcision: Crown Jewels</td>
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<td>Riverside Theatre/Auditorium</td>
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<td>ASHM Session: Diagnostics and Assay Development</td>
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<td>Meeting Room 1,2,3</td>
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<tr>
<td>7.30pm - 11.30pm</td>
<td>Joint Conference Dinner, 'Diamonds are Forever' - Bellevue Ballroom, Perth Convention Centre</td>
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<td>Sponsored by the Australian Government Department of Health and Ageing, WA Health, GlaxoSmithKline, Boehringer Ingelheim, Gilead and Merck Sharp &amp; Dohme</td>
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Novartis is a world leader in the research, development and supply of products to protect and improve health and well-being.

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 98 000 people and operates in over 140 countries around the world.

In Australia the company now employs more than 600 people, and invests over AUD $30 million annually in local research. This research underpins our commitment to developing effective medicines and improving health of patients.

Novartis medicines treat some of the most serious health conditions confronting healthcare professionals and their patients. The company’s work is spread across many diseases in the areas of Primary Care, Oncology, Transplantation, and Ophthalmics.
DR JEFFREY KLAUSNER
Since 1998 Dr Jeffrey Klausner has been Director of Sexually Transmitted Disease Prevention and Control Services for the San Francisco Department of Public Health and is currently an Associate Clinical Professor of Medicine at the University of California San Francisco, School of Medicine.

Dr Klausner is Board Certified in Internal Medicine and Infectious Diseases and has an active clinical practice. Dr Klausner received his Medical Degree from Cornell University and a Masters of Public Health degree from the Harvard School of Public Health.

Dr Klausner has published over 150 manuscripts related to the epidemiology of sexual risk behaviour, substance use, the Internet, antimicrobial resistance, STDs and HIV infection. He is the senior editor of the new text book “Current Diagnosis & Treatment of Sexually Transmitted Diseases.”

Dr Klausner received the 2002 American STD Association Young Investigator Award and in 2006 a Special Recognition Award from UCSF for his contributions in teaching.

DR JORMA PAAVONEN
Dr Jorma Paavonen graduated from the Medical School, University of Helsinki in 1973, specialised in Obstetrics and Gynecology in 1979, and received his PhD in 1979. He spent two years as a Visiting Scientist at the Departments of Obstetrics and Gynecology and Medicine at the University of Washington, Seattle from 1981 to 1982. He returned to the University of Washington as Visiting Professor from 1984 to 1987. He then returned to the Department of Obstetrics and Gynecology, University of Helsinki as a clinical assistant Physician-in-Chief. He was nominated as an Associate Professor in Obstetrics and Gynecology, University of Helsinki, in 1991, and became full professor in 1998. He is currently Professor of Obstetrics and Gynecology and divides his time amongst teaching, research and clinical work. Since 1978 he has published around 400 original or review articles in peer-reviewed journals. His main research areas are sexually transmitted infections, particularly chlamydial and HPV infections, adverse pregnancy outcome, and menorrhagia. He has two sons, also medical doctors, and four grandchildren.

DR JOEL PALEFSKY
Dr Joel Palefsky is Professor of Medicine at the University of California, San Francisco and Associate Dean for Clinical and Translational Research. He is co-director of the UCSF Clinical and Translational Sciences Institute. A graduate of the McGill University School of Medicine, Dr Palefsky was a resident in Internal Medicine at McGill University and did his fellowship in Infectious Diseases at Stanford University. His research focus is on the molecular biology, treatment and natural history of anogenital HPV infections. He is an internationally recognised expert in the manifestations of HPV infection and anogenital pre-cancerous disease. He is the director of the world’s first clinic devoted to prevention of anal cancer, the Anal Neoplasia Clinic at the UCSF Cancer Center. He is the head of the HPV Working Group of the NCI-sponsored AIDS Malignancy Consortium and is co-director of the Cancer and Immunology Program of the UCSF Cancer Center. He is the author of over 160 publications.

PROFESSOR BASIL DONOVAN
Professor Basil Donovan is a practising sexual health physician at the Sydney Sexual Health Centre, Sydney Hospital, where he was the Director from 1990 to 2003. He is also the Professor of Sexual Health at the National Centre in HIV Epidemiology & Clinical Research, University of New South Wales in Sydney. His research and policy interests include: clinical and public health aspects of HIV/AIDS and other sexually transmissible infections (STIs); STI prevention strategies; and the health of priority populations such as homosexually active men, sex workers, prisoners, travellers, and Indigenous people.
PROFESSOR SUZANNE GARLAND
Professor Suzanne Garland is Director of Microbiological Research and Head of Clinical Microbiology and Infectious Diseases, Royal Women's Hospital, Senior Consultant Microbiology and Infectious Diseases, Royal Women's and Royal Children's Hospitals, Women's and Children's Health Melbourne. She is also a practising sexual health physician. As one of Victoria's leading clinical microbiologists, Professor Garland is well known for her research on infectious diseases, having been involved in clinical trials of antivirals and vaccines for herpes simplex virus. She has a special interest in the management of herpes in the pregnant woman and the neonate, and she chairs the Obstetrics and Gynaecological working group of the Australian Herpes Management Forum (AHMF).

PROFESSOR RICHARD HILLMAN
Richard trained as a general physician in Edinburgh, Scotland, before specialising in HIV & Sexual Health in London.

On arrival in Australia, he became Senior Staff Specialist at the STI Research Centre, Westmead Hospital and Conjoint Senior Lecturer at the University of Sydney. He also holds appointments as Consultant Immunology Specialist at St Vincent's Hospital and is a Visiting Senior Lecturer at NCHECR, University of New South Wales.

Richard completed his doctorate in the molecular epidemiology of HPV at the University of Edinburgh and has published 35 peer-reviewed original publications, 9 published letters, 6 published reviews, two books and two chapters in books.

Richard currently is Postgraduate Coordinator of the University of Sydney STI/HIV Program and is Chair of Education Committee, Chapter Of Sexual Health Medicine, Royal Australasian College of Physicians. His research interests include HPV, anal cancer and sexual health education.

PROFESSOR MATTHEW LAW
Professor Matthew Law is Associate Professor and Head of the Biostatistics and Databases Program at the National Centre in HIV Epidemiology & Clinical Research (NCHECR). He has more than 20 years' experience as a biostatistician, working on randomised clinical trials. His research interests include clinical research in HIV, HCV and STIs, mathematical modelling of infectious disease epidemics, and biostatistical methodology.

PETER LEONE
Dr. Leone is an Associate Professor of Medicine at University of North Carolina at Chapel Hill, NC. He is the Director of the North Carolina HIV/STD Prevention and Control Branch and is an expert in HIV/STD surveillance, prevention, and control. Dr. Leone is well versed in epidemiology and policy. His many publications focus on screening practices for Primary Care Providers, issues for patients regarding evolving the health care environment, self-treatment patterns, and the effect of self treatment on symptom duration. His work is comprehensive and encompasses the breadth of issues related to STDs, diagnostics, and treatment.

Under Dr. Leone's direction, North Carolina became the first state in the country to test for acute HIV in November 2002. This new model is very different than anything that's been done for HIV anywhere in the world. There is no other state in the union that's doing this program. The benefit of identifying acute HIV on the individual level gets a patient into care, perhaps making a difference in their long term progression. The benefit to partners is by preventing transmission.

Dr. Leone has combined laboratory services through the state lab with field service activities.

KATHLEEN MAZZELLA
Kathleen Mazzella is Founder of GAIN (Gynaecological Awareness Information Network). Kath has endured the trauma of being diagnosed and treated for a gynaecological cancer – vulval cancer. Kath sought a support network for women who had endured similar trauma of a gynaecological cancer and, as a result, set up GAIN. Many women afflicted with gynaecological conditions feel alienated and isolated. They often suffer in silence, afraid of what they don't know, and lacking the courage to share their anguish.

While Kath received adequate support from healthcare professionals and family, she felt there was a deep-seated need to be able to share her experiences with other women; to know that she was not alone in her suffering and healing.
**DR ELIZABETH PHILLIPS**
Dr Elizabeth Phillips has been Professor and Director of the Centre for Clinical Pharmacology and Infectious Diseases at Murdoch University, Perth, Western Australia since 2006. She is also Consultant in the Department of Immunology at Royal Perth Hospital and Sir Charles Gairdner Hospital where she treats patients with HIV and runs a drug-hypersensitivity program across disciplines. She qualified through the Royal College of Physicians & Surgeons of Canada in internal medicine, infectious diseases, clinical pharmacology and clinical microbiology. She was previously on faculty at the University of Toronto, and consultant in the Divisions of Infectious Diseases and Clinical Pharmacology at Sunnybrook Health Sciences Centre (Toronto) from 1999 to 2004 and the University of British Columbia and Division of Infectious Diseases, British Columbia Centre for Excellence in HIV/AIDS, St. Paul’s Hospital, (Vancouver) from 2004 to 2006 where she ran clinical and research programs related to drug-hypersensitivity and pharmacology in Infectious Diseases and HIV Medicine.

**DR DAVID SPEERS**
Dr David Speers is an Infectious Diseases Physician at Sir Charles Gairdner Hospital (SCGH), a Clinical Microbiologist at PathWest Laboratory Medicine (PWLM) and a Clinical Senior Lecturer for the Department of Medicine and Pharmacology at the University of WA. He is a fellow of the Royal Australasian College of Physicians and the Royal College of Pathologists of Australasia. He has been appointed to the Executive Advisory Group of the WA Infection and Immunology Network, the WA Communicable Diseases Control Directorate Strategic Advisory Group, the Healthcare Associated Infection Council of WA and the WA Therapeutics Advisory Group. Nationally he is a member of the TGA Advisory Group for Biologicals and the Communicable Diseases Network of Australia Steering Group on blood borne viruses in health care workers. He works in the PWLM Molecular Diagnostics, Serology and Virology section and the SCGH Hepatology and Liver Transplantation Service, being involved in the clinical management and laboratory diagnosis of viral hepatitis.

**DR DAVID SMITH**
Dr David Smith is a graduate of the University of Western Australia, and trained in medical microbiology in Perth. He is currently Head of the Division of Microbiology and Infectious Diseases at PathWest. He also has appointments as a Clinical Associate Professor in the Department of Microbiology at the University of Western Australia, and as an Adjunct Professor in the Australian Biosecurity Cooperative Research Centre at Curtin University of Technology. He serves on a number of state and commonwealth government advisory committees, including the Microbiology Advisory Committee of the Royal College of Pathologists of Australasia, as well as the advisory committees for the Microbiology and Serology Quality Assurance Programs. His research interests include molecular methods for diagnosis of infectious diseases and laboratory-based surveillance of communicable disease. This has included improved methods for diagnosis of genital ulcer disease, molecular studies of gonococcal and chlamydial infections, and laboratory guidelines for diagnosis of gonorrhoea. He has authored or co-authored several book chapters and many medical journal articles on infectious diseases.

**JAMES WARD**
James Ward is the Program Manager, Aboriginal and Torres Strait Islander Health at the National Centre in HIV Epidemiology and Clinical Research based at the University of NSW. He has a long history of working in sexual health, public health and Aboriginal health in Australia across jurisdictions. He is a member of the NSW Ministerial Advisory Committee on HIV/AIDS and Sexually Transmitted Infections, a member of the Indigenous Australians Sexual Health Committee and Chair of the NSW Aboriginal Sexual Health Advisory Committee.
Give them the privacy they prefer

**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 25 cm² 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 SKs has not been established. There are limited data of Aldara cream on recurrence of SK. Aldara should not be used in an area >25 cm² 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 1 cm 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 $159.52. 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: 1.0 Mahony C. Am J Clin Dermatol 2005;6(4):239-243. iNova Pharmaceuticals (Aust) Pty. Ltd. ABN 88 000 222 408. 9-15 Chilvers Road, Thornleigh NSW 2120. www.inovapharma.com © 2008 iNova Pharmaceuticals (Aust) Pty. Ltd. URSA IN00831.
Gilead recognizes the urgent need for access to healthcare capacity as well as HIV medications worldwide, particularly in developing countries where the AIDS epidemic is devastating communities. We believe that the medicines we develop should be accessible to all patients who need them worldwide, regardless of income or location.

Our heart is in the right place.

We are undertaking the following initiatives locally and globally to help further expand access to our medicines and build healthcare capacity in resource-limited settings:

**Gilead Access Program** – to provide Viread® (tenofovir disoproxil fumarate) and Truvada® (emtricitabine/tenofovir disoproxil fumarate) at substantially reduced prices in many low and middle income countries. This has been ongoing since 2003.

**Partnerships with Generic Manufacturers** – Gilead has signed non-exclusive licenses with multiple Indian generic manufactures to provide low cost high-quality generic versions of Viread® in 95 resource-limited countries, which are home to 95% of the world’s HIV infected people.

**The Gilead Foundation** – focused on improving health infrastructure in the developing world.

**A member of the Collaboration for Health in Papua New Guinea (CHPNG)** – to create sustainability and capacity in HIV management in PNG and meet the needs identified by our primary stakeholders and partners – ASHM and NAPWA.
GENERAL INFORMATION

For more information contact:
The Conference Secretariat on
Tel: 61 2 8204 0770
Email: info@sexualhealthconference.com.au
www.sexualhealthconference.com.au
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.

VENUE
Perth Convention and Exhibition Centre
21 Mounts Bay Road
Perth, Western Australia 6000
PO Box 7451
Cloisters Square
Perth Western Australia 6850
Ph: +61 8 9338 0300
Fax: +61 8 9338 0309

The venue will host the conference sessions, poster presentations, the breakfast session, conference day catering, the trade exhibition and the Gala Dinner.

REGISTRATION DESK
All enquiries should be directed to the registration desk, located on Level 2 of the Perth Convention and Exhibition Centre. The desk will be open at the following times:
- Monday 15 September 2008: 7.30am – 5.30pm
- Tuesday 16 September 2008: 7.30am – 5.30pm
- Wednesday 17 September 2008: 7.30am – 6.30pm

SPEAKER PREPARATION ROOM
A speaker preparation room will be located in Meeting Room 12. This room will be open at the following times:
- Monday 15 September 2008: 7.30am – 6.00pm
- Tuesday 16 September 2008: 7.30am – 6.00pm
- Wednesday 17 September 2008: 7.30am – 6.00pm

All speakers are requested to 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.

EXHIBITION
An exhibition will be held in Pavilion 1 of the Perth Convention Exhibition Centre.

The Australasian Sexual Health Conference exhibition opens on Monday 15 September 2008 at 8.30am and concludes on Wednesday 17 September 2008 at 5.00pm. It will close at 3.30pm on Tuesday 16 September 2008 to allow the ASHM Conference exhibitors to set up. The exhibition will be open during the following hours:
- Monday 15 September 2008: 8.30am – 7.00pm (includes Welcome Reception)
- Tuesday 16 September 2008: 8.00am – 3.30pm
- Wednesday 17 September 2008: 8.00am – 5.00pm

POSTER DISPLAY
Posters will be displayed for the duration of the Conference in Pavilion 1 in the Exhibition area. Posters will be available for viewing on Monday 15 September from 11.00am until Wednesday 17 September at 3.30pm. 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 during the conference reception.

INTERNET CAFÉ
An Internet café, proudly sponsored by the Australasian Chapter of Sexual Health Medicine will be available on Monday 15 September 2008 and Tuesday 16 September 2008 at booths 31 and 32 in Pavilion 1.

The Internet café, proudly sponsored by Janssen-Cilag Tibotec will be available in Pavilion 1, at Booths 31 and 32. This will be available from Wednesday 17 September 2008 at 8.00am until Friday 19 September 2008 at 3.30pm.

INFORMATION HUB
The Information Hub will be located on Level 2 next to the registration desk. Three computers will be available for:
- Completing an online conference evaluation survey
- Printing a certificate of attendance
- Viewing the Australasian Chapter of Sexual Health Medicine Mock Exit Assessment Presentation
- Viewing the abstract search database
- Viewing delegate lists
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. Sign-in sheets for RACGP will be available at the conference and must be signed by GPs. You will be able to print a certificate of attendance at the Information Hub.

SMOKING
This conference has a no smoking policy. Outdoor areas are available close to the venue.

MOBILE PHONES/BEEPERS
As a courtesy to all delegates and speakers, please switch off, or set to silent, your mobile phones and beepers during all sessions.

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

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

EVALUATION SURVEYS
Evaluation Surveys will be available on-line at the Information Hub. We ask that all delegates complete this survey electronically to go into a prize draw to win two tickets for the Sydney Harbour Bridge Climb.

DELEGATE LIST
A delegate list will be viewable at the Information Hub.

EXIT ASSESSMENT DVD
Trainees are invited to view the newly produced DVD on one of the PCs located at the Information Hub.

AWARDS
The following awards will be presented during the closing session of the conference on Wednesday 17 September 2008.

THE JAN EDWARDS PRIZE, SPONSORED BY NOVARTIS
Jan Edwards/Novartis Prize was named in honour of the long-serving Executive Secretary of the previous Australasian College of Sexual Health Physicians. On 15 September 2005 Dr Jan Edwards left after serving 19 years with the College of Sexual Health Physicians and overseeing the affiliation to the Chapter of Sexual Health Medicine with the RACP.

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

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

The judging panel will be chaired by the President of the Chapter Committee and will comprise two Fellows who attended all the presentations by the eligible trainees. In choosing the best paper the judges shall take into account the concept and content of the study and the manner of presentation.
Value: A$500.00

THE SEXUAL HEALTH SOCIETY OF VICTORIA PRIZES
There are two prizes in this category. One for the best poster presentation on clinical/epidemiological research, the other for the best poster presentation on social/behavioural research.
Value: 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 ASHNA AWARD
The Australasian Sexual Health and HIV Nurses Association Inc offer a prize to the best poster or oral presentation by nurses. Open to members and non-members
Value: A$500.00
WELCOME RECEPTION
5.30pm - 7.00pm, Monday 15 September 2008
Pavilion 1, Perth Convention and Exhibition Centre
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 to make new ones, 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.

The Welcome Reception is sponsored by Novartis.

TRAINEE UPDATE BREAKFAST SESSION
7.00am, Tuesday 16 September 2008
Riverview 4, Perth Convention and Exhibition Centre
Special presentations will take place at this early-morning session. These are aimed at updating trainees on areas of sexual health medicine as requested by trainees. Breakfast will be served from 7.00am, and the presentations will 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.

CONFERENCE GALA DINNER
7.30pm - 11.30pm, Wednesday 17 September 2008
Bellevue Ballroom, Level 3
Perth Convention and Exhibition Centre
The theme of the dinner is ‘Diamonds are Forever’. You are welcome to be part of the James Bond adventure or just to sparkle.

Ticket cost is included in the joint conference registration fees to the ASHM & Sexual Health Conferences and for Sexual Health Conference only registrants.

Ticket cost: A$120.00 for day registrants and guests.

The dinner is supported by the Australian Government Department of Health and Ageing, WA Health, GlaxoSmithKline, Boehringer Ingelheim, Gilead, and Merck Sharp & Dohme.

Attendees are encouraged to come either in fancy dress or in evening attire.

TICKETS TO ASSOCIATED EVENTS
Tickets and/or name badges will be required for entry into all associated events. All tickets will be given out on registration.

If you would like to purchase tickets to the Trainee Update Breakfast Session you may do so up until 12.00noon on Monday 15 September at the registration desk.

If you have a ticket to the Gala Dinner but do not wish to attend, please advise the staff at the registration desk by 12.00noon on Monday 15 September. We will facilitate swaps of conference dinner tickets but cannot guarantee availability.

A no-refund policy operates for cancellation of function tickets.

SYPHILIS IN METROPOLITAN PERTH WORKSHOP
Strategies to contain the epidemic
Tuesday 16 September 12.30pm - 1.15pm
Meeting Room 8, Perth Convention and Exhibition Centre

Chairs: Jeff Klausner, Jenny McCloskey
Panel- Lisa Bastian (Health Department of WA), Trish Langdon (WA AIDS Council), Graham Brown (AFAO), Jenny McCloskey, Christine Dykstra (RPH), Chris Bourne (NSW), Di Rowling (Queensland), Steve Plecas (Sauna Clinic), Community Nurses, Jeff Klausner (SFO Public Health Department)

Epidemiology of Syphilis in Perth - Kellie Kwan
RPH Epidemiology - Christine Dykstra RPH
Contact Tracing - Sue Szalay/ Joyce Keith/ Community Nurses

What has worked and not worked in other places
NSW- Chris Bourne
Queensland - Di Rowling

Commentary with ways forward to contain the Perth epidemic
The SFO experience - Jeffrey Klausner

Open floor discussion
HAVE YOU HAD YOUR THIRD DOSE?

CERVICAL CANCER VACCINE STILL FREE FROM YOUR GP, FOR WOMEN 18 TO 26
To achieve optimal benefit and the best chance of long-term protection, you need your second and third dose, ideally within a six month period. Then keep fighting cervical cancer by telling your friends about the free vaccine and maintaining regular Pap smears. Speak to your GP about any late doses. www.cervicalcancer.com.au

Trademark of CSL Biotherapies, Parkville Vic 3052

KATE WILLETTS
CLIENT ADMINISTRATION
EXHIBITOR DIRECTORY

For more information contact:
The Conference Secretariat on
Tel: 61 2 8204 0770
Email: info@sexualhealthconference.com.au
www.sexualhealthconference.com.au
<table>
<thead>
<tr>
<th>COMPANY NAME</th>
<th>BOOTH NUMBER</th>
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<td>Abbott</td>
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<td>Australian Therapeutic Supplies</td>
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<tr>
<td>Australasian Chapter of Sexual Health Medicine</td>
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<td>Australasian Society for HIV Medicine</td>
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<td>Boehringer Ingelheim</td>
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<td>Bristol-Myers Squibb</td>
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<td>CSL Biotherapies</td>
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<td>iNova Pharmaceuticals</td>
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<td>Marie Stopes International</td>
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<td>Novartis</td>
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<td>Qiagen</td>
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<tr>
<td>WA Health and Burnet Institute</td>
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The following organisations are exhibiting during the ASHM Conference and will be available to visit on Wednesday 17 September only.

- HIV & HCV Education Projects The University of QLD .................................................. 28
- HIV Consortium ................................................................. 41
- Janssen-Cilag Tibotec ........................................................................... 31, 32
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- The UnderView Collection - Glen Cowans ............................................... 33
EXHIBITOR DIRECTORY

ABBOTT (24,25)
We are a global, health care company devoted to discovering new medicines, new technologies and new ways to manage health. Our products span the continuum of care, from nutritional products and laboratory diagnostics through medical devices and pharmaceutical therapies including Kaletra, Humira and Reductil. Throughout our 100+ year history, Abbott people have been driven by a constant goal: to advance medical science to help people live healthier lives. It’s part of our heritage. And, it continues to drive our work. Today, 65,000 Abbott employees around the world share the passion for “Turning Science Into Caring.”

AUSTRALIAN THERAPEUTICS SUPPLIES (40)
Australian condom maker Australian Therapeutic Supplies has over 25 years experience in sexual health products. The iconic Four Seasons condom and lubricant brand continues to be a leading innovator of condom products, such as the recently launched Quickie easy-on condom. Come to our stand for free samples and a demonstration of the Quickie condom applicator. Additionally we have developed a range of Pure - all natural lubricants ideal for consumers with allergic reactions to petro chemical based products. We have a library of sexual health FAQs on our website www.condoms.com.au driven by direct consumer feedback, plus survey information, sexual positions and much more. Contact Australian Therapeutic Supplies P/L for more information:

Four Seasons Condoms
5/25 George Street
North Strathfield NSW 2137
Phone: +61 2 9743 6144
Fax: +61 2 9743 6244
Email: ats@condoms1.com

AUSTRALASIAN CHAPTER OF SEXUAL HEALTH MEDICINE (6)
The Australasian Chapter of Sexual Health Medicine is the professional body responsible for the education and training of doctors wishing to specialise in sexual health. It contributes to the professional development of other health professionals through its training courses, and the development and dissemination of guidelines and other educational products. It provides expert advice to government and other agencies on sexual health matters and its Fellows contribute to policy development at state and national level.

Contact:
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
AUSTRALASIAN SOCIETY FOR HIV MEDICINE (11, 12)
The Australasian Society for HIV Medicine (ASHM) is a peak representative professional body for medical practitioners and other health care workers in Australasia who work in HIV, viral hepatitis and related disease areas.

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

ASHM is a key partner in the Australasian and regional response to HIV, viral hepatitis and related diseases. It works closely with government, advisory bodies, community agencies and other professional organisations in Australia and the Asia Pacific region. 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.

ASHM is governed by an elected voluntary board and managed by a secretariat. It receives support from the Australian Government Department of Health and 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 which raises funds in support of educational activities. ASHM works on a range of issues affecting its members, including education and training, resources, HIV treatment, viral hepatitis, international/development issues and professional affairs. ASHM conducts an annual medical scientific conference. In addition, the ASHM conference division provides professional conference organisation to third parties.

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

BOEHRINGER INGELHEIM (3,4)
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 (19-22)
Bristol-Myers Squibb is a global biopharmaceutical 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 and cost-effective medicines addressing significant unmet medical needs.

The Bristol-Myers Squibb R&D organisation is working on treatments for cancer, atherosclerosis/thrombosis, diabetes, obesity, psychiatric disorders, Alzheimer’s disease, hepatitis, HIV/AIDS, rheumatoid arthritis, and solid organ transplant rejection.

For many years Bristol-Myers Squibb has been a leader in the area of HIV/AIDS and currently provides Reyataz® (atazanavir sulfate) to thousands of Australians.
CARADATA (5)

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 is SHIP – Sexual Health Information Program. SHIP has been designed to reduce the workload for Medical, Administration, Nursing and Laboratory staff and to support the transition to a full electronic patient record. SHIP is user friendly, flexible and adaptable to meet minimum data set requirements. In 2004 CaraData took over from Dickson Computer Services (DCS) where SHIP was first developed by CEO Bridget Dickson in 1992. Since then SHIP is now installed in more than 68 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. In 2005 CaraData established another branch over in Dublin, Ireland. Through this CaraData is able to provide 24/7 support to all its clients.

Contact:
Email: info@caradata.com
Phone: +61 7 5594 9328
Fax: +61 7 5571 5376
Web: www.caradata.com

CSL BIOOTHERAPIES (45)

Based in Melbourne, CSL Biotherapies manufactures and markets vaccines and pharmaceutical products in Australia and New Zealand and supplies influenza vaccines internationally.

The CSL Biotherapies Product Portfolio includes vaccines to prevent pediatric, adult and travel-related infectious diseases, as well as the world’s first cervical cancer vaccine – GARDASIL®. CSL Biotherapies manufactures products of national significance such as antivenoms and Q Fever vaccine.

CSL Biotherapies also markets a range of neurological, dermatological, analgesic, urological, and emergency products.

CSL is a major Australian employer and is listed in the ASX Top 200.

GILEAD (15 - 18)

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®), and serious bacterial and systemic fungal infections (AmBisome®).

Contact:
Address: Level 1, 128 Jolimont Road, East Melbourne, Victoria, 3002, Australia
Phone: +61 (0)3 9272 4400
Fax: +61 (0)3 9272 4411

We look forward to seeing you at the Gilead Sciences booth at Sexual Health & ASHM.

GLAXOSMITHKLINE (7 - 10)

GSK Australia (GSK) is one of the largest research based pharmaceutical companies in Australia. GSK’s vision is to “help people to do more, feel better and live longer”.

The company’s product portfolio is closely aligned with the country’s key health priorities of asthma, immunisation, depression, diabetes, oncology, indigenous health and infectious diseases. GSK also supplies 25% of the world’s medicinal opiate needs from its Australian operations.

GSK invests more than $35 million a year in Australian research and development, confirming the company’s place as one of the largest and most active innovators in the country.

Through a series of cooperative partnerships - with government, the scientific research sector and the broader Australian community – GSK makes a substantial contribution to important economic, social and health initiatives.
iNOVA PHARMACEUTICALS (35-38)
iNova Pharmaceuticals develops and markets a range of over-the-counter and prescription medicines to Australasia, Asia-Pacific, South Africa, the Americas and other international markets directly and also through other pharmaceutical companies and agents. These include prescription medicines in the areas of weight management, dermatology, heart conditions, asthma and pain management.

To learn more about iNova Pharmaceuticals, go to http://www.inovapharma.com

MARIE STOPES INTERNATIONAL (39)
Marie Stopes International is Australia’s leading sexual and reproductive healthcare provider striving to make a difference to both women’s and men’s sexual health in Australia. We provide abortion, vasectomy, contraception, STI (STD) check-ups and general sexual health advice through our licensed and accredited centres in the ACT, NSW, Queensland, Victoria and Western Australia.

As part of a global not-for-profit organisation, we also support vital sexual healthcare services which are implemented by the Marie Stopes International Partnership in 40 countries worldwide.

For more information please visit www.mariestopes.com.au or contact our National Support Centre on Freecall 1800 003 707.

NOVARTIS (13,14)
Novartis is a world leader in the research, development and supply of products to protect and improve health and well-being. 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 98 000 people and operates in over 140 countries around the world.

In Australia the company now employs more than 600 people, and invests over AUD $30million annually in local research. This research not only assures the effectiveness of the company’s current range of treatments, 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 diseases in the areas of Primary Care, Oncology, Transplantation, and Ophthalmics.

QIAGEN (2)
QIAGEN is the worldwide leading provider of sample and assay technologies for life sciences, applied testing and molecular diagnostics. QIAGEN’s products are considered standards in areas such as pre-analytical sample preparation and assay solutions. QIAGEN offers the broadest portfolio of molecular diagnostic assays for infectious diseases including the only test for human papillomavirus, which has both FDA and CE-approvals. QIAGEN has developed a comprehensive portfolio of more than 500 proprietary, consumable products and automated solutions for sample collection, nucleic acid and protein handling, separation, purification, open and target specific assays.

WA HEALTH (23)
Using a partnership approach, the Sexual Health and Blood-borne Virus Program, WA Department of Health directs and coordinates the prevention and control of sexually transmitted infections, human immunodeficiency virus and blood-borne viruses (STI/ HIV/BBV) for the population of WA. Priority populations within WA include young people, Aboriginal people, people who inject drugs, gay and other homosexually active men, sex workers (including opportunistic sex workers) and clients of sex workers, people living with HIV/AIDS and hepatitis C and health care workers.
### MONDAY 15 SEPTEMBER

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<th>Time</th>
<th>Event</th>
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<tr>
<td>7.30am</td>
<td>Registration Opens</td>
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<tr>
<td>8.30am - 9.30am</td>
<td>Arrival Coffee/Tea and Exhibition Opening in Pavilion 1</td>
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<tr>
<td>9.30am - 11.00am</td>
<td><strong>Opening Ceremony and Gollow Lecture</strong></td>
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<td></td>
<td><strong>Meeting Room 1,2,3</strong></td>
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<td></td>
<td><strong>Chairs:</strong> Jenny McCloskey and Darren Russell</td>
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<tr>
<td>9.30am - 9.35am</td>
<td>Introduction by Jenny McCloskey - Convenor, 2008 Sexual Health Conference Committee</td>
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<tr>
<td>9.35am - 9.45am</td>
<td>Welcome to Country and Performance by the Wadumbah Dance Group</td>
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<tr>
<td>9.45am - 9.50am</td>
<td>Opening address by Peter Flett, A/Director General, Department of Health Government of Western Australia, Perth, Western Australia</td>
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<tr>
<td>9.50am - 9.55am</td>
<td>Welcome to the conference by Darren Russell - President, Australasian Chapter of Sexual Health Medicine, Australia</td>
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<tr>
<td>9.55am - 10.00am</td>
<td>Morris Gollow - Retired Head, Sexually Transmitted Diseases Clinic, Perth, Western Australia</td>
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<tr>
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<td>Introduction to the Gollow Lecture</td>
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<tr>
<td>10.00am - 11.00am</td>
<td>David Smith - Clinical Director, Microbiology, Department of Health Government of Western Australia, Perth, Western Australia</td>
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<td></td>
<td>Gollow Lecture: Diagnosis of Sexually Transmitted Infections</td>
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<tr>
<td>11.00am - 11.30am</td>
<td>Morning Tea in Exhibition and Poster Area in Pavilion 1</td>
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<td>11.30am - 1:00pm</td>
<td><strong>Plenary 2 - Pearls to Think About</strong></td>
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<td><strong>Meeting Room 1,2,3</strong></td>
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<td></td>
<td><strong>Chairs:</strong> Lewis Marshall and David Smith</td>
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<td>11.30am - 12.00pm</td>
<td>Suzanne Garland - Director, Department of Microbiology, Royal Women's Hospital, Melbourne, Victoria, Australia</td>
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<td>HPV (Human Papillomavirus) Genotype Prevalence in Australian Women Pre-HPV Vaccine Rollout</td>
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<td>12.00pm - 12.30pm</td>
<td>Jorma Paavonen - Professor, Department of Obstetrics and Gynecology, University of Helsinki, Finland</td>
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<td>Chlamydia Trachomatis and PID As It Is Seen Today</td>
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<tr>
<td>12.30pm - 1.00pm</td>
<td>James Ward - Program Manager, Aboriginal and Torres Strait Islander Health, National Centre in HIV Epidemiology and Clinical Research, Sydney, New South Wales, Australia</td>
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<tr>
<td></td>
<td>Epidemiology in Indigenous Australians</td>
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<tr>
<td>1.00pm - 2.00pm</td>
<td>Lunch in Exhibition and Poster Area in Pavilion 1</td>
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<tr>
<td>2.00pm - 3.30pm</td>
<td><strong>Symposium - Aboriginal Health: Mining For Gold</strong></td>
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<td><strong>Meeting Room 1, 2</strong></td>
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<td></td>
<td><strong>Chairs:</strong> Rene Reddingius and Lewis Marshall</td>
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<tr>
<td>2.00pm - 3.30pm</td>
<td><strong>Proffered Papers - Epidemiology:</strong> Bangles</td>
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<td><strong>Meeting Room 3</strong></td>
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<td><strong>Chairs:</strong> Stella Heley and Andrew Grulich</td>
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<tr>
<td>2.00pm - 3.30pm</td>
<td><strong>Proffered Papers - Systems:</strong> Baubles</td>
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<td>2.00pm - 3.30pm</td>
<td><strong>Proffered Papers - Chlamydia:</strong> Beads</td>
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<td>2.00pm - 3.30pm</td>
<td><strong>Meeting Room 6</strong></td>
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<td><strong>Chairs:</strong> Katherine Brown and Donna Keeley</td>
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<td>Time</td>
<td>Speaker and Title</td>
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<tr>
<td>2.00pm</td>
<td>Cissy Gore-Birch-Gault, East Kimberley Coordinator, Social Advocacy Outreach Program, Strong Family Strong Culture Program, St John of God Healthcare, Kununurra, West Australia</td>
</tr>
<tr>
<td>2.20pm</td>
<td>Dawn Gilchrist - Regional Aboriginal Health Promotion Coordinator, WACHS - Goldfields Population Health, Western Australia and Donna Shultz, Community Development, Norseman, Western Australia</td>
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<tr>
<td>2.40pm</td>
<td>Lisa Lockyer, Senior Sexual Assault Counsellor, Pilbara Population Health Unit, Western Australia</td>
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**2.00pm - 2.15pm**
- Combs B - Audit of Antenatal Testing of Sexually Transmissible Infections and Blood Borne Viruses at Western Australian Hospitals
- Bourne C - A Sexually Transmissible Infection Programs Unit for NSW: Guiding Strategy Implementation
- Ooi C - Make Contact: A Project to Evaluate Contact Tracing Strategies for Chlamydia

**2.20pm - 2.40pm**
- Dawn Gilchrist - Regional Aboriginal Health Promotion Coordinator, WACHS - Goldfields Population Health, Western Australia and Donna Shultz, Community Development, Norseman, Western Australia
- Yarning About Learning Planning Communities
- Ryder N - Trends in First Episode Anogenital Herpes due to HSV-1, 1992-2007
- Richters J - Circumcision in Australia: Further Evidence on its Effects on Sexual Health and Wellbeing from the Australian Longitudinal Study of Health and Relationships
- Dykstra C - Royal Perth Hospital Emergency Department Screening Project for Chlamydia Trachomatis

**2.45pm - 3.00pm**
- Middleton M - Recent Trends in Infectious Syphilis in Men who have Sex with Men
- Laing N - Community Testing - It’s a Piece of Piss
- Temple-Smith M - Best Practice Pathway: Increasing Chlamydia Screening in the General Practice Setting

**2.40pm - 2.50pm**
- Jin F - Prevalence, Incidence and Risk Factors for Hepatitis C in HIV Negative and HIV Positive Homosexual Men
- Garrier J - The Acceptability of Self-Collected Specimens for Asymptomatic Sexual Health Screens
- Gray R - The Potential Impact of a Vaccine on Chlamydia Epidemiology and Morbidity

**2.45pm - 3.00pm**
- Middleton M - Recent Trends in Infectious Syphilis in Men who have Sex with Men
- Laing N - Community Testing - It’s a Piece of Piss
- Temple-Smith M - Best Practice Pathway: Increasing Chlamydia Screening in the General Practice Setting
<table>
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<tr>
<th>Time</th>
<th>Session</th>
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</table>
| 3.00pm - 3.30pm | **Shelley Coleman and Gerry Faulkner**  
**Aboriginal Educator, Family Planning WA, Sexual Health Services, Perth, Western Australia**  
Bruce E - Periodic Presumptive Treatment (PPT) of Common Curable Sexually Transmitted Infections (STIs) Among Female Sex Workers in Port Moresby, Papua New Guinea: Measuring STI Incidence and PPT Effects  
Walker J - The Prevalence of Chlamydia and Mycoplasma Genitalium in a Cohort of Australian Young Women  
Buhner Skinner M - The Check was in the Mail: Contact Preferences of Participants |
| 3.15pm - 3.30pm | **Moodit J**  
**A Sexual Health and Lifeskills Program for Indigenous Young People**  
Mindel A - Upstairs and Downstairs: Socio-Economic and Gender Interactions in Herpes Simplex Virus Type 2 (HSV-2) Seroprevalence in Australia  
Oral Poster: Hince D - Opportunistic Screening in General Practice for Chlamydia Trachomatis in Young Men |
| 3.30pm - 4.00pm | **Afternoon Tea in Exhibition and Poster Area in Pavilion 1** |
| 4.00pm - 5.30pm | **Proffered Papers - Aboriginal Health: Prospecting for Diamonds**  
Meeting Room 1, 2  
Chairs: Lisa Bastian and To be advised  
Nelson C - A Systematic Primary Health Care Approach to STI Screening Recording in Kimberley Aboriginal Community Controlled Health Services 2001/07  
MacFarlane F - Is it Necessary to Examine a Woman Diagnosed with Asymptomatic Chlamydia Infection?  
Bilardi J - Partner Notification of Chlamydia in General Practice: Examining Current Practices and Possible Supports to Assist GPs in Partner Notification  
O'Connor J - The Sex Industry in Perth before Decriminalisation |
| 4.00pm - 5.30pm | **Proffered Papers - Clinical: Precious Pearls**  
Meeting Room 3  
Chairs: Fraser Drummond and Catriona Ooi  
Guy R - Chlamydia Testing Rates in General Practices Across Australia: The Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance (ACCESS)  
Brown K - STI Awareness - Online Education Modules for General Practitioners Focused on Chlamydia Testing |
| 4.00pm - 5.30pm | **Proffered Papers - Public Health: Cultured Pearls**  
Riverview 4  
Chairs: Maree O’Sullivan and To be advised  
Bhuiyan A - Sustainable Systems: Effective Long Term Health Programs for Aboriginal Australians  
Guy R - Chlamydia Testing Rates in General Practices Across Australia: The Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance (ACCESS)  
Brown K - STI Awareness - Online Education Modules for General Practitioners Focused on Chlamydia Testing |
| 4.00pm - 5.30pm | **Proffered Papers - Education: Keshi Pearls**  
Meeting Room 6  
Chairs: Robin Wansborough and Claire Reynolds  
Guy R - Chlamydia Testing Rates in General Practices Across Australia: The Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance (ACCESS)  
Brown K - STI Awareness - Online Education Modules for General Practitioners Focused on Chlamydia Testing |
| 4.00pm - 5.30pm | **Proffered Papers - Public Health: Cultured Pearls**  
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| 4.00pm - 5.30pm | **Proffered Papers - Education: Keshi Pearls**  
Meeting Room 6  
Chairs: Robin Wansborough and Claire Reynolds  
Guy R - Chlamydia Testing Rates in General Practices Across Australia: The Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance (ACCESS)  
Brown K - STI Awareness - Online Education Modules for General Practitioners Focused on Chlamydia Testing |
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<tr>
<th>Time</th>
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<tbody>
<tr>
<td>4.30pm -</td>
<td>Ward J - The First Survey of Sexual Health and Blood Borne Virus Knowledge, Risk Behaviours and Health Service Utilisation of Young Aboriginal People in NSW Aged 16-30 - Preliminary Findings and Innovations in Data Collection</td>
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<tr>
<td>4.30pm - 4.45pm</td>
<td>McCloskey J - Correlation of Anal Cytology and Histopathology in Cases of Anal Warts, and High Risk Digene HC2 Testing</td>
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<tr>
<td>4.30pm - 4.45pm</td>
<td>Mindel A - Chlamydia Testing in General Practice in Australia</td>
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<td>4.30pm - 4.45pm</td>
<td>Brown G - How They Did It and How They Wanted It – Young People's Perspectives on their Experiences of Sexual Health Education</td>
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<td>4.45pm - 5.00pm</td>
<td>Rumbold A - An Epidemic of Vulvar Pathology in Young Australian Indigenous Women</td>
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<td>4.45pm - 5.00pm</td>
<td>Couldwell D - Non-Gonococcal Urethritis in Sydney Men</td>
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<td>4.45pm - 5.00pm</td>
<td>Ryder N - Confidentiality and Access to Sexual Health Services</td>
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<td>4.45pm - 5.00pm</td>
<td>Martin S - Self-Assessment of Competencies in Sexual Health and HIV by Graduating Medical Students</td>
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<tr>
<td>5.00pm - 5.10pm</td>
<td>Oral Poster: Brazzale A - Seroprevalence of Herpes Simplex Virus Type 1 and Type 2 Amongst the Indigenous Population of Cape York, Far North Queensland, Australia</td>
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<tr>
<td>5.00pm - 5.10pm</td>
<td>Dykstra C - Anogenital Lymphogranuloma Venerum Reported in Western Australia</td>
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<td>5.00pm - 5.10pm</td>
<td>Oral Poster: Wilson D - Modelling Optimal Syphilis Screening Programs for Men who have Sex with Men</td>
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<tr>
<td>5.00pm - 5.15pm</td>
<td>McKay E - Providing On-Line Support for Teachers in Delivering Sexuality Education in Western Australia</td>
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<tr>
<td>5.10pm - 5.20pm</td>
<td>Oral Poster: Mak D - Improving the Accuracy of Aboriginal and Non-Aboriginal Disease Notification Rates using Data Linkage</td>
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<td>5.10pm - 5.20pm</td>
<td>East L - Effects of having a Sexually Transmitted Infection on Women's Sexuality and Self-Concept</td>
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<td>5.10pm - 5.20pm</td>
<td>Oral Poster: Hellard M - Sex and Sport: Chlamydia Screening in Rural Sporting Clubs</td>
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<tr>
<td>5.15pm - 5.30pm</td>
<td>Harcourt C - Health Promotion for Female Sex Workers under Three Different Legal Regimes</td>
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<tr>
<td>5.20pm - 5.30pm</td>
<td>Oral Poster: Lenton J - 'Dangling the Carrot' – Utilising the Human Papilloma Virus Quadrivalent Immunisation Program in a Remote Community in NSW to Increase STI Screening Rates Amongst a Priority Population</td>
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<tr>
<td>5.20pm - 5.30pm</td>
<td>Oral Poster: Lim M - Community-Based Surveillance of Sexual Behaviour, 2005-2008</td>
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<tr>
<td>5.20pm - 5.30pm</td>
<td>Oral Poster: Lim M - Community-Based Surveillance of Sexual Behaviour, 2005-2008</td>
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<td>5.30pm - 7.00pm</td>
<td>Welcome Reception in Exhibition and Poster Area, Pavilion 1, Perth Convention Centre</td>
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<tr>
<td>7.00pm</td>
<td>AChSHM Trainee Dinner</td>
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**MONDAY 15 SEPTEMBER 2008**
**TUESDAY 16 SEPTEMBER**

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<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>7.30am</td>
<td>Registration Opens</td>
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| 7.00am - 9.00am | Trainee Update Breakfast Session  
Panel: Richard Hillman, Stuart Aitken and Cathy Cook  
Chair: Richard Teague |
| 7.30am - 8.00am | Louise Tomlins, Sexual Health Registrar, Taylor Square Private Clinic, Sydney, New South Wales, Australia  
Syphilis Re-Infection in a HIV-Positive Man |
| 8.00am - 8.30am | Christine Dykstra - Sexual Health Registrar, Royal Perth Hospital, Perth, Western Australia  
The Saga of the Purulent Vaginal Discharge |
| 8.30am - 9.00am | Melanie Bissessor - Sexual Health Registrar, Melbourne Sexual Health Centre, Melbourne, Victoria, Australia  
Mycoplasma Genitalium |
| 8.00am - 9.00am | Arrival Coffee/Tea in Exhibition and Poster Area in Pavilion 1 |
| 8.00am - 10.45am | Plenary 3 - Elusive STIs  
Meeting Room 1,2,3  
Chairs: Jenny McCloskey and Basil Donovan |
| 9.00am - 9.45am | Jorma Paavonen - Professor, Department of Obstetrics and Gynecology, University of Helsinki, Finland  
The Natural History of HPV in the Anal Canal: Everyone’s Getting Into The Act |
| 10.00am - 10.45am | Jeffrey Klausner - Director, Sexually Transmitted Disease Prevention and Control Services, San Francisco, USA  
Public Health Response to Epidemic Syphilis |
| 9.00am - 10.45am | Morning Tea in Exhibition and Poster Area in Pavilion 1 |
| 11.15am - 12.15pm | Plenary 4 Debate: The Great Debate: To Screen or Not to Screen?  
Meeting Room 1,2,3  
Chair: Darren Russell |
| 11.15am - 12.15pm | Joel Palefsky - Professor of Medicine, University of California, San Francisco, USA and Jeffrey Klausner - Director, Sexually Transmitted Disease Prevention and Control Services, San Francisco, USA |
| 12.15pm - 1.30pm | Lunch in Exhibition and Poster Area in Pavilion 1 |
| 12.30pm - 1.15pm | Syphilis Symposium in Meeting Room 8; Lunch will be provided at Meeting Room 8 to attendees |
| 1.30pm - 3.00pm | Symposium: Gynaes are a Girl’s Best Friend  
Meeting Room 1,2  
Chairs: David Jardine and Katherine Brown |
| 1.30pm - 3.00pm | Symposium: Sticky Moments  
Riverview 4  
Chairs: Christine Dykstra and Fraser Drummond |
| 1.30pm - 3.00pm | Proffered Papers - Social Research: Champagne Diamonds  
Meeting Room 3  
Chairs: Chris Bourne and Frank Bowden |
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<th>Time</th>
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<th>Speaker/Presenter</th>
<th>Location/Title</th>
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<tbody>
<tr>
<td>1.30pm</td>
<td>Yee Leung - Gynaecological Oncology Specialist, Murdoch Hospital, Western Australia</td>
<td>Dr Debbie Couldwell - Staff Specialist, Parramatta Sexual Health Clinic, Sydney, New South Wales, Australia</td>
<td>Ureaplasma and its Role in Clinical Disease</td>
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<td>1.45pm</td>
<td>Davidson O - Understanding and Influencing Sexual Risk Behaviour: The Current Status of Evidence Based Models of Sexual Risk Taking</td>
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<td>1.50pm</td>
<td>Stan Wisniewski - Urologist, Private Practice, Western Australia</td>
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<td>2.00pm</td>
<td>Louise Farrell - Director Obstetrics, Gynaecology &amp; Neonatology St John of God Hospital Subiaco, Perth, Western Australia</td>
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<td>2.00pm</td>
<td>Ferris J - Young Adults, Sexual Behaviour and Multiple Relationship Partners: Data from the Australian Longitudinal Study of Health and Relationships</td>
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<td>2.15pm</td>
<td>Judy Cole - Consultant Dermatologist, Private Practice, Western Australia</td>
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<tr>
<td>2.15pm</td>
<td>Hendriks J - Avenues of Support: Perceptions and Experiences of Female Adolescents with Different Pregnancy Outcomes</td>
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<td>2.30pm</td>
<td>Bronwyn Stuckey - Clinical Professor, School of Medicine and Pharmacology, Sir Charles Gairdner, Western Australia</td>
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<td>2.30pm</td>
<td>Gold J - Evaluation of the Victorian 'You'll Never Know Who You'll Meet' Youth STI Awareness Campaign</td>
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<td>2.30pm</td>
<td>Mei-Ling Tay-Kearney - Consultant Ophthalmologist, Head of the Ophthalmology Department, Royal Perth Hospital, Western Australia</td>
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<td>2.30pm</td>
<td>Oral Poster: Ferris J - Australian Men and Chronic Pelvic Pain (CPP): Comparative Results of the National Institute of Health Chronic Prostatitis Symptoms Index (NIH-CPSI) and the CPP Scale Using Data from the Australian Longitudinal Study of Health and Relationships.</td>
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<td>2.45pm</td>
<td>The Eyes Have it!</td>
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<tr>
<td>2.45pm</td>
<td>Oral Poster: Lucke J - Factors Associated with STI Among Young Women: Findings from the Australian Longitudinal Study on Women's Health</td>
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<td>3.00pm</td>
<td>Afternoon Tea in Exhibition and Poster Area in Pavilion 1</td>
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<td>3.30pm</td>
<td>Exhibition Closes for ASHM Conference Exhibition set up</td>
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</table>
3.30pm - 4.30pm
Trainee Session: Diamonds in the Rough. Presented by Chapter Trainees
All Delegates are invited to attend. Jan Edwards Prize awarded to the best oral presentation
Meeting Room 3
Chair: Richard Hillman

3.30pm - 3.42pm
Srirajalingam M - Prevalence and Incidence of HSV-1 And HSV-2 in an HIV Seropositive Cohort in the Gold Coast

3.42pm - 3.54pm
Hilton J - Prevalence of Mycoplasma Genitalium (M Genitalium) in Men with Non-Gonococcal Urethritis (NGU) at Auckland Sexual Health Service (ASHS)

3.54pm - 4.06pm
Bissessor M - Importance of Early Recognition and Treatment of Symptomatic Syphilis in Men who have Sex with Men (MSM)

4.06pm - 4.18pm
Dykstra C - Syphilis at Royal Perth Hospital: The Eye of the WA Storm

3.30pm - 3.37pm
Jin F - Pharyngeal Gonorrhoea and Chlamydia in the Community-Based Him Cohort of Homosexual Men in Sydney, Australia

3.37pm - 3.44pm
Richters J - Agreements about Sexual Exclusivity and Subsequent Concurrent Partnering in Australian Couples: The Australian Longitudinal Study of Health and Relationships

3.44pm - 3.51pm
Ferris J - Changes in Lifetime Probability of Abortion for Australian Women: Results from the Australian Longitudinal Study of Health and Relationships

4.05pm - 4.12pm
Dabbhadatta J - Promoting Sexual Health and Access to Young People using a Partnership Approach within a Community Based Youth Service in Sydney

3.58pm - 4.05pm

4.05pm - 4.12pm
Kingston M - What has Sex Got to Do with It? Reconsidering Vulnerability in Young People Based on Findings of a Retrospective Chart Audit of Under 16 Year Old Attendees at Family Planning Queensland (FPQ) Clinics

4.12pm - 4.19pm
Michelson J - Real Choices: Women, Contraception & Unplanned Pregnancy

4.19pm - 4.26pm
Su J - The Public Health Applications of Laboratory Testing Data for Sexually Transmitted Infections

4.26pm - 4.32pm
Brown A - Sexual Health Needs of Young People with Psychosis

3.30pm - 3.37pm
Lee W - Reasons for Termination of Pregnancy in Two Age groups

4.45pm - 5.45pm
Annual Chapter Meeting
Meeting Room 3

4.45pm - 5.45pm
ASHNA Nurses Meeting
Meeting Room 11

5.45pm
Free Evening
## FULL CONFERENCE PROGRAM

### WEDNESDAY 17 SEPTEMBER

<table>
<thead>
<tr>
<th>Time</th>
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<tr>
<td>7.30am</td>
<td>Registration</td>
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<tr>
<td>8.00am - 9.00am</td>
<td>Arrival Coffee/Tea in Pavilion 1</td>
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<tr>
<td>9.00am - 10.30am</td>
<td>Sexual Health Plenary 5: A Mixed Bag of Jewels</td>
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<td>Meeting Room 1,2,3</td>
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<td>Chairs: John Chuah and Alexandra Marceglia</td>
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<tr>
<td>8.30am - 10.30am</td>
<td>ASHM Opening Ceremony</td>
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<td>Riverside Theatre/Auditorium</td>
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<td>Chair: John Dyer and Levinia Crooks</td>
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<td>9.00am - 9.30am</td>
<td>Should we be Vaccinating Boys as well as Girls with the HPV Vaccine?</td>
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<td>9.30am - 10.00am</td>
<td>Kathleen Mazzella - Founder, Gynaecological Awareness Information Network, Western Australia</td>
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<td>A Woman’s Personal Perspective and Experience of What is Missing in Sexual Health and Society, the Vulva</td>
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<td>10.00am - 10.30am</td>
<td>Morning Tea in Exhibition and Poster Area in Pavilion 1</td>
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<td>11.00am - 12.30pm</td>
<td>Sexual Health Plenary 6: Drugs</td>
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<td>Meeting Room 1,2,3</td>
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<td>Chairs: Fraser Drummond and Richard Teague</td>
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<tr>
<td>11.00am - 12.00pm</td>
<td>ASHM Session: Women Risk HIV - International</td>
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<td>Riverside Theatre/Auditorium</td>
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<td>Chairs: Susan Kippax and Gita Ramjee</td>
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<tr>
<td>11.00am - 12.15pm</td>
<td>Holmes W - A Novel Approach to Antenatal Risk Assessment in Very Low HIV Prevalence Settings in Resource-Poor Countries</td>
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<td>11.15am - 11.30am</td>
<td>Ofasias E - Addressing Gender-Based Violence in Settlement Areas of Port Moresby</td>
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<td>11.30am - 11.45am</td>
<td>Kupul M - Tribal Fighting, Violence Against Women and Girls and HIV in Papua New Guinea</td>
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<td>11.00am - 11.15am</td>
<td>Jeffrey Klausner - Director, Sexually Transmitted Disease Prevention and Control Services, San Francisco, USA</td>
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<tr>
<td>11.15am - 11.30am</td>
<td>Purcell D - Towards Vaccines Eliciting Broad Neutralising Antibody Responses by Selecting for HIV-1 ENV Immunogens that Prominently Expose Conserved Neutralisation Epitopes</td>
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<tr>
<td>11.30am - 11.45am</td>
<td>Price P - Understanding Susceptibility to CMV/Immune Restoration Disease and the Immunological Consequences of Extreme Immunodeficiency</td>
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</table>

**Meeting Room 8**

**Chairs:** Tony Cunningham and Scott Bowden
<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Speaker</th>
<th>Location</th>
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<tbody>
<tr>
<td>11:45am - 12:00pm</td>
<td>Natural History of HPV in the Anal Canal</td>
<td>Joel Palefsky - Professor of Medicine, University of California, San Francisco, USA</td>
<td>Riverside Theatre/Auditorium</td>
<td>Katrina Allen and David Smith</td>
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<tr>
<td>11:40am - 12:00pm</td>
<td>Male Sex Workers in Sri Lanka: Why are Men Who Work on the Street More Likely to Use Condoms Compared with Women Who Work in Other Locations?</td>
<td>Rawstorne P - Female Sex Workers in Sri Lanka</td>
<td>Meeting Room 8; Lunch will be provided here to attendees from 12.30pm</td>
<td>Ingrid van beek and Tamara Speed</td>
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<tr>
<td>11:40am - 12:00pm</td>
<td>Predicting Neuropathy Risk before Stavudine Prescription: An Algorithm for Minimizing Neurotoxicity in Resource-Limited Settings</td>
<td>Cherry K - Predicting Neuropathy Risk before Stavudine Prescription</td>
<td>Meeting Room 8; Lunch will be provided here to attendees from 12.30pm</td>
<td>Damian Purcell and Nitin Saksena</td>
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<tr>
<td>11:45am - 12:00pm</td>
<td>Tissue-Specific Adaptive Changes in V3 of gp120 Enable Persistence of Maraviroc-Sensitive R5x4 HIV-1 in Brain</td>
<td>Gorry P - Tissue-Specific Adaptive Changes in V3 of gp120 Enable Persistence of Maraviroc-Sensitive R5x4 HIV-1 in Brain</td>
<td>Meeting Room 8</td>
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<td>2.30pm - 3.00pm</td>
<td>Basil Donovan - Professor of Sexual Health, National Centre in HIV Epidemiology and Clinical Research, Sydney, New South Wales, Australia</td>
<td>It's only a cold sore, Love...”</td>
<td>2.30pm - 2.45pm</td>
<td>Gahan G - A Gap Analysis of People with a History of Injecting Drug use who are not Currently Accessing HIV and Sexual Health Services in South Eastern Sydney Illawarra Area Health</td>
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<td>2.45pm - 3.00pm</td>
<td>Coupland H - Increasing Hepatitis C Treatment Uptake by Injecting Drug Users from Culturally and Linguistically Diverse Backgrounds: Outcomes of a Pilot Study of Indochinese Injectors</td>
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<td>2.50pm - 3.00pm</td>
<td>Discussion</td>
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<td>3.00pm - 3.30pm</td>
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<td>Afternoon Tea in Exhibition and Poster Area in Pavilion 1</td>
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<td>3.30pm - 5.00pm</td>
<td>Sexual Health Conference Closing</td>
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<td>Meeting Room 1,2,3</td>
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<td>3.30pm - 3.45pm</td>
<td>Keane NM - An HLA-C*0702 Restricted T-Cell Response Directed Against an Immune Escaped HIV NEF KY11 Epitope Exhibits Higher Functional avidity but Lesser Cytolytic Activity when Compared with the Anti-Wild Type Response</td>
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<td>Chairs: Jenny McCloskey and David Jardine</td>
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<td>3.30pm - 3.45pm</td>
<td>Anderson J - A Critical Analysis of the Quality and Transferability of Economic Evaluations of HIV Interventions for Australian Decision-Making</td>
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<td>3.30pm - 3.45pm</td>
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<td>3.30pm - 4.00pm</td>
<td>Basil Donovan - Professor of Sexual Health, National Centre in HIV Epidemiology and Clinical Research, Sydney, New South Wales, Australia</td>
<td>LASH Study - Law and Sexworker Health</td>
<td>3.45pm - 4.00pm</td>
<td>Stratov I - Robust NK-Cell Mediated HIV-Specific Antibody-Dependent Responses in HIV-Infected Subjects</td>
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<td>3.45pm - 4.00pm</td>
<td>Hillman R - Cost Effectiveness of Screening for Anal Cancer in HIV-Positive MSM</td>
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<tr>
<td>4.00pm - 4.30pm</td>
<td>Peter Leone - Associate Professor of Medicine, University of North Carolina, and Director, North Carolina HIV/STD Prevention and Control Branch, USA</td>
<td>Acute HIV and STDs: Screening and Co-infection</td>
<td>4.00pm - 4.15pm</td>
<td>Fernandez S - CMV-Specific Effector Memory CD4+ T-Cells in HIV Patients on Long-Term ART are Predominantly CD28 Null' Immunosenescent Cells</td>
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<td>4.15pm - 4.30pm</td>
<td>Bernard D - Effective Partnership and Adequate Investment Underpin a Successful Response: Key Factors in Dealing with HIV Increases</td>
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<td>4.15pm - 4.30pm</td>
<td>Savage J - Models of Access and Clinical Service Delivery in Australia Today</td>
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<td>4.30pm - 4.50pm</td>
<td>Prize Presentations and Closing Remarks by Darren Russell - President of the Australasian Chapter of Sexual Health Medicine Committee</td>
<td>4.30pm - 4.45pm Seddiki N - Identification of Human Antigen-Specific Regulatory T Cells, Phenotyping and Functional Analysis</td>
<td>4.45pm - 5.00pm Seddiki N - Regulatory T Cell Abnormalities are Associated with Aberrant CD4+ T-Cell Responses in Patients with Immune Inflammatory Syndrome (IRIS)</td>
<td>4.50pm - 5.00pm Anderson J - Measuring Quality of Life for Economic Evaluation in HIV</td>
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<td>4.50pm - 5.00pm</td>
<td>Presentation of Next Year's Conference by David Jardine - Committee Convener, 2009 Australasian Sexual Health Conference, Brisbane</td>
<td>4.45pm - 5.00pm Anderson J - Measuring Quality of Life for Economic Evaluation in HIV</td>
<td>4.45pm - 5.00pm Discussion</td>
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<tr>
<td>5.15pm - 6.15pm</td>
<td>ASHM Session: Circumcision: Crown Jewels</td>
<td>Riverside Theatre/Auditorium Chairs: Graham Brown and Andrew Grulich</td>
<td>5.15pm - 6.15pm ASHM Session: Diagnostics and Assay Development Chairs: Elizabeth Dax and Andrew Lloyd</td>
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<td>5.15pm - 5.30pm</td>
<td>Templeton D - Reduced Risk of HIV Seroconversion among Circumcised Homosexual Men who Report a Preference for the Insertive Role in Anal Intercourse</td>
<td>5.15pm - 5.30pm Guy R - The Accuracy of HIV Incidence Assays in Estimating the Population Rate of New Infections: A Systematic Review</td>
<td>5.30pm - 5.45pm Gold J - Sensitivity and Specificity of HIV Incidence Assays: A Systematic Review</td>
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<td>5.30pm - 5.45pm</td>
<td>Londish G - Small Population Health Benefits on HIV by Circumcising Men who have Sex with Men</td>
<td>5.30pm - 5.45pm Plate M - Evaluation of the New Version 3 Cavidi Exavir™ Load Quantitative HIV RT Load Kit as an Alternative HIV Viral Load Monitoring Assay for use in Both Resource-Constrained and Developed Countries</td>
<td>5.45pm - 6.00pm Anderson J - Cost-Effectiveness of Circumcision for the Prevention of HIV in Gay Men in Australia</td>
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<td>6.00pm - 6.15pm Donovan S - Promoting Circumcision within the Australian HIV Prevention Response</td>
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<tr>
<td>6.00pm - 6.15pm</td>
<td>Donovan S - Promoting Circumcision within the Australian HIV Prevention Response</td>
<td>6.00pm - 6.15pm Zaunders J - Persistence of High Levels of HIV Antigen-Specific CD4+ T Cells in Untreated Chronic Infection, Detected by a Novel Flow Cytometric Assay</td>
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<tr>
<td>7.30pm - 11.30pm</td>
<td>Joint Conference Dinner, 'Diamonds are Forever' - Bellevue Ballroom, Level 3, Perth Convention Centre</td>
<td>7.30pm - 11.30pm</td>
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Sponsored by the Australian Government Department of Health and Ageing, WA Health, Gilead, GlaxoSmithKline, Boehringer Ingelheim and Merck Sharp & Dohme
ORAL PRESENTATION ABSTRACTS
MONDAY 15 SEPTEMBER 2008
The past decade has seen major changes in the way we approach the diagnosis of sexually transmitted infections. This has been largely due to the introduction of nucleic acid detection testing for a range of sexually transmitted infections. Since then they have become the standard methods for virus detection in many laboratories, and increasingly for the detection of bacterial and other pathogens. In addition to their ability to detect a wider range of infections, the tests are robust, tolerant of adverse collection and storage conditions, highly sensitive and specific, some can be performed on less invasive specimens, and they can be used for more detailed organism identification and characterisation, and for monitoring of disease progression and response to therapy. These have found applications for a number of sexually transmitted infections. Chlamydia trachomatis serotyping was rarely performed in the past due to the technical difficulties. Sequencing of PCR products now allows us to differentiate between genital and trachoma strains, and for the identification of LGV. Similarly we have been able to track gonococcal strains, and are also now building up a more complete picture of HPV genotypes and their circulation and association with cytological changes. It also provides a powerful tool for the monitoring of HPV genotype changes following the introduction of the vaccine.

These tests are not without their challenges and the proper performance of nucleic acid detection tests require rigorous adherence to good laboratory practice and protocols. Laboratories need to be continually alert to mutations that affect test performance. Gonorrhoea poses special challenges due to the continually changing nature of the organism and its ability to exchange genetic information. Also, monitoring of antimicrobial resistance cannot yet be achieved by molecular methods.

Despite the problems, the clear advantages of molecular tests have seen them adopted widely for their convenience and reliability. The future holds promise of further advances in the range and applications of these tests, as well as moving into the newer approaches such as DNA arrays, and the use of new platforms for NAT will allow these tests to be performed reliably in smaller laboratories.
**Plenary 2 – Pearls to Think About**  
11.00am – 1.00pm

**HPV (HUMAN PAPILLOMAVIRUS) GENOTYPE PREVALENCE IN AUSTRALIAN WOMEN PRE-HPV VACCINE ROLLOUT**

Suzanne Garland*, Julia Brotherton, John Condon, Sepehr Tabrizi, Peter McIntyre and David Smith on behalf of the WHINURS Study Group

*Director of Microbiology Infectious Diseases, Royal Women's Hospital, Senior Consultant Microbiologist, Royal Children's Hospital, Professor Department of Obstetrics and Gynaecology, University of Melbourne

**Aim:** To estimate prevalence of type-specific genital HPV infection in the Australian female population, with stratification by age group, Indigenous status, cervical Pap status and region of residence.

**Methods:** Women living in remote and urban areas presenting for Pap screening were consented for collection of a dedicated PreservCyt sample for HPV DNA testing using consensus PCR with PGMY09/11 primers, with genotyping of positive samples by Roche Linear Array.

**Results:** At March 2008, 2729 women had been recruited. An interim analysis at 2461 women identified 680 as Indigenous. Of the 1776 non-Indigenous women, 74% had a documented normal Pap smear result from a satisfactory sample (7% LSIL, 0.7% HSIL or higher). The overall rate of high risk HPV positivity was 23.6%, with highest rates in the youngest women (44% age 15-19, 42% age 20-24, 34% age 25-29) with rates < 10% after 40 years. Overall rates of HPV16 and 18 positivity were 5.9% and 2.4% respectively (peaking at 13% and 6% in the youngest age group).

Multivariate analyses of the results will be presented.

**Conclusion:** This data forms an important baseline against which the impact and effectiveness of vaccine rollout can be measured for Australian women.

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**CHLAMYDIA TRACHOMATIS AND PID AS IT IS SEEN TODAY**

Jorma Paavonen, MD  
Department of Obstetrics and Gynecology  
Helsinki University Central Hospital, Helsinki, Finland

Chlamydia trachomatis is the ultimate intracellular pathogen. C. trachomatis infections cause substantial morbidity including PID, tubal infertility, chronic pelvic pain, and ectopic pregnancy. C. trachomatis has also been linked to cervical cancer. C. trachomatis infection increases susceptibility to and transmission of HIV. Most women and men with chlamydial infection are asymptomatic. Recent major breakthroughs in the diagnosis and management of C. trachomatis infection include the development of accurate amplification tests, first void urine testing, vaginal or vulvar sampling, self-sampling, single dose therapy, and patient delivered partner therapy, just to name a few. The disease burden is still enormous and increasing. There is major frustration with opportunistic screening programs, implementation of management guidelines, contact tracing efforts, and school health education programs. This suggests that recommendations for screening may be inadequate, inefficient, and poorly implemented. Also, there is lack of connection between young adults and health care systems in general. Young adults do not acknowledge that chlamydial infection remains asymptomatic. PID comprises a spectrum of upper genital tract inflammatory disorders in women which includes any combination of endometritis, salpingitis, tubo-ovarian abscess, pelvic peritonitis, and perihepatitis. Salpingitis is the most important feature of PID because salpingitis increases the risk for permanent tubal damage resulting in ectopic pregnancy or subfertility. Most PID in developed countries is sexually transmitted often caused by C. trachomatis. Infections following delivery or induced abortion are categorised separately as puerperal or postabortion infections. Clinical spectrum of PID manifestations varies from subclinical to severe. Recently, severe inpatient PID has been decreasing in many European countries. Most PID today is managed in outpatient clinics. Although Chlamydia rates in young adults have been increasing PID rates have been declining. At the same time tubal pregnancy rates and the proportion of tubal factor infertility of all infertility have been decreasing. Recent population based studies suggest that the risk for PID associated with chlamydial infection has been over-estimated. This is not surprising since historical studies have been focusing on selected high risk populations which easily leads to overestimation of the risks and rates of complications. Thus, old studies have included several biases including selection bias, performance bias, ascertainment bias, detection bias, and perhaps also exclusion bias. Truly population based data may differ from data reported in...
case-control studies. This also means that the cost-effectiveness and health economical analyses of screening programs should be revised. Implementation of PID management guidelines has improved treatment of PID which may decrease risk for long-term complications. In conclusion, it appears that good news regarding PID are emerging. Inpatient PID has become a rare disease, ectopic pregnancy rates are decreasing and the proportion of tubal factor infertility of all infertility is decreasing suggesting that the primary objective of prevention of PID, i.e. to improve reproductive health in women can be reached. However, this is only true for developed countries and only countries with organised health care systems.

STI RATES IN YOUNG ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE: 2002-2006

Ward J, McDonald A, Middleton M, Kaldor J
National Centre in HIV Epidemiology and Clinical Research, University of NSW Sydney Australia

Much negative attention has been focused on Aboriginal and Torres Strait Islander (TSI) communities regarding the population rate of diagnosis of sexually transmissible infections (STIs) in young people. A by product of this has been to erroneously link the occurrence of all STIs in young people to child sexual assault (CSA). We describe the extent and age breakdown of STIs in young Aboriginal and non-Indigenous people in Australia.

Systematic collection of information on new diagnoses of specific STIs occurs through the National Notifiable Diseases Surveillance System (NNDSS). We analysed chlamydia and gonorrhoea notifications from NNDSS with a focus on cases aged less than 16 years and compared notifications in Aboriginal and Torres Strait Islander and non-Indigenous people. Only jurisdictions where Aboriginal and Torres Strait Islander status was reported for at least 50% of cases were included in the analysis; Northern Territory, Western Australia, Victoria, Queensland (gonorrhoea only) and South Australia.

During the period 2002-2006 there were a total of 1234 chlamydia and 1553 gonorrhoea notifications reported among Aboriginal and Torres Strait Islander people aged less than 16 years of age; 96% of chlamydia and 94% of these gonorrhoea notifications were among people aged 12-15 years. During the same time period, among non-Indigenous people, 1198 chlamydia and 253 gonorrhoea notifications were reported in people aged less than 16 years. Similar to the Aboriginal and Torres Strait Islander population, the majority of these chlamydia (93%) and gonorrhoea (88%) notifications occurred among 12-15 years olds. Moreover, in both populations over 80% of chlamydia and gonorrhoea reports were in 14-15 year olds.

This analysis showed that most STI notifications in young people in Australia occurred among 14-15 year olds, irrespective of Aboriginal and Torres Strait Islander status and very few cases occurred in those aged less than 12 years. It is likely that the rates of STI notifications among people aged 12-15 occur as a result of early sexual debut and activity among similar aged peers rather than as a result of child sexual assault. The majority of STI infections in young Aboriginal and Torres Strait Islander people occurred in areas of known high endemicity of bacterial STIs and where regular programs for STI testing occur.
MOODITJ: A SEXUAL HEALTH AND LIFESKILLS PROGRAM FOR INDIGENOUS YOUNG PEOPLE

Coleman S1, Faulkner G1
1FPWA Sexual Health Services, Perth, Australia

Mooditj (Noongar for solid/deadly) is a sexual health and life skills program for Aboriginal youth aged 11-14. Mooditj was written in consultation with communities throughout Western Australia in response to the need for a culturally specific sexual health program.

The Mooditj program uses an integrated approach to sexual health, building links between sexual, physical, emotional, environmental and social well-being. The ten sessions cover issues including: identity, puberty, emotions, relationships, sexual issues/health, parenting and goal-setting. These sessions can be delivered weekly or over a two to three day camp.

Local service providers and key community people are given the opportunity to attend Mooditj Leader Training programs that focus on building comfort and confidence in delivering the program to their young people. The program is supported by a comprehensive and easy to follow manual.

Mooditj has been received with a great deal of enthusiasm throughout Western Australia and the Northern Territory, and is also being taken up in other states. Mooditj won the 2006 Healthway Excellence in Health Promotion Award.

Feedback and evaluation data is being gathered and results will be available at the completion of the current funded round of training workshops in 2008.

For this presentation we invite participants to experience the program by taking part in 'The Relationship Tree', a very popular Mooditj activity. This activity uses creative visual representation to get young people thinking about relationships.

The workshop will conclude with an opportunity for participants to reflect on their experiences of participation, ask questions, and consider how Mooditj may be adapted for use in their communities.
AUDIT OF ANTENATAL TESTING OF SEXUALLY TRANSMISSIBLE INFECTIONS AND BLOOD BORNE VIRUSES AT WESTERN AUSTRALIAN HOSPITALS

Combs BG Kwan KSH Giele CM Mak DB
Communicable Disease Control Directorate, Department of Health, Perth, Western Australia, Australia

In August 2007, the Western Australian Department of Health (DOH) released updated recommendations for testing of sexually transmissible infections (STI) and blood-borne viruses (BBV) in antenates. Prior to this, the Royal Australian & New Zealand College of Obstetricians & Gynaecologists (RANZCOG) antenatal testing recommendations had been accepted practice in most antenatal settings. The RANZCOG recommends that testing for HIV, syphilis, hepatitis B and C be offered at the first antenatal visit. The DOH recommends that in addition, chlamydia testing be offered. We conducted a baseline audit of antenatal STI/BBV testing in women who delivered at selected public hospitals prior to the DOH recommendations.

We examined the medical records of 200 women who had delivered prior to 1st July 2007 from each of the seven WA hospitals included in the audit. STI and BBV testing information and demographic data were collected.

Of the 1,409 women included, 1,205 (86%) were non-Aboriginal and 200 (14%) were Aboriginal. High proportions of women had been tested for HIV (76%), syphilis (86%), hepatitis C (87%) and hepatitis B (88%). Overall, 72% of women had undergone STI/BBV testing in accordance with RANZCOG recommendations. However, chlamydia testing was evident in only 18% of records. STI/BBV prevalence ranged from 3.9% (CI 1.5-6.3%) for chlamydia, to 1.7% (CI 1.2-2.4%) for hepatitis C, 0.7% (CI 0.3-1.2) for hepatitis B and 0.6% (CI 0.2-1) for syphilis.

Prior to the DOH recommendations, nearly three-quarters of antenates had undergone STI/BBV testing in accordance with RANZCOG recommendations, but less than one fifth had been tested for chlamydia. The DOH recommendations will be further promoted with the assistance of hospitals and other stakeholders. A future audit will be conducted to determine the proportion of women tested according to the DOH recommendations.

TRENDS IN FIRST EPISODE ANOGENITAL HERPES DUE TO HSV-1, 1992-2007

Ryder N1, McNulty AM1,2, Jin F3, Grulich AE2,3, and Donovan B1,2,3
1Sydney Sexual Health Centre, Sydney Hospital, Sydney, NSW, Australia; 2School of Public Health and Community Medicine, UNSW, Kensington, NSW; 3National Centre in HIV Epidemiology & Clinical Research, University of New South Wales, Sydney, Australia.

Background
HSV-1 is causing an increasing proportion of genital herpes however it is unknown if this is true for men who have sex with men (MSM). Few studies have collected data on sexuality or site, and none reported trends over time. Currently HSV-2 serology is used as a surrogate for anogenital herpes, so any rise in the proportion of anogenital herpes due to HSV-1 would be missed. We investigated trends and characterised first episodes of anogenital herpes due to HSV-1.

Method
All cases of first episode genital herpes (n=1845) were identified from the Sydney Sexual Health Centre database for the period 1992-2006. Cases were culture confirmed to 2004 and PCR thereafter, with no previous diagnosis of genital herpes.

Results
The proportion of anogenital herpes due to HSV-1 increased from 30% to 40% (p<0.01) overall. Among MSM this trend was only apparent for younger men: in MSM less than 30 years old the proportion due to HSV-1 increased from 22% to 73% (p=0.012). HSV-1 caused a greater proportion of anogenital herpes in MSM than in women or heterosexual men (p<0.05). Overall HSV-1 caused 48% of anal herpes and only 35% of genital herpes (p<0.01).

Conclusion
We have confirmed HSV-1 is causing an increasing proportion of first episode anogenital herpes, particularly in young MSM. In older MSM HSV-2 remained the most common type. HSV-2 serology in young MSM will not detect the majority of cases of anogenital herpes.
PREVALENCE, INCIDENCE AND RISK FACTORS FOR HEPATITIS C IN HIV NEGATIVE AND HIV POSITIVE HOMOSEXUAL MEN

Jin E¹, Prestage GP¹, Dore GJ¹, Zablotska I¹, Rawstorne P², Kippax SC², Kaldor JM³, Grulich AE¹
¹National Centre in HIV Epidemiology and Clinical Research, UNSW; ²National Centre in HIV Social Research, UNSW

Objectives: To determine the prevalence, incidence and risk factors for hepatitis C virus (HCV) infection in homosexual men, and to examine whether HCV is frequently sexually transmitted in this population.

Methods: Participants were HIV negative and HIV positive homosexual men recruited in two community-based cohorts in Sydney, the Health in Men (HIM, HIV negative) and Positive Health (pH, HIV positive) cohorts. HCV sero-status was determined by an enzyme immunoassay (EIA, Abbott Architect) and a supplementary EIA testing (Abbott Murex). Indeterminate (i.e. weak positive and equivocal) results were resolved by a qualitative HCV RNA PCR. PCR was also performed on all HIV positive participants with CD4 counts of less than 200.

Results: At baseline, the prevalence in HIV negative and positive men was 1.07% (n=15, 95% CI 0.60-1.76) and 9.39% (n=23, 95% CI 6.04-13.75) respectively, and during follow up the incidence was 0.11 cases/100 PY (n=5, 95% CI 0.03-0.26) and 0 cases/100 PY (95% CI 0-0.02 one-sided). At baseline, a history of injecting drug use (IDU) was reported in 87% of cases in HIV negative men (OR=56.27, 95% CI 12.56-252.0) and 89 % of cases in HIV positive men (OR=24.46, 95% CI 5.44-109.95). The two HCV positive HIV negative men who reported no history of IDU both reported body tattooing or piercing. During follow up, there were 5 HCV seroconversions in HIM, and only 1 reported recent IDU.

Conclusion: HCV prevalence in HIV positive homosexual men is about 10 times higher than their HIV negative counterparts, in which the rate is similar to the general population. HCV positivity is strongly associated with injection drug use in both cohorts, but 4 of 5 HCV seroconversions were in men who reported no IDU. Sexual transmission of HCV was very uncommon in this setting, but 4 cases which did not appear to be IDU related did occur.

RECENT TRENDS IN INFECTIOUS SYphilIS IN MEN WHO HAVE SEX WITH MEN

Middleton MG¹, Guy RJ¹, Grulich AE¹, Donovan BJ², McDonald AM¹, Kaldor JM¹
¹National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney, Australia; ²Sydney Sexual Health Centre, Sydney Hospital, Sydney, NSW 2000, Australia

Since 2000, there have been increasing reports of syphilis infections among men who have sex with men (MSM) in Australia. We provide an overview of infectious syphilis epidemiology in MSM between 2000 and 2007.

The following surveillance data were sourced; infectious syphilis case reports in males from the National Notifiable Disease Surveillance system; infectious syphilis enhanced surveillance data in MSM from select jurisdictions and area health services; syphilis testing outcomes among MSM from a network of sentinel surveillance sites in Melbourne and incidence estimates from cohorts of HIV negative and HIV positive MSM in Sydney.

In New South Wales, the rate of infectious syphilis diagnoses among men increased from 1.4 to 8.2 per 100,000 population (2000-2004), decreased to 5.6 in 2006 and increased to 12.1 in 2007. In Victoria there was a steady annual increase from 0.2 to 8.2 per 100,000 population (2000-2006). The rate increased from 2.6 to 6.8 in Queensland (2002-2006) and from 2.4 to 3.3 in WA (2004-2006). Published reports from Victoria and NSW found the majority of diagnoses occurred in MSM aged 30-39 years, and of MSM 40 - 54% of cases were co-infected with HIV. The prevalence of infectious syphilis among clinic attendees in Melbourne increased from 0.5% to 2.5% in HIV negative men and 0.0% to 6.1% in HIV positive men (2000-2004). The Sydney cohorts showed rates of syphilis in HIV positive men were 5-10 times higher than in negative men in 2006-7 and the incidence doubled in those reporting more than 6 casual partners in the last 6 months.

This review has demonstrated a resurgence of infectious syphilis in MSM in Australia since 2000 which has been sustained until 2007. HIV infected men have been disproportionately affected. Syphilis in MSM is of particular public health importance because of its potential to increase the risk of HIV transmission. New, innovative approaches to syphilis control are desperately needed.
PERIODIC PRESumptIVE TREATMENT (PPT) OF COMMON CURABLE SEXUALLY TRANSMitted INFECTIONS (STIs) AMOnG FEMALE Sex WORKERS IN PORT MORESBy, PAPUA NEW GUINEA: MEASURING STI INCIDENCE AND PPT EFFECTS

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Background: Sexually transmitted infections (STIs) are among the world’s most common diseases. Both ulcerative and non-ulcerative STIs have been implicated as major co-factors in the human immunodeficiency virus (HIV) transmission. Female sex workers are at increased high risk due to high partner exchange rates coupled with unprotected sex. Worldwide, high STI prevalence has been reported among sex workers. In Port Moresby Papua New Guinea, the prevalence of chlamydia, syphilis, gonorrhoea, and HIV are estimated to be as high as 31%, 32%, 36%, and 17% respectively among sex workers. Adequate STI treatment and management have shown to decelerate and prevent further spread by reducing infection “window” periods when potential transmission to other susceptible individuals is likely. This is known to achieve reduction in STI prevalence, thus rendering HIV transmission less efficient. In the quest for alternative STI treatment protocol to the syndromic management approach for PNG, a pilot of periodic presumptive treatment (PPT) of common curable sexually transmitted infections (STIs) among female sex workers was commenced November 2003 – September 2004 in Port Moresby. Methods: One hundred and twenty nine female sex workers and forty nine clients were enrolled in the study. Informed consent obtained, voluntary counselling offered, a rapid STI/HIV risk assessment questionnaires administered. Cross-sectional pre and post serum measurements of common curable STIs were obtained using polymerase chain reaction (PCR) and syphilis via VDRL and TPHA and stratified by type of groups. All participants were tested for HIV. Three monthly rounds of PPT were administered. All study participants were provided with HIV/STI information and resources.

Results: The prevalence of chlamydia, gonorrhoea, syphilis, trichomonas and HIV was 24%, 27%, 28%, 43%, and 14% respectively at pre-PPT (N=178) and 16%, 21%, 19%, 26% and 18% (of which 5% were new infections) respectively at post-PPT follow up (N=100). The overall HIV prevalence for the total study population (N= 178) was 17.0 %, male clients 10.2% and 19.4% for sex workers. Conclusions: The overall study was significant P<0.05 and successful. PPT was effective in decreasing STIs among the study population. PPT approach could be implemented as an alternate tool in rapid STI reduction strategy among sex workers in the short term.
UPSTAIRS AND DOWNSTAIRS: SOCIO-ECONOMIC AND GENDER INTERACTIONS IN HERPES SIMPLEX VIRUS TYPE 2 (HSV-2) SEROPREVALENCE IN AUSTRALIA

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Objectives: To investigate socio-economic differentials in herpes simplex virus type 2 (HSV-2) seroprevalence in Australian men and women using both individual and geographic measures of socio-economic status.

Methods: HSV-2 seropositivity among men and women aged over 25 years was investigated by levels of individual and area-based measures of socio-economic status (SES) in a series of Poisson regression models, variously adjusting for age, country of birth, marital status, indigenous status and urban/rural residence as potential confounders. Serum and socio-demographics were collected during 1999 and 2000 in a population-based Australia-wide prevalence survey.

Results: HSV-2 seroprevalence was significantly lower in areas of low SES than in high SES areas among both men (p for trend <0.001) and women (p for trend = 0.005) for all ages. A similar pattern was evident for individual education level for men with lower rates of HSV-2 in respondents with lower educational achievement (RR=0.77, 95%CI 0.61-0.97, p=0.024). In contrast, HSV-2 prevalence was higher for women with lower individual levels of education for all ages (RR=1.23, 95%CI 1.04-1.45, p=0.015). Analyses stratifying HSV-2 prevalence for individual education level by area-based SES showed the highest prevalence of HSV-2 in women with the lowest education level residing in the highest SES areas. This pattern was not evident in men, with a greater concordance between individual and area-based SES.

Conclusion: HSV-2 seroprevalence is not consistently distributed across individual and area measures of SES, suggesting that upward and downward mixing between social strata in men and women is an important mode of HSV-2 transmission.
A SEXUALLY TRANSMISSIBLE INFECTIONS PROGRAMS UNIT FOR NEW SOUTH WALES TO GUIDE STRATEGY IMPLEMENTATION

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The New South Wales (NSW) Sexually Transmissible Infections (STI) Strategy 2006-2009 provides a state-wide framework for sexual health programs and identifies key areas and actions required to reduce STI and associated morbidity and mortality. The Strategy aims to work with priority populations and the public and private health sectors to build capacity for prevention, treatment and management of STIs. Working in partnership with health and community sector agencies and across Area Health Service (AHS) boundaries are key to implementation. Accordingly, the NSW STI Programs Unit (STIPU) was established in 2007 by NSW Health to assist implementation of the Strategy by: coordinating some state-wide activities, providing leadership to the sexual health clinical and health promotion workforce; and establishing some dedicated sexual health projects. An advisory group provides expert advice and guidance to STIPU while multidisciplinary working groups guide specific projects.

The current focus of STIPU is to assist publicly funded sexual health services to orientate service delivery toward priority populations; strengthen the capacity of general practitioners to manage STIs within the primary care setting; promote community awareness through state-wide STI social marketing and information campaigns. A STIPU strategic plan incorporates each project work plan.

The STIPU plan will be presented highlighting some achievements and challenges, including engaging the sexual health sector at a state level for the first time with a non-HIV focus; conducting the first state wide snap shot of NSW sexual health services; developing a state wide manual for sexual health services; convening a NSW general practice STI working group of general practitioners, practice nurses and sexual health specialists; incorporating general community STI and HIV social marketing activities; coordinating review and development of community and workforce support tools like the NSW sexual health website and telephone information line.

CIRCUMCISION IN AUSTRALIA: FURTHER EVIDENCE ON ITS EFFECTS ON SEXUAL HEALTH AND WELLBEING FROM THE AUSTRALIAN LONGITUDINAL STUDY OF HEALTH AND RELATIONSHIPS

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Objective: To report on the prevalence of circumcision across various social categories in Australia and examine sexual health outcomes.

Methods: A representative household sample of 4,009 Australian men aged 16-64 years completed a computer-assisted telephone interview.

Main Outcome Measure(s): Circumcision status, demographic variables, reported lifetime experience of selected sexually transmissible infections (STIs), experience of sexual difficulties in the previous 12 months, and sexual practices at last heterosexual encounter.

Results: More than half the men (57%) were circumcised. Circumcision was less common among men under 30 and more common among those born in Australia. After correction for age and number of partners, circumcision was unrelated to STI history except for non-specific urethritis (more common among the circumcised) and penile candidiasis (less common among the circumcised).

Circumcision was unrelated to any of the sexual difficulties we asked about. An association between lack of circumcision and erection difficulties in older men found in two earlier studies was not detected.

There were no significant differences by circumcision status in practices at last sexual encounter with a female partner.

Conclusions: Circumcision appears to have minimal protective effects on sexual health in the Australian context. This study provides no evidence about HIV risks or effects on sexual sensitivity.
THE ACCEPTIBILITY OF SELF-COLLECTED SPECIMENS FOR ASYMPTOMATIC SEXUAL HEALTH SCREENS

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Kirketon Road Centre (KRC) is a primary health care service, providing a range of services including sexual health screening to target populations including sex workers, injecting drug users (IDU) and at risk young people.

In 2007 KRC developed a survey to investigate the acceptability of self-collection of vaginal and anal specimens among existing clients presenting for asymptomatic sexual health screening. In addition, KRC set out to determine the rate of practitioner-identified signs from genital examination of asymptomatic first attendees.

Between September and December 2007, 253 clients had asymptomatic sexual health screens comprising of 59% female, 38% male, 3% transgender, 30% <25 years, 47% sex workers, 27% IDUs and 4% Aboriginal. Eighty-five surveys were administered, indicating that approximately 50% of clients preferred to collect their own specimens, 30% preferred practitioner collection and 20% stated no preference. Results were similar when considering vaginal and anal specimens separately, by gender and by sex work status.

Clients preferring practitioner-collected specimens responded in 3 categories: 15 were concerned about the quality and reliability of self-collected specimens; 5 reported not being comfortable/confident to self-collect; and 1 wanted a practitioner genital examination.

In order to estimate the number of genital infections that would potentially be missed by introducing self-collection, medical files of all asymptomatic sexual health screens of existing clients during November 2007 were audited. Of 76 consultations, only 1 client presenting as asymptomatic was found to have genital warts on practitioner examination.

In view of these results, KRC is now offering self-collection to existing clients presenting for asymptomatic sexual health screening. Data is being collected on clients choosing self-collection, the rate of practitioner-identified signs from genital examination and client acceptability. This data will be analysed to evaluate the project and determine future directions.

COMMUNITY TESTING - IT’S A PIECE OF PISS

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Background
Chlamydia trachomatis is the most commonly diagnosed sexually transmitted infection (STI) in New Zealand. In sexual health clinics, under-25-year-olds account for 72% of chlamydia infections. Chlamydia infection is asymptomatic in approximately 70% of female and up to 73% of male cases. A joint clinical and health promotion team attended various community events, to demonstrate the ease of chlamydia testing, to offer information about sexual health services and to assess the rates of asymptomatic chlamydia.

Method
The project used the Health Belief Model and on-the-spot testing. People who agreed to be tested were given a tick-box history form to complete. Those who were symptomatic were triaged by a clinician and if necessary referred for an appointment at an appropriate service. Specimens were collected by self-swabbing (vaginal or rectal) or first-void urine. Those who chose not to test on the day were provided with contact details for Auckland Sexual Health Service (ASHS) as well as free condoms and information on STI prevention. Specimens were tested at LabPlus Auckland City Hospital. Text messaging, calls to mobile phones and email were used to contact people with their test results and to arrange follow-up if required. The testing method was reviewed and modified after each community event to improve ease of assessment and the quality of the information collected.

Results
A total of 517 people agreed to be tested, of which 75% were under 25 years. The rate of Chlamydia trachomatis infection was 4.06% overall, with some differences in prevalence rates between the various community events ranging from 3.5% to 11.3%. All those who tested positive were followed up and treated. The method of testing was seen as acceptable, particularly for men. Overall feedback from those who agreed to be tested was very positive.

Conclusion
The testing and health promotion model developed from the project could be used to target other specific sectors of the community. Information collected about the the rates of chlamydia infection in those community sectors could be used to inform targeted health promotion and testing.
THE PREVALENCE OF CHLAMYDIA AND MYCOPLASMA GENITALIUM IN A COHORT OF AUSTRALIAN YOUNG WOMEN

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Background: This longitudinal study aims to determine the optimal screening frequency for Chlamydia trachomatis in Australia by estimating the incidence and re-infection rates of chlamydia among women aged 16 to 25 years. As a secondary aim, we are also measuring the incidence of Mycoplasma genitalium. We present the interim results for baseline chlamydia and M. genitalium prevalence.

Methodology: Sexually active women aged 16 to 25 years are recruited from general practices, sexual health centres and family planning clinics in Victoria, New South Wales and the ACT. All participants provide 2 vaginal swabs, one for chlamydia and one for M. genitalium testing at the time of recruitment. Women are followed up over a 12 month period and regularly tested for chlamydia and M. genitalium using self-collected vaginal swabs mailed to women. Women complete questionnaires at baseline and at each stage of the study. 1200 women will be recruited in total.

Results: A total of 800 women have been recruited thus far and have been tested for both chlamydia and M. genitalium at baseline. Approximately 50% of the sample is aged 16 to 21 years, with an average and median age of 21.6 years. The prevalence of chlamydia and M. genitalium at baseline was 4.8% (95%CI: 3.4%, 6.5%) and 2.2% (95%CI: 1.3%, 3.4%) respectively. Chlamydia and M. genitalium prevalence estimates were higher among the younger age group (5.8% versus 3.6% for chlamydia; and 2.3% versus 1.9% for M. genitalium).

Conclusion: This study has found a high baseline prevalence of chlamydia among young Australian women and will generate chlamydia incidence estimates, valuable for determining Australia’s optimal chlamydia testing interval. In addition, this study has determined the first prevalence estimates for M. genitalium among young Australian women and shows that the prevalence of M. genitalium is about half that of chlamydia.

ORAL POSTER: Douglas J - see page 115
ORAL POSTER: Moore S - see page 167
MAKE CONTACT: A PROJECT TO EVALUATE CONTACT TRACING STRATEGIES FOR CHLAMYDIA

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AIM
To evaluate contact tracing outcomes and current resources for contact tracing for chlamydia.

METHOD
Clients, >18 years, diagnosed with chlamydia at the Pacific Clinic were invited to participate. A questionnaire on contact tracing was administered by telephone, two weeks after the index was advised of the need for contact tracing. Information was collected on contact tracing outcomes, the methods used and considered useful for notification. Comparison was made to contact tracing outcomes from a pre-study audit. The study was the first phase of a project to develop and evaluate new resources for contact tracing for Chlamydia.

RESULTS
From November 2007 to May 2008 there were 56 chlamydia diagnoses, 36 (64.3%) consented to study participation. Thirty interviews have been completed. The mean number of contacts for tracing was 2.3 (total 69, median 2, range 1-5). Seventy eight percent (54/69) contacts were known to be notified, giving a ratio of 1:1.8 for index cases to contacts known notified.

The majority of index cases notified a contact in person (50%) or by telephone (40%), although two (6.7%) notified a contact through a third party and one (3.3%) used provider notification. Approximately one third of subjects responded that they would have used each of the following had they been available; provider notification, a text message to forward on, a website to allow anonymous notification and a wallet sized card to give contacts. Seventeen index cases (56.7%) reported being given a letter or brochure but only seven (23.3%) passed this on to a contact.

There were 59 chlamydia diagnoses in the pre-study audit period (March - September 2007). The mean number of contacts for contact tracing was 1.6 (total 93, median 1, range 0-8). Sixty three percent (59/93) of these contacts were known to be notified, giving a ratio of 1:1 for index cases to contacts known notified.

DISCUSSION
Participants in the study identified more contacts for tracing and were known to have notified a greater proportion of contacts compared to the audit period. Although the majority of people preferred to notify contacts themselves, many would consider other methods if they were offered including provider notification. Offering a variety of resources for contact tracing should be considered.
ROYAL PERTH HOSPITAL EMERGENCY DEPARTMENT SCREENING PROJECT FOR CHLAMYDIA TRACHOMATIS

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Western Australian (WA) rates of Chlamydia are consistently higher than the national average. Chlamydia screening programs often miss hard-to-reach populations, including young men, indigenous peoples, and the homeless.

Objectives: A pilot study to determine if screening patients for genital Chlamydia in the ED is:
· feasible in an Australian setting,
· able to access the hard-to-reach populations,
· practical, for the purpose of notifying and treating those found to have Chlamydia.

Methodology: Urinary screening for Chlamydia was offered to people aged 18-25 years who are attending the RPH, including visitors. Recruitment via a nurse-led strategy was compared to a patient self-initiated strategy. A resource package (including brochure and DVD) was designed to facilitate recruitment and screening, as well as to provide information on Chlamydia to those choosing not to participate. Options for notifying patients of their results have been evaluated (including text messaging and e-mail).

Results: 823 people (male 532, female 291, aboriginal 58) were recruited, revealing an asymptomatic population Chlamydia prevalence of 5.5%. Further analysis of the proportion of people in the hard-to-reach target groups, pre-existing knowledge of Chlamydia, risk-behaviours analysis, favoured means of notification and their relative success will be presented.

Conclusion: This pilot study did reach the hard-to-target population, and nurse-led recruitment was the more successful strategy. Most people preferred to get their results by mobile phone. Further conclusions will be presented on completion of the data analysis.

This project was funded by the Commonwealth, as part of a National Chlamydia Pilot program testing the effectiveness of a number of models for Chlamydia testing in Australia. This project will assist in developing recommendations for a National Chlamydia Program.

THE POTENTIAL IMPACT OF A VACCINE ON CHLAMYDIA EPIDEMIOLOGY AND MORBIDITY

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Chlamydia trachomatis infections have serious consequences for the reproductive health of women, being a leading cause of pelvic inflammatory disease, ectopic pregnancy, and infertility. Worldwide a number of interventions (such as screening) have been introduced to control the incidence of Chlamydia. However the most effective intervention is likely to be Chlamydia vaccines which are currently in the early stages of development.

The potential impact of a vaccine on the prevalence and incidence of Chlamydia is investigated using a mathematical model that describes the sexual partnership dynamics and C. trachomatis transmission within a heterosexual population containing a highly active core group. By describing the chlamydial load within an infected individual and their resulting infectiousness this model links the within-host biology of infected individuals to population-level epidemiology. The impact of a vaccine on Chlamydia epidemiology is then determined by its effect on the chlamydial load in, and subsequent infectiousness of, infected individuals and the susceptibility of vaccinated individuals to infection.

For various vaccination roll-out strategies we determine the biological properties required of a vaccine in order to be effective in mitigating a Chlamydia epidemic. We show that an imperfect vaccine can still result in significant reductions in overall Chlamydia transmission as long as it has a sufficiently long duration of action and the population coverage is relatively large.

Our model suggests that effective vaccines should ideally aim to reduce the peak chlamydial load post infection and the duration of an infection. Even relatively small decreases in infection duration can greatly reduce the incidence of Chlamydia sequelae within a population.
BEST PRACTICE PATHWAY: INCREASING CHLAMYDIA SCREENING IN THE GENERAL PRACTICE SETTING

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In response to rising chlamydia rates, the Australian Government has recently funded pilot chlamydia screening programs for young women aged 18-24 attending general practitioners. Issues of public health concern, such as screening, are often not well addressed in general practice, being an additional burden in an already time-poor setting. Yet the strong correlation between testing rates and chlamydia notification in both men and women suggest that increased testing would identify further infections.

As part of a randomised controlled trial examining the impact of a monetary incentive on chlamydia screening rates, we examined the international literature, and then, in detail, 12 general practices, to explore potential structural or procedural barriers that might inhibit chlamydia screening in young women in this setting.

The practices included a mixture of rural, urban, small, large, private, community and indigenous services. One researcher visited each practice and collected details about issues likely to impact on the ease of screening, such as presence of youth-friendly literature in the waiting room, clear instructions for urine collection in the toilet, and the current system of managing a positive test result. Potential positive and negative elements in each practice were identified and fed back to each practice. From these data, we have designed a screening pathway outlining currently known best practice for screening to be successful in the general practice setting. At the conclusion of the trial, we plan to assess whether aspects of this pathway were associated with increased chlamydia screening rates.

THE CHECK WAS IN THE MAIL: CONTACT PREFERENCES OF PARTICIPANTS

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Objectives
In Queensland a novel self-collection kit for Chlamydia trachomatis testing was piloted in 2007/2008 to lower barriers to testing. The present study evaluated the clients’ preferences for being contacted for results.

Methodology
A self-collection testing kit consisting of all necessary items and instructions to obtain a sample for Chlamydia testing was developed. The kit contains a standardised questionnaire. During the study about 3,000 kits were distributed by mail or through partner organisations which were in contact with the target population (16 to 25 year olds and the socially and geographically isolated). A centralised system was developed to co-ordinate the distribution of kits and the management of results.

Results
A total of 294 samples were returned. The positivity of Chlamydia was 12.9%; six samples were inhibited. Of the respondents, 92.2% (n=271) provided contact details – 91.8% with names: 63.0% mobile phone number, 13.3% email, 10.2% mail, and 5.8% home phone number. Four participants (1.5%) provided contact details, but were not contactable. All 38 positive participants were contacted and treated. Five of the six participants with inhibited samples were contactable for repeat sampling. Ninety percent of negative participants were contactable. None of the participants who did not provide contact details communicated with the service.

Conclusions
This study showed that providing contact details (including names) was acceptable for clients. Providing contact details proved advantageous to the clients (knowledge of result) and to the service provider who was able to manage client communication and follow-up from a centralised position.

This project was funded by the Commonwealth, as part of a National Chlamydia Pilot program.

ORAL POSTER: Hince P - see page ??
A SYSTEMATIC, PRIMARY HEALTH CARE APPROACH TO STI SCREENING AND RECORDING IN KIMBERLEY ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES 2001-7

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There is a weight of evidence indicating that the excess of STIs in Aboriginal populations relates to a lack of access to effective screening and treatment. This has been reflected in the approach taken by the Kimberley Aboriginal Medical Services Council (KAMSC) and its affiliated member services, recognizing the need for long-term prevention strategies to include at their core a commitment to improve access to primary health care services, with appropriate sexual and reproductive health care services embedded in routine service delivery. After six years of systematic recording of STI testing activity and test results throughout Kimberley ACCHS, we have been able to demonstrate a region-wide, overall increase in STI testing activity across the ACCHS sites, which is coupled with an overall decline in STI rates. Key elements of this successful regional approach to STI control are explored in detail. We also highlight the adverse impact of a short-term decline in regional ACCHS workforce on STI testing and test-positive rates as demonstration of the vulnerability of STI control effort to fluctuations in health service capacity.

AN EVALUATION OF TIWI SEXUAL HEALTH PROGRAM, 2002-2005

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Objectives: To assess the effectiveness of a comprehensive sexual health program implemented between 2002-2005 in the remote Indigenous communities on the Tiwi Islands.

Methods: Quantitative evaluation included using notification data and laboratory testing data to assess the change in the prevalence of bacterial sexually transmitted infections (STIs) in relation to the program implementation with rate comparisons with nearby regions. Semi-structured interviews with staff were conducted to explore the reasons for the effectiveness of the program as well as its strengths and weaknesses.

Results: Over the four years’ period of program implementation, the rate of chlamydia, gonorrhoea and syphilis decreased by 95%, 60% and 89%, respectively; testing positivity rates showed similar decreasing trends. This had occurred despite a high level of testing being maintained throughout the period. No similar trends were observed in nearby regions. Two reasons for the success of the program emerged from the staff interviews. The first was community ownership of and engagement with the program. Community concern about the high infertility rate caused by STIs was identified as an important factor in motivating community support. Secondly, the presence of a dedicated coordinator to drive the program within the primary health care sector was essential for the sustained effectiveness of the program in the communities.

Conclusion and implications: The Tiwi Sexual Health Program achieved a significant reduction in STI rates between 2002-2005. This model of a comprehensive sexual health program with a dedicated coordinator located within a primary health care service can be recommended as an effective approach to address high rates of STIs in remote Indigenous community settings.
THE FIRST SURVEY OF SEXUAL HEALTH AND BLOOD BORNE VIRUS KNOWLEDGE, RISK BEHAVIOURS AND HEALTH SERVICE UTILISATION OF YOUNG ABORIGINAL PEOPLE IN NSW AGED 16-30 - PRELIMINARY FINDINGS AND INNOVATIONS IN DATA COLLECTION

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Despite young Aboriginal people being identified as a priority population in almost every strategy relating to STIs and BBVs in Australia, very little behavioural data exists to shape and influence policy and program decisions for this group. In 2006 the Aboriginal and Health and Medical Research Council of NSW and the National Centre in HIV Social Research collaborated on a research project to address this deficient evidence base, by conducting a cross sectional survey of Aboriginal people aged 16-30 at NSW Aboriginal cultural events. Participants were surveyed regarding levels of knowledge, risk behaviours and the types of health services utilised by them for sexual health, and blood borne viruses.

To date almost 300 surveys have been completed. This research involved the use of new technology to Australia-personal digital assistants, rather than paper based surveys.

Results to date include 42% of participants being male, median age of 20 years, 90% identified as heterosexual and almost two-thirds (64.2%) described their relationship status as single. Almost 20% of the participants did not know you could have an STI without symptoms. 90% of participants knew you could get hepatitis C or HIV from used injecting equipment however 20% and 26% thought HIV could be acquired through kissing and sharing a bong respectively. 44% of participants had used at least one illicit drug in the previous 12 months, with marijuana most used (40%), ecstasy (13%) and amphetamines (10%). 16% of participants reported no alcohol use in the previous 12 months, however, 5% reported drinking alcohol daily.

The results of this survey are important as this project is the first survey of its kind in Australia to address this issue. Further behavioural research that can assist in the shaping of policy is needed if we are to comprehensively address this priority population.

AN EPIDEMIC OF VULVAR PATHOLOGY IN YOUNG AUSTRALIAN INDIGENOUS WOMEN

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Objective: To confirm and document the epidemiological features of a possible cluster of cases of vulvar cancer and pre-cancers in Indigenous women in the Northern Territory (NT).

Methods: All NT resident women with a confirmed histological diagnosis of vulvar cancer or vulvar intraepithelial neoplasia (VIN) grade 2 or 3 (high-grade VIN) between 01/01/1996 and 31/12/05 were included.

Results: Between 1996 and 2005, 71 women were identified; 32 had a confirmed diagnosis of invasive vulvar cancer and 39 had a confirmed diagnosis of high-grade VIN. The majority of women diagnosed were Indigenous, aged less than 50 years and living in remote communities in the East Arnhem (EA) district, on the north-east coast of the NT. The age-adjusted incidence rate of vulvar cancer in EA Indigenous women aged less than 50 years was over 50 times higher than the national Australian rate for the same age group. The age-adjusted incidence rate of high-grade VIN for EA Indigenous women aged less than 50 years was over 5 times higher than for Indigenous women living elsewhere in the Top End of the NT (national data about VIN incidence are not available). Just under half of all Indigenous women diagnosed with either vulvar cancer or VIN had other anogenital neoplastic or pre-neoplastic lesions.

Conclusion: We have confirmed an epidemic of vulvar cancer and VIN in younger Indigenous women in the East Arnhem district of the NT. The cause of this epidemic is unknown, however the epidemiologic features suggest there may be a higher prevalence of oncogenic human papillomavirus infection in this population.

ORAL POSTER: Brazzale A -see page 131
ORAL POSTER: Mak D -see page 141
ORAL POSTER: Lenton J -see page 117
IS IT NECESSARY TO EXAMINE A WOMAN DIAGNOSED WITH ASYMPOTOMATIC CHLAMYDIA INFECTION?

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Background: Urines and self-collected specimens are often used for testing asymptomatic women for chlamydia. Some are concerned that by not performing a pelvic examination, important findings such as pelvic inflammatory disease (PID) may be missed. This study aimed to determine the pelvic examination findings of asymptomatic women diagnosed with chlamydia.

Methods: A case control study comparing the pelvic examination findings in asymptomatic women with and without chlamydia was conducted. Cases were women aged under 30 years who presented to Melbourne Sexual Health Centre between January 2006 and June 2007 with asymptomatic chlamydia and who had a pelvic examination (speculum and/or bimanual) at the time of diagnosis. Controls were asymptomatic women who tested negative for chlamydia and who had a pelvic examination. Two controls for each case were selected, matched by age, test date and practitioner. A standardised data extraction form was developed to audit the medical records.

Results: 98 cases and 167 controls were included. After adjusting for number of partners, history of sex work and contact with infection, cases were more likely to have easily induced bleeding (OR=2.7; 95%CI: 0.9, 7.9) or cervical discharge (OR=2.4; 95%CI: 1.1, 5.5) on speculum examination. However, these findings did not lead to any change in the standard treatment for chlamydia. Only one case (1%; 95%CI: 0.5%, 6.4%) and no controls were found to have any signs suggestive of PID on bimanual examination.

Conclusions: These results suggest that while asymptomatic women diagnosed with chlamydia are more likely to have evidence of inflammation at the cervix, this does not lead to any change in their standard treatment for chlamydia. Further, they are unlikely to have signs of PID, providing evidence that it is not necessary to perform a pelvic examination when testing young asymptomatic women.

WHAT'S THE FUSS ABOUT? CORRELATIONS OF BACTERIAL VAGINOSIS (BV) IN UNIVERSITY STUDENTS

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Bacterial vaginosis (BV) is one of the commonest genital infections in women of reproductive age yet its precise aetiology is unknown. BV is associated with serious sequelae, including facilitation of transmission of HIV and STIs and adverse pregnancy outcomes. There is evidence from observational studies that BV has many of the epidemiological characteristics of a sexually transmitted infection in that it is associated with multiple/new male sexual partners, co-infection with STIs, and condoms confer some protection against acquisition and reinfection. Unlike other STIs however, BV is noted to be higher amongst women who have sex with women (WSW) than exclusively heterosexually active women.

The Female University Student Study (FUSS) is a 12 month cohort study to explore the demographic, sexual and other behavioural associations of BV in 17-21 year old university students.

FUSS is a cross-sectional, prevalence survey and 12 month cohort study of 500 17-21 years old female university students. Participants were posted a kit containing a questionnaire, vaginal swab, participant information and consent form and a reply paid envelope. An option of an online questionnaire was also available. Detailed behavioural and contraceptive data was collected. BV was diagnosed by the Nugent method from self-collected vaginal swabs.

Non penetrative sexual practices are known to transmit STIs, especially viral STIs such as HPV and HSV. The high rates of BV in WSW suggest sexual risks may not be limited to vaginal intercourse. FUSS is the first research of its kind to explore in depth sexual and other behavioural correlates with BV prevalence and incidence in a cohort of relatively sexually inexperienced women. The cross sectional baseline data from 500 women who have participated in FUSS will be presented.
CORRELATION OF ANAL CYTOLOGY AND HISTOPATHOLOGY IN CASES OF ANAL WARTS, AND HIGH RISK DIGENE HC2 TESTING

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Objective
The objective of this study is to describe the frequency of HPV positivity to high-risk strains of HPV in the anal canal and possible correlation between anal cytology, histopathology and disease in patients undergoing surgery for perianal/anal warts and mapping biopsies.

Methodology
In this case series 90 patients (69 male, 21 female) with anal condylomata acuminata underwent scissor excision of the lesions under general anaesthesia and 10 patients (9 males) underwent mapping biopsies for investigation of intraepithelial neoplasia, (IN). Prior to removal of tissue, anal cytology and Digene hybrid capture-2 testing for high-risk strains of HPV was performed through a proctoscope.

Summary
The demographic characteristics of the patients will be described as well as the correlation between anal cytology and histopathology. The prevalence of HPV positivity amongst the cases was 67.7% (male 75%, female 40.9%). Among HIV positive cases the prevalence of HPV positivity was 96.8% compared to HIV negative cases 55.6%. Cytology reported 35.3% of high-grade IN, and histology reported 44.1% of high-grade IN. A high, significant correlation was found between cytology and histology (% agreement = 75%, kappa = 0.49, P<0.0001). Further analysis of the correlation between the cytological and histological findings, rates of IN and Digene positivity will be reported.

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Conclusion
High rates of IN are reported in HIV positive patients. Most male patients with anal warts are positive for high risk HPV in the anal canal. Recognising Histology as the gold standard, cytology under-recognises the true extent of high-grade IN. Cytology detects an additional 8% of cases of high-grade IN that would be otherwise missed. Cytology is a complementary test to histology.

NON-GONOCOCCAL URETHRITIS IN SYDNEY MEN

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Questions about the aetiology and diagnostic criteria for non-gonococcal urethritis (NGU) remain unanswered. We determined the prevalence of a range of microorganisms in Sydney men with (cases) and without (controls) urethral symptoms (urethral discharge, dysuria and/or urethral discomfort), recruited from two sexual health clinics in Sydney between April 2006 and November 2007. Our main aims were to investigate the role of Ureaplasma urealyticum in NGU, the prevalence of Mycoplasma genitalium in our population, and the usefulness of urethral smear Gram stain microscopy.

Multiplex polymerase chain reaction (PCR)-based and reverse line blot assay and/or bacterial culture was performed for Chlamydia trachomatis, Mycoplasma genitalium, Mycoplasma hominis, Streptococcus pneumoniae, group B streptococcus (GBS) Haemophilus influenzae, Neisseria gonorrhoeae, Neisseria meningitidis, Gardnerella vaginalis, adenovirus, herpes simplex virus types 1 & 2 and two species of human ureaplasmas, U. urealyticum and U. parvum. 516 subjects were eligible for analysis.

C. trachomatis was significantly more likely to be detected among cases than controls (OR 8.036, p<0.001). The presence of any symptom was not significantly associated with detection of U. urealyticum (OR 1.3, p=0.4) or M. genitalium (OR 3.5, p=0.06). However, for both these organisms, each symptom was more likely among cases than controls, and when specifically examining dysuria alone, there was a significant association (U. urealyticum OR 2.0, p=0.02; M. genitalium OR 5.5, p=0.004). The presence of GBS was significantly protective (OR 0.52, p=0.02). Prevalence of M. genitalium was relatively low (4.2% cases, 1.2% controls). Although 59% of men with any urethral symptom did not have >=5 polymorphonuclear leucocytes per high power field on Gram stain, there was a significant association between being a case and this finding (OR 4.5, p<0.001).

C. trachomatis was the only microorganism significantly associated with any urethral symptom/s, but both M. genitalium and U. urealyticum were significantly associated with dysuria.
ANOGENITAL LYMPHOGRANULOMA VENEREUM REPORTED IN WESTERN AUSTRALIA

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This is the first reported case of anogenital lymphogranuloma venereum (LVG) due to the L2 serovar of Chlamydia trachomatis in Western Australia. LGV outbreaks in men who have sex with men (MSM) have been reported overseas, and some cases have been reported in the Eastern States.

The patient is a 45 year old HIV infected male on anti-retroviral therapy with good virological control and CD4 count 532. He presented to the sexual health clinic at RPH in May 2008 because of recent rectal bleeding. He had a mucopurulent rectal discharge and active peri-anal herpes. Anoscopy revealed a marked proctitis with a 2 cm ulcer at the dentate line. Chlamydia trachomatis DNA was detected from a rectal swab using Roche Amplicor, and subsequent typing using an in-house tandem PCR. Sequencing from the MOMP gene found the strain to be genoserovar L2. Other investigations demonstrated reinfection with syphilis. He reported engaging in frequent episodes of fisting, and casual anal intercourse with anonymous partners at local sex-on-premises venues. He had not travelled in the previous 15 months and an STI screen on return was negative for rectal C. trachomatis by PCR. A more complete description of the clinical case will be presented. Contact tracing is underway.

It has been the policy of the RPH Sexual Health clinic to do LGV testing of PCR-positive rectal C. trachomatis specimens in those presenting with proctitis or in those whose infections fail to clear at trial of cure testing. Until this case no LGV serovars have been reported. It is planned to retrospectively test the PCR-positive rectal C. trachomatis samples from the clinic over the past 12 months to establish if this is an incidental case or whether there is ongoing local transmission within the Perth MSM community.

EFFECTS OF HAVING A SEXUALLY TRANSMITTED INFECTION ON WOMEN’S SEXUALITY AND SELF-CONCEPT

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Objective: The aim of this study was to explore the experiential aspect of having a sexually transmitted infection (STI) from young women’s perspectives.

Methodology: This study utilised a qualitative design and was informed by a feminist methodology. All data was collected via computer mediated communication and was subjected to thematic analysis.

Results: Preliminary findings from this study have revealed that contracting a STI had an immense impact on the women’s psychological and sexual wellbeing. The women suffered from significant disturbances in their sexuality and self-concept. The women feared revealing their infections to potential partners, which caused the women to refrain from relationships. They felt that they lacked sexual spontaneity resultant of their infections and perceived themselves as less than adequate sexual beings.

Conclusions: Contracting a STI caused these women significant emotional distress through disrupting their intimate lives. The women felt that they were inadequate and feared engaging in romantic and intimate relationships with men. From this research greater insight and understanding into the experiential aspects of women with STIs is provided. Through this knowledge healthcare professionals working with women that have experienced a STI can be equipped with better understanding of the psychological and sexual health needs of these women.
PARTNER NOTIFICATION OF CHLAMYDIA IN GENERAL PRACTICE: EXAMINING CURRENT PRACTICES AND POSSIBLE SUPPORTS TO ASSIST GPS IN PARTNER NOTIFICATION

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Objective: To examine GPs current partner notification practices and identify what supports GPs would find most useful to assist them with partner notification. There are limited data on how Australian general practitioners (GP) undertake partner notification for chlamydia, their views on it, and what supports GPs would find most useful to assist them with it.

Method: A cross sectional survey was conducted between July and December 2007 with GPs from Victoria, the ACT and Queensland. Self administered questionnaires were mailed to a random sample of 550 GPs.

Results: Of the 550 GPs, 234 (43%) returned a completed questionnaire. Considerable variation was evident in GPs advice to patients on how far back they should trace partners. Overwhelmingly, 95% (223/234) of GPs considered it their role to discuss partner notification with their patients and 97% (226/234) felt comfortable doing so. However, only 51% (120/234) reported being sure of how to best assist patients with this process. Of the GPs, 84% (196/234) agreed that they would find information and resources useful in assisting with partner notification. Possible supports and resources rated most highly were a website GPs could refer patients to which would assist people in telling their sexual partners, 90% (210/234), and patient information sheets built into practice software, 90% (210/234). A considerable number of GPs, 43% (100/234), sometimes prescribed an additional dose of antibiotics for patients to give to their sexual partner and 46% (107/234) reported that they would support changes to laws and regulations to allow them to provide patient delivered chlamydia therapy for their patients.

Conclusions: While partner notification for chlamydia is being undertaken by Australian GPs to some degree, there is considerable room for improvement. GPs see it as their role to discuss partner notification with their patients but want and need greater information, guidance and resources in order to do it more effectively.
CHLAMYDIA TESTING RATES IN GENERAL PRACTICES ACROSS AUSTRALIA: THE AUSTRALIAN COLLABORATION FOR CHLAMYDIA ENHANCED SENTINEL SURVEILLANCE (ACCESS)


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Chlamydia is the most common bacterial sexually transmitted infection (STI) in Australia. Notifications have more than doubled between 2002 and 2007, with the majority being among 15 to 24 year olds, but there is so far limited information on the time trends and predictors of chlamydia prevalence in the Australian population. In 2007, the Australian Government funded the ‘Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance’ (ACCESS) to provide better national information on chlamydia testing and outcomes in a range of clinical contexts. One key setting is general practices (GPs).

ACCESS is making use of three data sources related to testing at GPs: (i) Health Insurance Commission (HIC), which provides data from GPs making Medicare-rebatable claims for chlamydia testing in Australia, (ii) a national sentinel network of GPs, which provides chlamydia testing data electronically through clinical data management systems and (iii) the Bettering the Evaluation and Care of Health (BEACH); which provides chlamydia testing and diagnosis data from a continuous national study of general practice activity. For the purpose of this paper, we analysed Medicare data for the period October 2007 to March 2008. We used population denominators to calculate age and sex specific rates of chlamydia testing in general practice.

During the study period, 6.3% of 15-24 year old females and 1.6% of 15-24 year old males were recorded by HIC as having been tested for chlamydia. In this age group, chlamydia testing rates varied by jurisdiction; the highest observed in Northern Territory (21.9% females, 6.8% males), Western Australia (8.7% females, 2.4% males) and Queensland (7.9% females, 2.1% males) and lowest in Tasmania (1.7% females, 0.4% males). Rates in other jurisdictions were in the range 5.0-5.8% for females and 1.2-1.5% for males.

Despite chlamydia testing being recommended for sexually active youth, Medicare data highlights that GP testing rates in this group are low; the highest observed in jurisdictions with the greatest numbers of Aboriginal people, suggesting that community screening programs in these jurisdictions are playing an important role in the uptake of testing. These findings will support the evaluation of testing initiatives designed to control chlamydia infection in Australia.
CHLAMYDIA TESTING IN GENERAL PRACTICE IN AUSTRALIA

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Objectives: To ascertain how frequently Australian general practitioners (GPs) test patients for chlamydia and to determine the GP and patient characteristics of those who were tested.

Methods: A secondary analysis of data from the BEACH programme. BEACH is a cross sectional national survey of GP activity: approximately 1000 GPs per year, each records details of 100 consecutive patient encounters. We identified all GPs who ordered at least one chlamydia test from April 2000 to March 2007 and compared their characteristics with other GPs in the BEACH database. We also looked at characteristics of the patients who had a chlamydia test. Multiple regression was used to measure the independent effect of each patient and GP characteristic on testing for chlamydia.

Results: Data were available for 689,000 encounters from 6,890 GPs, of which 2,236 were chlamydia test encounters. Seventy-five percent of the encounters were from females and 25% from males. Over 50% of tests were taken from individuals aged 25-44 and 38% in those aged 15-24. Testing rates increased from 2000-2007 in males and females in all age groups. On regression analysis, GP characteristics independently associated with chlamydia testing were female sex, younger age, and practice in a metropolitan area. Patient characteristics associated with more testing included male sex, being new to a practice, younger age and selected morbidities. To test the effect of “opportunity to test”, we removed the selected morbidity variable from the model and this showed that females received more chlamydia tests than males.

Conclusion: Chlamydia testing rates have increased in general practice in Australia, but initiatives to overcome GP and patient barriers will need to be established and evaluated.

CONFIDENTIALITY AND ACCESS TO SEXUAL HEALTH SERVICES

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Confidentiality is often described as a barrier to sexual health clinic attendance, particularly for members of some higher risk groups. There has been little research describing the relative importance of confidentiality and other factors to clients of sexual health clinics, and whether members of high-risk groups have greater concerns. The aim of this study was to assess the importance of confidentiality and anonymity to clients accessing care at a sexual health clinic, and to describe associations with gender and sexuality. A self-administered questionnaire was offered to 350 consecutive new English speaking clients in October and November 2007. Participants were asked to describe the reasons for presenting, likelihood of disclosing specific identifying information and concern about specific people and bodies becoming aware of their attendance. Of 350 eligible clients, 270 (77%) participated in the survey. Expert care was included in the top 3 reasons for choosing a sexual health clinic rather than a GP by over half of participants, confidentiality and cost were included by one third each. Given a list of personal identifiers, over 90% of clients stated they were likely to give accurate information to the clinic. Participants were comfortable with disclosure of information to other health care workers but became increasingly unwilling for information to be shared with services not directly involved in their care. Overall there were few associations with gender or sexuality. Clients chose to attend our clinic for a variety of reasons, with confidentiality and anonymity being of lesser importance than competence and cost. Confidentiality is important to the majority of clients whereas few desire anonymity. Most clients would accept information being shared with other health services, suggesting confidentiality may not be a barrier to the use of electronic health records in sexual health clinics. Clients of sexual health clinic are willing to provide identifying information in the expectation that this information will be treated in a confidential manner.

ORAL POSTER: Wilson D -see page 147
ORAL POSTER: Hellard M -see page 139
ORAL POSTER: Lim M -see page 140
THE SEX INDUSTRY IN PERTH BEFORE DECRIMINALISATION

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Objective: As part of the Law and Sex Worker Health (LASH) Study, we investigated the brothel-based sex industry in Perth in 2007, just prior to law reform.

Methods: With the assistance of key informants in the community and health sectors, plus sex industry advertisements, we mapped the brothel-based industry in Perth. We then approached all brothels in central Perth to questionnaire female sex workers on the premises at that time. Participants were also invited to provide a self-collected tampon for screening for chlamydia, gonorrhoea, Mycoplasma genitalium, and trichomoniasis.

Results: Despite their criminal status around 35 brothels were openly tolerated in central Perth. We surveyed 175 women, with an overall participation rate of 87%. Only 31% were aware that sex work was illegal in WA, and a further 32% were unsure of the legal status. While the women reported regular visits from the police they generally described them as friendly, though 50% reported that they would feel uncomfortable about going to the police with a complaint about a sexual assault or another offence. Threats against the women (15% of respondents), assaults (10%), and sexual pressure (29%) were commonly perpetrated by clients. Among the women surveyed, 68% used tobacco and 14% reported having injected a drug (mostly amphetamines) in the previous 12 months. Drug use at worksites was observed more frequently in Perth than in the other cities. While 89% of the women reported regular sexual health checks, only 22% used public sexual health services. There was an absence of health promotion resources in brothels, and health promotion programs provided limited outreach. Only 12% of sex workers reported that condoms were provided free at their workplace. Nevertheless, STI prevalences were low: chlamydia 2.7%, gonorrhoea 0%, M genitalium 3.6%, trichomoniasis 0.9%, and HIV 0% (by self-report).

Conclusion: It will be interesting to see what effect law reform has on the sex industry in Perth.

STI AWARENESS – ONLINE EDUCATION MODULES FOR GENERAL PRACTITIONERS FOCUSED ON CHLAMYDIA TESTING

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As part of the national chlamydia strategy, a grant was obtained from the Department of Health and Ageing to develop an online education program for general practitioners (GPs) that would increase awareness of the importance of testing sexually active young adults for Chlamydia trachomatis and enhance skills in sexual history taking, appropriate testing for sexually transmissible infections (STIs) and contact tracing in the context of a primary care setting.

Use of an online format was seen as a way of increasing access for GPs to the educational intervention as it could be undertaken in their own time and worked on in a sequential fashion without the need to attend a formal meeting. The online format allows a large amount of support information to be embedded in the module so that each doctor could access as much or as little additional information as their personal learning needs demands.

Genesis Ed was chosen to produce the program as the principals are all general practitioners with extensive experience in registrar teaching and RACGP continuing professional development (CPD) policies. The website ThinkGP has over 8000 registered GPs who access the site for online CPD thus providing wide access to the target group for the intervention.

Three online modules were developed using a mix of video clips, voiceover segments, PowerPoint presentations and self-directed Q&A tasks.

To date 370 GPs have attended the site and 156 have claimed CPD points for completing active learning modules (ALMs). An evaluation of the GP responses to the learning format will be presented. The pitfalls encountered in producing a program with a short timeline and a fixed budget will also be discussed.
HOW THEY DID IT AND HOW THEY WANTED IT – YOUNG PEOPLE’S PERSPECTIVES ON THEIR EXPERIENCES OF SEXUAL HEALTH EDUCATION

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In order to inform the continued development of sexual health promotion programs, a statewide consultation about where and how young people currently receive their sexual health education and from where and how they would like to receive it was conducted.

Assembling genuine and honest voices of young people, and gaining insight into their experiences and perspectives, requires very interactive and engaging methodology. This study used a participatory research methodology which consisted of a series of workshops with young people using arts based enquiry, psychodynamic techniques and photovoice approaches. This consisted of 88 young people aged between 15 and 20 engaging in highly interactive workshops. Participants used photography, drama, role-play and discussion to express their experiences and ideas about developing sexual health knowledge and skills. Data from the workshops were collected using digital recording devices, cameras and transcriptions. This information was analysed identifying recurring themes, images, statements and suggestions.

The experiences, perceptions and opinions of the young people who participated in this research demonstrated again that sexuality and relationships do not occur in isolation to the rest of young people’s lives.

There were five key themes that were derived from the workshops about how young people reported they had received, and how they wanted to receive, their sexual health education. These could be summarised as follows: peer networks, friends and locations; youth friendly and relevant sexual health education with credible educators family learning and influence; media and the Internet; and rites of passage events, parties, and alcohol.

Educators are continually challenged to create learning environments where young people can safely and openly learn about the complexity of sexual health in relation to their physical bodies and the social reality they live in. This paper provides some insight, from the perspective of young people, about solutions to these challenges.

SELF-ASSESSMENT OF COMPETENCIES IN SEXUAL HEALTH AND HIV BY GRADUATING MEDICAL STUDENTS

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Aims
To assess the efficacy of teaching in sexual health and HIV medicine at a newly established medical school by determining graduating medical student views on their competencies in sexual health and HIV medicine.

Methods
All graduating Australian National University Medical School (ANUMS) students in 2008 were invited to participate in an online anonymous survey to self-assess their skills and competencies in sexual health and HIV medicine and evaluate a range of teaching methods. The survey was adapted from a questionnaire developed by the British Association of Sexual Health and HIV to survey junior doctors in the UK.

Results
75% (53/71) of graduating students completed the survey. Students identified strengths in epidemiology and sexual health promotion and rated themselves as generally comfortable taking a sexual history in a range of circumstances. Students identified weaknesses in skills in male genital examinations and HIV medicine. Clinical experience in a sexual health centre was rated highly.

Conclusions
Self-assessment via online instrument is an efficient and effective way of contributing to the evaluation of undergraduate medical education. Information may be used to refine both teaching content and methodology.
PROVIDING ON-LINE SUPPORT FOR
TEACHERS IN DELIVERING SEXUALITY
EDUCATION IN WESTERN AUSTRALIA

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Sexual health education is a subject that teachers are frequently required to teach without any prior training. Some teachers view the subject as a priority while others may feel uncomfortable or insufficiently prepared to teach it.

A priority of the Department of Health’s (DOH) policy and programming in public health is to work with the school education sector to promote and support the conduct of quality sexual health education. In addition to parents, the DOH regards teachers and schools to be a fundamental partner in providing sexual health education to student.

Since 2002, The DOH has funded the development and implementation of set of resources for teachers called the “Growing and Developing Healthy Relationships” (GDHR) Curriculum Support Materials, and corresponding in-person professional development courses for teachers.

In 2005, an audit of the uptake of the GDHR materials found that the materials are having a positive impact on school sexual health education.

An impact evaluation is currently underway to examine the influence on teacher and school nurse practise from participation in the professional development and training. The results will be available by mid-2008.

The DOH, in partnership with the Department of Education and Training are moving towards providing on-line support for teachers in order to increase their access to up-to-date curriculum resources, training and support.

The Project involves two components:
Development of an interactive website based on updated GDHR content. This will incorporate a range of age-appropriate learning activities, links to resources, statistics, background information, and an on-line question box for teachers.

Development of a corresponding on-line training course. This course is designed to increase teachers’ confidence, comfort, knowledge and skills using on-line learning techniques such as asynchronous learning, podcasts, video clips, discussion forums, interactive games, and professional facilitation.

HEALTH PROMOTION FOR FEMALE SEX
WORKERS UNDER THREE DIFFERENT LEGAL REGIMES

Harcourt C1,2, O’Connor J1, Egger S3, Chen M4, Fairley C4,5, Kaldor JM2, Donovan B1,2
1Sydney Sexual Health Centre, Sydney Hospital, Sydney, NSW, Australia; 2National Centre in HIV Epidemiology and Clinical Research, University of New South Wales, Sydney, NSW, Australia; 3Faculty of Law, University of New South Wales, Sydney, NSW, Australia; 4Melbourne Sexual Health Centre, Melbourne, VIC, Australia; 5Department of Public Health, The University of Melbourne, Melbourne, VIC, Australia.

As part of a study to determine the health and welfare of sex workers in three Australian capital cities with different prostitution laws, we compared the operation of health promotion programs (HPPs) targeting sex workers.

The three cities were: (1) Melbourne, with a brothel licensing system; (2) Sydney, with decriminalisation; and (3) Perth, with the criminalisation of all forms of sex work. We questioned key informants (including HPP employees, health service providers, police, planning officers, sex workers, and owners of brothels). We also examined sex worker HPP websites.

In spite of the different laws, each city had a thriving and diverse sex industry, including some street-based sex workers. We identified 85 licensed brothels plus 76 advertisements for suspected unlicensed brothels in Melbourne, though we could not access most of the unlicensed brothels. There were nearly 400 advertised brothels in Sydney and about 40 in Perth. Each city had a government-funded sex worker HPP with shopfront, phone, online and outreach facilities; and each city had at least one free sexual health clinic targeting sex workers.

There were differences in the administration of funding for the HPPs and, although each offered outreach and drop-in services to street- and brothel-based sex workers, there were qualitative differences between the programs. Sydney had the best-resourced HPP and it was the only community-based agency, employing multi-lingual staff with rotational day and evening peer-conducted outreach. The Melbourne HPP was not resourced to provide education to the unregulated sector, while the Perth HPP was only able to provide outreach education services to brothels by invitation.

The legal context appeared to affect the conduct of HPPs targeting the sex industry.
ORAL PRESENTATION ABSTRACTS TUESDAY 16 SEPTEMBER 2008
Trainee Update Breakfast Session
7.30am – 9.00am

The trainee update breakfast session is a 1.5 hour session exclusively for Chapter Trainees to present cases about interesting or unusual conditions. At the conclusion of each presentation, the panel of expert Chapter Fellows will discuss the trainees’ presentations and offer advice.
THE NATURAL HISTORY OF HPV INFECTION IN WOMEN

Jorma Paavonen, MD
Department of Obstetrics and Gynecology
Helsinki University Central Hospital, Helsinki, Finland

Anogenital HPV infections are transmitted mainly by skin-to-skin or mucosa-to-mucosa contact. Although the probability of HPV infection per exposure is not known, these infections are extremely prevalent. High risk HPV types have been linked to cervical and other anogenital cancers. Low risk HPV types have been linked to genital warts. Infections caused by multiple HPV types are common. Persistent infection by high risk HPV type or types is a necessary cause of cervical cancer. Cervical cancer is the second most common cancer in women worldwide. Other anogenital cancers caused by HPV are much more rare. Most HPV infections are transient and approximately 90% are cleared within 1 to 2 years. High risk HPV types tend to persist longer, and longer HPV persistence increases the risk for cellular transformation and neoplasia. The lag time between infection and appearance of high grade precancer can be surprisingly short. The risk factors for persistent infection are not well known. However, infectious co-factors, host cell-mediated immune response, HPV type, infection by multiple HPV types, and viral load play a role. Although the molecular virology underlying HPV persistence, progression, and invasion is not well understood, cervical cancer arises through a series of steps including HPV transmission, HPV persistence, progression of persistently infected cells to high grade precancer, and finally invasion. With longer HPV persistent the probability of the development of precancer increases. Of multiple high risk HPV types, types 16/18 are more carcinogenic than other high risk HPV types. These 2 types cause approximately 70% of cervical squamous cell carcinomas and adenocarcinomas. The attributable proportion for other high risk HPV types is low. In longitudinal studies of cytologically normal adult women who are HPV DNA positive at enrolment, the cumulative risk of incident cytological abnormalities rises to 25-50% 1-2 years after enrolment. The cumulative risk of precancer and cancer continues to rise for as long as 10 years, suggesting that many women remain persistently infected. The average age of diagnosis of precancer varies from 25 to 35 years and depends both on the average age at first intercourse, which is a proxy for first exposure to HPV, and on the intensity of screening. Screening by HPV testing can promptly detect precancers that would otherwise grow slowly detected by less sensitive methods like cytology and colposcopy. However, more sensitive screening will also detect more lesions and infections that would clear without treatment. The development of HPV16/18 VLP vaccines has been a major breakthrough in cancer prevention. Primary prevention by vaccines will decrease the global disease burden caused by HPVs. Cervical cancer prevention including cytologic screening, colposcopy biopsy and deciding whether to treat or not, surgical treatment by loop conisation, and finally post treatment follow-up is extremely problematic and costly. Furthermore, screening programs vary widely by country. Also, cervical cancer incidence has been increasing among young women in many countries. Therefore, new technologies such as HPV vaccination and primary screening by HPV DNA testing will be the future. There is a pressing need to educate health professionals and the public regarding the natural history of HPV as we move towards HPV-based prevention strategies. Many important research topics need to be addressed; the average clearance versus persistence of each type of HPV; the risk of precancer given persistence of each of the types; the effect of age on the rates of clearance, persistence, and progression; the risk of re-appearance of an HPV type via reinfection or latency following initial clearance; the significance of differences by region; and the unique carcinogenicity of HPV16, including molecular mechanism and natural history.
The incidence of anal cancer while low may be increasing, particularly in men with HIV infection. The detection of the precursors of anal cancer and early treatment could lead to reduced incidence of anal cancer, morbidity and mortality. However it is not proven that anal cancer is a direct consequence of these precursors, and the safety and efficacy of treatment for precancerous anal lesions are not yet well established. Will the advent of anal cancer screening programs be harmful and cause undue patient anxiety, adverse outcomes of unnecessary treatment or be beneficial and reduce the frequency of anal cancer and save lives? Is anal screening cost effective or would the health dollars be better spent on other means of disease prevention?
The rates of Cervical adenocarcinoma are increasing in Australia. If the sensitivity of PAP smears falls as a consequence of HPV immunisation will cervical adenocarcinoma be missed? How will the HPV vaccine affect cervical screening programs in Australia? Will we have to shift to HPV screening and reflex cytological testing? Given the recent scare to women about hormone replacement therapy, many women are avoiding treatment even though there is still a role for...
HRT. When should it be provided?
The Sticky Moments session has been a session at the recent Sexual Health conferences, and the idea behind the session and the title, reflects those moments when you are running a sexual health clinic and a patient comes in with dilemmas that cause you to stop and think as you try and recall (often from the back of your mind) what to do.

Over the years we have requested topics for this session from our advanced trainees of the Chapter of Sexual Health Medicine - particularly those questions which are “jaw dropping” or fill them with dread.

This year the topics chosen for the session are:
- Ureaplasma urealyticum and its role in clinical disease,
- Prostatitis,
- Non-infectious genital ulceration,
- Reactive arthritis, and
- Ocular manifestations of syphilis.

At this year’s conference, we have a group of clinical experts from a number of medical fields, many from Western Australia, who have agreed to present during the Sticky Moments session to share with us their expertise with the aim of minimising the angst when a patient presents with one of these less frequently seen conditions.

Each speaker will present for 15 minutes allowing 5 minutes for questions and discussion, please join us at this session and have your questions ready!

**Symposium: Sticky Moments**

1.30pm – 3.00pm

**UREAPLASMA AND ITS ROLE IN CLINICAL DISEASE**

Couldwell DL

1Parramatta Sexual Health Clinic, 162 Marsden St, Parramatta, NSW 2150, Australia;

Ureaplasmas have been thought to play a role in non-gonococcal ur ethritis (NGU) for over 30 years but research has yielded conflicting results. One of the most compelling experiments to implicate ureaplasmas in NGU was reported in 1977 by Bowie et al, and involved the intra-urethral inoculation of two investigators with a pure culture of Ureaplasma urealyticum obtained from patients with NGU. However, the association was not consistently found in larger studies of men with and without NGU, and interest in ureaplasmas waned.

In 2002, two species of ureaplasma, Ureaplasma parvum and Ureaplasma urealyticum, were distinguished using phylogenetic analysis. The naming of these two species is potentially confusing, as previously all organisms in the genus were referred to as Ureaplasma urealyticum. This discovery enables the role of each species in human disease to be separately examined using PCRBased assays. It has now been demonstrated that U. parvum is a commensal organism in the male urethra. At least two recent studies have found an association between U. urealyticum and NGU, whereas another did not. It may be that only certain subtypes of U. urealyticum are involved in NGU, or that other risk factors are important.

The role of ureaplasmas in other genitourinary syndromes is unclear. Although ureaplasmas have been implicated in preterm birth and chronic lung disease among premature neonates, most studies have not separately reported the role of the two ureaplasma species. Further study of the role of ureaplasmas in human disease is needed.

Meanwhile, an understanding of the history of research to date will assist sexual health clinicians in interpreting results and managing men with NGU.
Proffered Papers – Social Research: Champagne Diamonds
1.30pm – 3.00pm

PREVALENCE, INDICENCE AND PERSISTENCE OF A COMMON SEXUAL DIFFICULTY: INSIGHTS FROM THE AUSTRALIAN LONGITUDINAL STUDY OF HEALTH AND RELATIONSHIPS

Smith AMA1, Richters J2, Ferris J1, Pitts M1, Shelley J3, Simpson J4
1ARCSHS, La Trobe University, Melbourne, VIC, Australia; 2School of Public Health and Community Medicine, University of New South Wales, Sydney, NSW, Australia; 3School of Health and Social Development, Deakin University, Burwood, VIC, Australia; 4School of Public Health, The University of Sydney, Sydney, NSW, Australia.

Objective: To document the prevalence, incidence and resolution of the most common sexual difficulties: lacking interest in having sex.

Methods: A representative household sample of 8,656 Australians aged 16-64 years completed a computer assisted telephone interview. Data relate to those who answered questions about sexual difficulties at annual interview in Waves 1 and 2 of the study.

Main Outcome Measure(s): Reporting having lacked interest in sex for one month or more in the previous year.

Results: At Wave 1, 496 of 2654 (18.7%) of men and 1359 of 2680 (50.7%) of women reported lacking interest in sex for one month or more in the previous 12 months. Of the men who did not report a lack of interest in sex at Wave 1, 13.0% did so at Wave 2 as did 28.5% of women. Of those reporting a lack of interest in sex at Wave 1, 50.8% of men again reported a lack of interest in sex at Wave 2; of the women reporting a lack of interest in sex at Wave 1 65.6% also did so at Wave 2.

Being unemployed was associated with a higher likelihood of reporting a lack of interest at either Wave 1, Wave 2 or both Waves. And there was similar variation with respect of education and reporting a lack of interest in sex. While there was no apparent association smoking and reporting a lack of interest in sex, there appeared to be a relationship being a current drinker and reporting a lack on interest in sex.

Conclusions: Reporting a lack of interest in sex is the most common sexual difficulty and demonstrates substantial temporal variation and some complex associations with demographic and behavioural variables.

UNDERSTANDING AND INFLUENCING SEXUAL RISK BEHAVIOUR: THE CURRENT STATUS OF EVIDENCE BASED MODELS OF SEXUAL RISK BEHAVIOUR

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We are all familiar with the impressive data summarising changes in sexual risk taking and associated rises in STI and unwanted pregnancy rates across many contexts, within both resource rich and resource poor settings. However, robust epidemiological data alone is limited in its ability to further our understanding of the complex determinants of sexual behaviour underlying these changes and the implications of these determinants for effective interventions.

This paper reviews the empirically based health behaviour models developed over the past 20 years which have aimed to model and predict the interactions between sexual behaviour and sexual health outcomes. It explores the question as to why they have been so essential in our attempts to better understand individual level and group level changes in sexual behaviour, but also as to why they have historically been limited in their ability to do so.

This paper argues for the necessity to include individual level and group level attitudinal, motivational and systemic data, in addition to the behavioural and biomedical outcome data already collected within on-going key epidemiological surveillance of sexual health. Only then can we better understand the patterns of change in sexual risk taking, and only then can we better develop effective evidence-based primary and secondary sexual health interventions.
Young adults, sexual behaviour and multiple relationship partners: data from the Australian longitudinal study of health and relationships

Ferris J1, Smith AMA1, Pitts MK1, Shelley J2, Richters J1, Simpson J1
1Australia Research Centre Sex Health and Society, La Trobe University, Melbourne, VIC, Australia; 2School of Health and Social Development, Deakin University, Burwood, VIC, Australia; 1School of Public Health and Community Medicine, University of New South Wales, Sydney, NSW, Australia; 2School of Public Health, The University of Sydney, Sydney, NSW, Australia.

Objective: To highlight the formation of relationships among young Australian adults and identify sexual behaviours and contraceptive use that may place them at risk of sexually transmitted infections (STIs) or unwanted pregnancies.

Methods: Analysis of data from a representative household sample of Australian men and women 16-64 years who completed a computer-assisted telephone interview.

Main outcome measure(s): Relationship status (i.e. types of relationships) and sexual history, last sexual practice, contraceptive practices and STI history.

Results: Among 1565 young adults (aged 16-25) 21% had never had sexual contact; 5% had not had sex in the last 12 months; 25% were not currently in a relationship but had recently had casual sex and the remaining 48% were in a regular relationship. Of those currently in a regular relationship (n=757), 7% had had sex a person outside the relationship in the past year. Much of this sexual activity was protected, but 11% did not use a condom at most recent sex with either the regular or the outside partner.

Of those who had multiple partners (i.e. more than one regular partner or regular + casual partners) 70% were men; 79% identified as heterosexual; 12% lived with one of their partners; and 13% reported having had an STI in the last 12 months. Age at first sex for young adults reporting multiple partners was typically younger (15.3 years; 95%CI 14.5-16.1) compared to those currently in a single regular relationship (16.8 years; 95%CI 16.7 to 17.0).

Conclusions: Rich and informative data identifying multiple-relationships in Australia are rare. This national representative study effectively illustrates the complexities of personal histories and risk for people in multiple relationships. The implications of these findings highlight the need for health professionals to promote condom use among young adults unless they are in guaranteed sexually exclusive relationships.

Avenues of support: perceptions and experiences of female adolescents with different pregnancy outcomes

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Objective: To explore if adolescent females with a history of pregnancy have differing experiences with support systems: parents, schools and health services; than their sexually active peers who have never been pregnant.

Methods: As part of a broader study exploring factors associated with unplanned adolescent pregnancy, 69 sexually active females (aged 14-20 years) living in Perth, Western Australia each participated in a semi-structured in-depth interview. Participants were recruited from antenatal clinics, termination clinics, sexual health clinics, postnatal groups and secondary schools to contrast various pregnancy experiences. Through thematic analysis, common experiences emerged and were compared across groups to elucidate differences. Themes were constantly verified through subsequent inquiry.

Results: In general, participants with no history of pregnancy shared positive experiences of youth-oriented health services and considered them ‘effective’ and ‘supportive’. In contrast, many participants with a history of pregnancy labelled their experience with health services ‘judgemental’ and ‘ineffective’. Both groups expressed difficulty discussing sensitive issues with primary caregivers, commonly stating ‘I can’t go there with them’ or ‘they won’t go there with me’. Universally, there was a tendency for adolescents to be negative towards school-based sexual health education, expressing ‘schools don’t go there’ and when they did ‘it meant nothing’. Recommendations were similar across groups, with adolescents commonly suggesting ‘a graduated and ongoing approach’ provided by ‘youth-friendly and credible educators’.

Conclusions: These findings suggest the needs of sexually active adolescents with and without an experience of pregnancy are not being addressed by home and/or school-based systems. In many instances, health services also failed to provide the support required. Safe sexual practices were more apparent in young females who accessed youth-oriented health services. Further development of the capabilities of all sectors to support sexually active minors is called for.
EVALUATION OF THE VICTORIAN ‘YOU’LL NEVER KNOW WHO YOU’LL MEET’ YOUTH STI AWARENESS CAMPAIGN

Gold J1,2, Goller J1, Hellard ME1,2, Lim MSC1,2, Clift P3, Fairley C4, Hocking JS1,5, McNamee K6, Guy R1
1Centre for Epidemiology and Population Health Research, Burnet Institute, Melbourne, VIC, Australia; 2Department for Epidemiology and Preventive Medicine, Monash University, Melbourne, VIC, Australia; 3Department of Human Services, Melbourne, VIC, Australia; 4Melbourne Sexual Health Centre, Melbourne, VIC, Australia; 5Key Centre for Women’s Health, University of Melbourne, Melbourne, VIC, Australia; 6Family Planning Victoria, Melbourne, VIC, Australia

Notifications of chlamydia, the most commonly notified sexually transmitted infection (STI) in Victoria, more than doubled between 2002 and 2007 with the majority among young men and women aged below 25 years. A youth STI awareness media campaign was conducted in mid 2007 to increase condom use and STI testing among 18 to 25 year olds with a total cost of $517,798.

To evaluate the initiative we assessed whether chlamydia testing increased through analysis of available data from (i) chlamydia sentinel surveillance in Victoria before (Apr 2006-Jun 2007) and during (Jul-Sep 2007) the campaign and (ii) chlamydia testing claims through Medicare during (Jul-Sep 2007) and after (Oct-Dec 2007) the campaign. We also assessed campaign recognition and changes in sexual behaviour and STI testing through an on-line cross-sectional survey of 600 young people conducted before (June 2007, n=300) and during (September 2007, n=300) the campaign.

There was no significant increase in the median number of tests conducted per month among 18 to 25 year olds at sentinel sites from before the campaign compared to during the campaign (487 vs 437 tests, p=0.05). Medicare claims for chlamydia tests in Victoria for 15 to 24 year olds did not significantly change during the campaign compared to after the campaign (median of 4,097 vs 3,927 tests per month, p=0.8). The online survey found that 37% of participants recalled the campaign when shown campaign advertisements; however history of STI testing, STI knowledge and condom use did not differ between those who recalled the campaign and those that didn’t, or between those surveyed before and during the campaign. Further sentinel surveillance and behavioural survey data will be presented.

Based on available data, it appears the campaign did not result in an increase of condom use or STI testing among the target group.

ORAL POSTER: Ferris J - see page 134
ORAL POSTER: Lucke J - see page 141
THE JAN EDWARDS PRIZE, SPONSORED BY NOVARTIS

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

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

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

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

PREVALENCE AND INCIDENCE OF HSV-1 AND HSV-2 IN AN HIV SEROPOSITIVE COHORT IN THE GOLD COAST

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Background: Genital herpes is associated with increased rates of acquisition and transmission of Human Immunodeficiency virus (HIV).

Objective: Determine the prevalence and incidence of Herpes Simplex virus type 1 and 2 (HSV-1,-2) infections in an HIV positive cohort.

Methods: Baseline HSV type-specific IgG serology was carried out on 256 HIV positive patients attending a Sexual Health Clinic. Follow-up testing was available for 106 subjects between 1997-2003.

Results: Prevalence study: Of the 256 subjects (232 males, mean age 39 y, range 19-71y and 24 females, mean age 32 y, range 18-47 y) 56% (56% of men and 58% of females) were HSV-2 seropositive and 83% (84% of men and 71% of females) were HSV-1 seropositive.

Longitudinal study: 106 subjects (96 males, 10 females) had testing performed on more than one occasion. Seven (70%) females were HSV-1 seropositive and 3 (30%) were HSV-2 seropositive. There were no seroconversions in this group. Among the males baseline seropositivity for HSV-2 and HSV-1 were 20.8% (n=20) and 67.8% (n=65) respectively. Among the 76 HSV-2-Neg males at baseline there were 11 HSV-2 seroconversions (52.71/103 P-Y). Among the 31 HSV-1-Neg males there were 3 HSV-1 seroconversions (30.9/103 P-Y).

Among the 65 HSV-2-Neg/HSV-1-Pos males there were 9 HSV-2 seroconversions (52.79/103 P-Y). Among the 11 HSV-2-Neg/HSV-1-Neg males, there were 2 HSV-2 seroconversions (52.38/103 P-Y). There were 3 seroconversions among the 31 HSV-1-Neg subjects (30.9/103 P-Y).

The Relative Risk of seroconversion to HSV-2-Pos status in HSV-1-Pos vs. HSV-1-Neg subjects was 0.76 (95% CI 0.19-3.07); the Risk Ratio based on incidence rates with person-years of follow-up was 1.01 (95% CI 0.97-1.03).

Conclusions: There was a high prevalence of HSV infection and evidence of ongoing HSV-2 acquisition in this group of HIV seropositive subjects. As genital herpes increases HIV transmission, and HIV infection is associated with increased risk of genital herpes acquisition, measures to control both infections are important.
PREVALENCE OF MYCOPLASMA GENITALIUM (M GENITALIUM) IN MEN WITH NON-GONOCOCCAL URETHRITIS (NGU) AT AUCKLAND SEXUAL HEALTH SERVICE (ASHS)

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Objective: Previous studies have identified M genitalium as a cause of urethritis in men. As there is no New Zealand data regarding male prevalence of M genitalium, a case-control study was conducted to determine whether this organism is a significant cause of urethritis in men presenting to ASHS.

Method: Enrolment occurred between March 2006 and February 2008. Inclusion criteria for cases included recent onset of symptoms of urethritis, confirmed by gram stain ≥ 10 PMNLs per high powered field. Controls included men presenting during the same time period for asymptomatic sexual health screening. All participants provided a first void urine for testing for M genitalium and Chlamydia trachomatis (C trachomatis). The presence of gonococcal infection was excluded either by culture or strand displacement amplification (SDA). Information regarding symptoms and sexual practices was collected using a standard questionnaire.

Results: We recruited 210 cases and 199 controls. The participation rate was 96%. The prevalence of C trachomatis and M genitalium in the cases was 33.8% and 10% respectively. The presence of both of these infections in the cases was uncommon (1.9%). C trachomatis was diagnosed in 4% and M genitalium was diagnosed in 2% of controls. Other results are pending.

Conclusion: This is the first study to investigate the prevalence of M genitalium in New Zealand men. Compared with the findings of other studies conducted overseas the prevalence of this organism is relatively low in our population.

IMPORTANCE OF EARLY RECOGNITION AND TREATMENT OF SYMPTOMATIC SYPHILIS IN MEN WHO HAVE SEX WITH MEN (MSM)

Bissessor M¹, DeGuingand D¹, Fairley CK¹,², Chen MY¹
¹Melbourne Sexual Health Centre, The Alfred Hospital; ²School of Population Health, University of Melbourne

Objective: There is currently an epidemic of syphilis among MSM in Victoria. The early detection and treatment of syphilis would reduce the period of infectiousness and improve control. The objective of this study was to determine the duration between onset of symptoms of primary and secondary Syphilis and diagnosis and treatment.

Methods: A retrospective case record review was conducted of MSM diagnosed at the Melbourne Sexual Health Centre (MSHC) with primary and secondary syphilis between 1st January 2003 and August 2007. Diagnosis was confirmed by serology and/or polymerase chain reaction (PCR) and included referrals from General Practitioners (GPs).

Results: The mean age of the 123 MSM included in the study was 37.4 years. Fifty two percent (n=64) had primary syphilis and 48% (n=59) had secondary syphilis. Twenty five percent were HIV positive, with 29% having lesions that were PCR positive for Treponema pallidum. The median RPR titre among the 123 men was 1:32. Referring GPs did not consider the diagnosis of syphilis in 10 cases of primary syphilis and 20 cases of secondary syphilis. For primary and secondary cases combined, the median duration between onset of symptoms and diagnosis, and symptom onset and treatment, was 15 and 20 days respectively. The respective durations for secondary syphilis (17 and 23 days) was significantly longer than for primary syphilis (13 and 15 days) (p<0.05). The mean number of sexual contacts reported for the prior 3 months was 8.8 (range: 1-15).

Conclusions: There was a considerable delay between the onset of symptoms of early syphilis and its diagnosis, a period during which further transmission probably occurred. Greater awareness of the symptoms and signs of syphilis need to be promoted among both GPs as well as MSM together with the need for early testing and treatment.
SYPHILIS AT ROYAL PERTH HOSPITAL THE EYE OF THE WA STORM

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1Sexual Health Service (SHC), Royal Perth Hospital (RPH), Wellington Street, Perth WA, Australia

Objectives: To describe a series of patients diagnosed with infectious syphilis at the Sexual Health Clinic at RPH since the commencement of the syphilis epidemic in Perth

Methods: Cases were extracted using the SHIP database. The demographic characteristics of the patients presenting to the RPH SHC will be described.

Results: From 2000-2005 there were 14 cases of infectious syphilis. In late 2006 increased numbers of infectious syphilis cases started being seen in the clinic. Initially the epidemic appeared in a serosorting cohort of HIV positive MSM, with a second wave involving more HIV negative MSM in 2007. In 2008 a third wave is occurring with a significant number of new cases being seen in all risk groups of MSM, with more cases being seen in BSM.

From 2006 to present there have been 100 cases (94 males, 6 females). Of the males 96.8% were MSM, 50.0% were HIV positive. There have been 9 repeat infections. New HIV diagnoses were made in 6 patients at the time of their diagnosis of syphilis. Nine percent had their diagnosis made whilst a hospital in-patient. Further discussion of the epidemiology will be presented. Serious complications including eye involvement have occurred and these will be further described. A pictorial review of some of the cases will be given.

Conclusion: There is an ongoing syphilis epidemic in Perth that appears to be sustained. New ways of tackling the epidemic are required. Cross over into the heterosexual population may occur and antenatal screening for syphilis is imperative.

REASONS FOR TERMINATION OF PREGNANCY IN TWO AGE-GROUPS

Lee W1,2, Mazza D1
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Women over 35 represented almost 17% of termination of pregnancy (TOP) in 2005, in contrast to 28% in the highest risk-group of women aged 20-24. Why older women have unintended pregnancies and TOP is poorly understood, yet determining underlying factors is important to tailor appropriate and effective interventions. This audit compared contraceptive practices and reasons for TOP between women over 35 and those below 25. Medical records of fifty women above 35 and fifty women under 25 who underwent TOP at a private pregnancy termination service, Women's Clinic on Richmond Hill (WCRH), from the 1st of February 2007 were examined for contraceptive practices and reasons for TOP. Most women in both age-groups stated they had a regular partner. 44% of older women and 28% of younger women had had at least one previous TOP. Women relied on less effective contraceptive methods or did not use contraception pre-pregnancy. Those over 35 were mostly not using contraception or relied on condoms. Younger women mainly used condoms. Post-TOP contraceptive choices of both groups tended toward more effective methods. For most, reasons for TOP were consistent with their life plans. Younger women most frequently cited “emotional unreadiness for children” and “financial concerns”, while older women most frequently cited “already have dependent children” and “focus on career/studies”. Contraceptive methods and specific factors leading to TOP appeared to be age-related. However, highly effective long-term contraception was poorly used by women in both groups. Further research is required to determine the influencing factors of unintended pregnancies, TOP and contraceptive use, and to examine the effectiveness of current interventions for each age-group.
Oral Poster Session: Pearls of Wisdom
3.30pm – 4.30pm

Jin F – see page 138
Richters J – see page 143
Ferris J – see page 145
Dabbhadatta J – see page 133
Zablotska I – see page 148
Kingston M – see page 157
Michelson J – see page 157
Su J – see page 146
Brown A – see page 163
ORAL PRESENTATION
ABSTRACTS
WEDNESDAY 17 SEPTEMBER 2008
SHOULD WE BE VACCINATING BOYS AS WELL AS GIRLS WITH THE HPV VACCINE?

Regan DR, Law MG, Philp DJ, Hocking JS
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HPV vaccination has been shown to be effective in preventing cervical cancer in females. While immunogenicity has been shown in males, trials are underway to demonstrate HPV vaccination is clinically effective.

Mathematical modeling of HPV transmission in Australia suggested that for a vaccine with 100% effectiveness and conferring lifelong immunity, then with coverage over 80%, vaccinating 12-year old males in addition to 12-year old females had only a modest impact on HPV incidence among females. Vaccinating 12-year olds only was estimated to take long periods to take effect, with an estimated 7 years to achieving 50% of the effect on HPV incidence. A catch-up campaign, vaccinating 13-25 year old females, was estimated to decrease this time to under 2 years. The models suggested that vaccination of males and females would not eradicate HPV with realistic vaccine coverage rates.

These models suggest that for a HPV vaccine of 100% effectiveness and conferring lifelong immunity, there is at most modest effect on cervical cancer risk in vaccinating males in addition to females. Vaccinating 12-year old males with such a vaccine would only be cost-effective if this resulted in appreciable reductions in HPV-associated disease in men, such as anal or penile warts, and anal or head/neck cancer. Vaccinating 12-year old males may be cost-effective in preventing cervical cancer among females if herd-immunity effects become important in the case that vaccination coverage rates are low, or that the vaccines prove to be only partially effective or confer limited duration of immunity. To answer these questions, it is important that the current HPV vaccination schedule in Australia is monitored, both in terms of coverage rates and conferred immunity.

IS YOUR CLITORIS IN YOUR VAGINA OR THE VULVA! WHAT IS A VULVA!

A Woman’s Personal Perspective and Experience of what is missing in sexual health and society, The Vulva
Kath Mazzella

This presentation aims to bring life to the vulva, bringing it out from the unknown or un-mentionable and giving it the recognition and the status it deserves.

It will highlight the stigmas, misconceptions and taboos that surround the vulva and ask how women, educator’s, health professionals and society can break down these barriers and move to a healthy and accurate knowledge of this vital part of female genitalia. These questions will be posed and related to you through the perspective of one woman.

A woman who’s experience of gynaecological cancer has taken her on an inspiring journey. A woman who went from knowing nothing about down there, to one who is now an empowered, assertive, understanding individual.

The presenter will relate how her own experience altered her to how women in the community suffer in silence and of the need to give these women a voice.

She will take you through her quest to raise the profile of this issue within Australia,

Her successes – which include the establishment of the Gynaecological Awareness Information Network (GAIN), National Gynaecological Awareness Day – the lessons learned and the work that is yet to be done. She was also involved with the Australian Senate Gynaecological Cancer Enquiry. Key themes of the presentation include:

i. Giving women better knowledge of, and responsibility for their sexual health

ii. Educators seeing it from a health consumers point of view. Working together.

iii. Calling a spade a spade, a vagina a vagina, and a vulva a vulva. How by not speaking about or acknowledging this part of the body can suppress emotions, disempower women and cause significant psychological and physical health problems.

iv. Encouraging women to be proud of their vulva instead of calling it something it is not: a vagina. Come and get inVULed!
A high proportion of anal cancers are associated with human papillomavirus (HPV), most commonly HPV16. The incidence of anal cancer is increasing annually in the general population among both men and women but has increased most dramatically among HIV-positive men and women.

Among HIV-negative men who have sex with men (MSM), the epidemiology of anal HPV infection resembles that of penile infection more than that of cervical infection with approximately 60% having anal HPV infection throughout a wide age range. In contrast nearly all HIV-positive MSM have anal HPV infection. Other high-risk groups include HIV-positive women and high-risk HIV-negative women, in whom anal HPV infection is more common than cervical infection. Anal HPV infection may also be as common or more common than cervical HPV infection in sexually active but healthy, lower risk women. Finally, more than 20% of heterosexual men have anal HPV infection.

The key consequence of anal HPV infection is anal cancer—some but not all individuals with anal HPV infection will develop anal intraepithelial neoplasia (AIN) and fewer still will develop anal cancer. The main risk factors for progression to high-grade AIN (HGAIN) are HIV-positivity with lower CD4+ level and oncogenic anal infection but risk factors for progression from HGAIN to anal cancer are not understood. ART has not reduced the incidence of HGAIN nor of anal cancer implying that the immune response plays a less prominent role in progression to anal cancer than in development of HGAIN. The data suggest that the incidence of anal cancer will continue to grow in the future, raising questions about whether at-risk individuals should be screened for HGAIN and/or anal HPV infection. Additional questions relate to the effect of anal HPV in women on the biology and natural history of cervical cancer and its precursors.
ANAL DYSPLASIA AND CANCER. AN AUSTRALIAN EXPERIENCE

Richard Hillman

Australian rates of anal cancer are rising in both males and females, with approximately 260 new cases being reported annually. Precursor lesions are typically asymptomatic, leading to frequent late-stage presentation and poor five year survival rates (typically 60 -70%). Furthermore, symptoms of anal cancer & associated treatments are often extremely unpleasant.

Anal cancer occurs as a consequence of sexually transmitted infection and has an unusual epidemiology. Overall, rates in women are generally slightly higher than in men. However, within the two sexes, the distribution varies markedly. In women, anal cancer typically presents over the age of 60 years, in smokers, and in those with a history of cervical cancer & receptive anal intercourse. In men, it presents at a younger age, in men who have sex with men, and in the HIV-infected. Indeed, rates in the latter group are approximately 100 times higher than in the general population.

This presentation will review what we know of the epidemiology of anal cancer & precancerous lesions in Australia, the potential value of screening programs and the possible public health impacts of HPV prophylactic vaccination.
IT’S ONLY A COLD SORE, LOVE…

B Donovan.  
National Centre in HIV Epidemiology and Clinical Research,  
University of New South Wales, Level 2, 376 Victoria Street,  
Darlinghurst NSW 2010, Australia; and Sydney Sexual  
Health Centre, Sydney Hospital.

Over recent generations oral sexual practices have grown in incidence while re-positioning themselves in our society, with variations within different sub-populations. For many teenagers, oral sex is the new abstinence (in the Clintonesque sense), and its contraceptive effect is a bonus. For men who have sex with men (MSM), the near-universal practice of fellatio is a pretty effective HIV prevention strategy. Indeed, sexual safety codes within MSM relationships are often seen as being honoured if oral sex is the only sex that takes place with third parties. Oro-anal sex (‘rimming’) with casual partners has gone from being a minority practice among MSM in Australia in the 1980s to a majority practice by the 2000s.

Oral sex brings with it advantages and dangers. Certainly, among MSM only anal sex and oral sex rate as ‘highly valued’ as a source of pleasure, with the widespread use of oral sex probably reducing the individual- and population-level risk of HIV transmission. And oral sex is one of the most efficacious and use-effective contraceptives.

On the public health down-side, oral sex is logistically easier to organise than anal or vaginal sex so it enables rapid and furtive sexual encounters. Only in commercial contexts is oral sex protected with a condom. Promoted since the 1980s, everyone talks about dental dams for cunnilingus and rimming, but hardly anybody has ever used one. Some of the diseases that have been linked to oral sex include ano-genital HSV-1 infection, gonorrhoea, syphilis, hepatitis A, shigellosis, giardiasis, amoebiasis, and ocular and oro-pharyngeal cancers. While unusual, there are occasional traumatic consequences to oral sex, though these are rarely fatal.
**THE LAW AND SEXWORKER HEALTH (LASH) PROJECT**

**Objective:** Based on the hypothesis that restrictive or punitive laws could have adverse consequences, we explored the impact of various prostitution laws on the health and welfare of the sex workers working in three jurisdictions.

**Methods:** Key informants, searches of advertisements, agency lists, and site visits enabled us to map the female brothel-based sex industries in Perth (where all forms of sex work were criminalised), Melbourne (decriminalised, but regulated), and Sydney (decriminalised and deregulated). Representative samples of sex workers were invited to self-complete a questionnaire (available in 5 languages) and to provide a vaginal tampon for testing for chlamydia, gonorrhoea, Mycoplasma genitalium, and Trichomonas vaginalis by multiplex PCR.

**Results:** All 3 cities had thriving and diverse sex industries, though the unregistered premises in Melbourne proved to be the most difficult to access. Questionnaire participation rates were high (>80%) when access was gained: 175 women in Perth, 229 in Melbourne, and 201 in Sydney. The Melbourne women were a median of 4 years older and had been working 2-3 times longer. Only 27% of the Sydney women had been born in Australia (cf 51% in Perth and 67% in Melbourne, p<0.001), while more Perth women had injected drugs (14%) in the last 12m (cf 2% in Sydney and 10% in Melbourne, p<0.001). There was no significant difference in mental health scores (K10) between the women in the 3 cities. Despite vastly more frequent screening of the Melbourne women as required by the law (72% monthly cf 12% in Sydney and 15% in Perth, p<0.001) STI prevalences were similarly low in each city. However, the under-sampling of unregulated sex workers in Melbourne limited the interpretation of these findings.

**Conclusions:** The demographic differences between the sex industries in the 3 cities may be partially explained by their legal frameworks. The policy of compulsory monthly STI screening of sex workers in Victoria should be reviewed.
POSTER LISTING
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POSTER ABSTRACTS

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**P1 WHAT MEN WHO HAVE SEX WITH MEN (MSM) THINK ABOUT THE HUMAN PAPILLOMA VIRUS (HPV) VACCINE.**

Simatherai D, Bush MR, Bradshaw CS, Fairley CK, Healey S, Chen MY.
School of Population Health, University of Melbourne
Department of Epidemiology and Preventive Medicine, Monash University; Melbourne Sexual Health Centre, The Alfred Hospital School of Medicine, University of Melbourne

**Objective**
This study aimed to ascertain the knowledge and attitudes of MSM about the HPV vaccine and to determine at what age MSM would be willing to ask for the HPV vaccine in relation to the commencement of sexual activity.

**Methods**
Two hundred MSM visiting Melbourne Sexual Health Centre between December 2007 and January 2008 were asked to complete a questionnaire on their knowledge of HPV and the HPV vaccine, and their sexual history with respect to specific sexual activities engaged in and health seeking behaviours.

**Results**
The median age of participants was 27 years. 74% of MSM were aware of HPV infection but only 30% knew of the vaccination. 47% of MSM surveyed were willing to pay for the vaccine despite the cost of $450. Cost was cited as the main obstacle for those MSM not willing to pay for the vaccination.

The youngest median age at which they were prepared to disclose their sexual activity in order to obtain the vaccine from a health professional was 20 years of age and 93.5% were willing to do so. This was two years after the median age of sexual debut (18 years), and after a median of 15 sexual partners.

**Conclusions**
MSM in this study were strongly in favour of having the HPV vaccine when advised of the risk of HPV-related anal cancer. If the HPV vaccine is targeted to this group, the challenge will be for MSM to be vaccinated before they acquire HPV infection, given the time delay from sexual debut to disclosing sexual activity to a health professional.

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**P2 CONVENIENT, BUT ARE THEY EFFECTIVE? EVALUATION OF AN AFTER HOURS CLINIC FOR MEN WHO HAVE SEX WITH MEN (MSM).**

Bush MR1, Lee DM1.
1 Melbourne Sexual Health Centre, The Alfred Hospital

**Objective**
Since 2005, rates of HIV and other sexually transmitted infections (STIs) in Melbourne’s MSM community have increased. Poor access to sexual health services is one factor contributing to decreased screening rates in MSM. This study aimed to ascertain the effectiveness of an after hour MSM clinic in screening for STIs and evaluate the risk profile of men attending the clinics.

**Methods**
Melbourne Sexual Health Centre commenced a nurse practitioner led after hours MSM clinic in January 2008. Epidemiological data of last HIV test, last STI screen, condom usage and rate of partner change and past history of STIs were established as part of the sexual history taking. Data were extracted and analysed using descriptive statistical methods on SPSS.

**Results**
54 men attended over the 12 week pilot clinic. Data is still being collated and analysed. Initial results show regular screening behaviour among MSM who attended and minimal rates of STIs.

**Conclusion**
After hours clinics are one service model that reduces barriers to access for core groups such as MSM. Low risk core group members with regular screening behaviour may access these services out of convenience. Accessing high risk core group members is complex and increasing service hours may not necessarily relate to increased detection of STIs or attract symptomatic clients. Clinics aiming to improve service options for MSM will navigate the complexities of providing flexible but effective services to this client group.
**P3**

**PROVISION OF HIV NEGATIVE TEST RESULTS BY TELEPHONE**

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**Aim:**  
To study the acceptability and feasibility of providing HIV negative test results by telephone to patients attending a Sexual Health Service.

**Background:**  
Currently, NSW Health HIV Antibody Testing Guidelines state that HIV test results should be given in person and not by telephone. However, the National HIV Testing Policy states that clinicians should use their best judgement to determine how to deliver test results. The relevant policy in New Zealand has recently changed such that provision of negative HIV test results by telephone has been endorsed. Much healthcare worker and service clinic time is taken up providing negative HIV (and other) screening test results to clients face-to-face in the contemporary Australian setting. Some clients do not return for their results and hence are not engaged in post-test discussion regarding issues such as the HIV window period, AOD use and ongoing risk behaviour.

**Method:**  
1) Review current published evidence regarding provision of HIV and other test results by telephone in Sexual Health Service settings.  
2) Request feedback from Sexual Health Services in Australasia already providing this service on that experience.  
3) Scope and frame a prospective study of provision of negative HIV test results by telephone during 2008-09.

**Results:**  
Presentation of the literature review, the experiences of those sites already providing this service and the prospective study design.

**Conclusion:**  
Current evidence from overseas suggests that it is both acceptable and feasible to provide HIV negative test results by telephone, but there has been no prospective study of this as yet in the contemporary Australasian Sexual Health setting. Our study will collect data during 2008-09 for subsequent conference presentation and/or peer-reviewed journal publication.

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**P4**

**SHORT-COURSE SELF-INITIATED FAMCICLOVIR AS EFFECTIVE AS A STANDARD 5-DAY REGIMEN FOR RECURRENT GENITAL HERPES IN ASIAN PATIENTS: SUBGROUP ANALYSIS OF THE FAST RANDOMISED CONTROLLED TRIAL**

Doong N, Bloch M, Herawati L  
1Burwood Road Practice, Burwood, NSW, Australia;  
2Holdsworth House Medical Centre, Darlinghurst, NSW, Australia;  
3Novartis Pharmaceuticals, North Ryde, NSW, Australia

The Famciclovir Short-course Herpes Therapy Study (FaST) established that a 2-day short-course regimen of famciclovir (500 mg stat then 250 mg 12-hourly) was non-inferior to the standard 5-day regimen (125 mg 12-hourly) for patient-initiated treatment of recurrent acute genital herpes in terms of lesion healing, safety and tolerability, resolution of symptoms, functional impact, recurrences aborted, and time to the next recurrence.

Of the 873 patients in the study (1038 recurrences, intent-to-treat analysis), 48 classified themselves as ‘Asian’ including 6 who identified themselves as being from the Indian subcontinent and they experienced 68 recurrences. 30 recurrences were treated with a 2-day regimen and 38 with a 5-day regimen.

Similar to the previously reported findings in general study population, there was no statistically significant difference in the Asian population in the probability of not being lesion-free at 5.5 days (the primary efficacy outcome) with a 2-day and 5-day regimen (0.131 vs 0.188, respectively). There was also no statistically significant difference in the Asian population in the time between successive recurrences (a secondary efficacy outcome) with a 2-day and a 5-day regimen (mean 115 vs 67 days, respectively). This is similar to the findings in general population for a 2-day and a 5-day regimen (mean 72 vs 71 days, respectively).

These results are from a retrospective subgroup analysis in a small number of patients, but suggest that a 2-day regimen of famciclovir is as effective as a 5-day regimen in patient-initiated treatment of recurrent acute genital herpes in Asian patients. A numerically longer time between recurrences following short-course therapy in Asian patients (although not statistically significant in this analysis) warrants further investigation.
Contact tracing is necessary to interrupt the ongoing transmission of infection at an individual and population health level. It also provides the opportunity for treatment and individual counselling which may result in behaviour change. It relies on the goodwill and cooperation of patients. It should be voluntary, without coercion, confidential and include strategies to protect all records and the anonymity of the index case. It should be undertaken only when appropriate, culturally sensitive support services are readily available. Contact tracing within custodial settings provides specific challenges and must be conducted with sensitivity, employing appropriate strategies which acknowledge the culture of prisons and prisoners.

The 2008 National Prison Entrants’ Blood Borne Virus survey identified two new HIV positive patients in NSW custody. Informing these patients of the positive results and then conducting contact tracing presented health staff with specific challenges particularly as one person identified 16 contacts.

Maintaining confidentiality and anonymity is difficult in custodial settings. Patients are often unable to make confidential telephone calls and mail can be intercepted. Provider referral can also compromise confidentiality and this may inadvertently provide proof, or high suspicion, of the identity of the source.

This presentation will describe the steps required to obtain contacts’ details and the challenges faced in informing the contacts from within the custodial setting while maintaining confidentiality and providing appropriate support for both the patient and the contact.
NEW SOUTH WALES SEXUAL HEALTH INFOLINE – WHO WANTS TO TALK ABOUT SEX?

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1 New South Wales Sexually Transmissible Infections Programs Unit,
2 Sydney Sexual Health Centre, PO Box 1614 SYDNEY, NSW, Australia

The New South Wales Sexual Health Infoline (SHIL) is a free, anonymous and confidential telephone information service. It aims to promote the sexual health of the community, facilitate efficient use of public funded sexual health services (PFSHS), and provide accurate and timely information to Health Care Workers (HCW). To establish a baseline for the priority issues identified in the NSW Sexually Transmissible Infection (STI) Strategy (2006-2009) and provide direction for SHIL operations, we analysed SHIL records from April 2007 to March 2008 by caller demographics, issues discussed, referrals and knowledge of the service.

2842 calls were received (484 from HCW; 2358 from community) in the evaluation period. Community calls increased by 43% and HCW calls decreased by 47%. Community callers were mostly male (57%), heterosexual (84%), aged 25-39 years (53.5%) and from metropolitan Sydney (82.5%). 8.5% called from rural/remote NSW. The main call reason was related to STI and most community callers found out about SHIL through the telephone book or the internet. In contrast, 42% HCW calls were from non-metropolitan Sydney and were initially non STI related. Most HCW (61%) found out about SHIL through another health agency. There was insufficient data to explore referral and triage activities for both community members and HCWs.

Community members and HCW are being provided with different types of support from different parts of NSW. Referral to GP and PFSHS is occurring and could be more accurately recorded. More specific promotion of the SHIL to HCW and GP and improved collection of specific data to support evaluation of local and state-wide health promotion projects are planned.
P9
IMPLEMENTING A HUMAN PAPILLOMA VIRUS (HPV) PROGRAM IN NSW PRISONS

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2 CNC Sexual Health /Hepatitis C, Justice Health, P.O. Box 150, Matraville, NSW, 2036

In 2007, a HPV vaccination became available in Australia to prevent cervical cancer in women between the ages of 12 – 25. Following an extensive community and health service education program in NSW, Area Health Services commenced vaccination.

There are approximately 650 adult and 100 adolescent women in custody in NSW. Justice Health provides services to these women and aims to provide a standard of care comparable to that of the community. As a result, Justice Health began preparation for the implementation of a HPV vaccination program for both adult and adolescent women in custody.

Undertaking a vaccination program for women in custody poses many challenges. Recidivism is high and lengths of stay are typically short. Patients are often moved between custodial centres on a regular basis, have complex health co-morbidities including injecting drug use and mental illness, and poorer general health status. This is in addition to patients being reluctant to attend regular health providers when living in the community and the need for improved release planning which can occur suddenly without notification to Justice Health.

Justice Health has commenced vaccinating women in custody in NSW against HPV. This presentation discusses the complexities of the NSW custodial environment, the challenges of implementing an effective HPV vaccination program and the strategies implemented to overcome these including staff training, surveillance, data management and release planning.

P10
ORAL POSTER MONDAY 15 SEPTEMBER 1720 – 1730

SEXUAL HEALTH PROFFERED PAPERS - ABORIGINAL HEALTH: PROSPECTING FOR DIAMONDS

‘DANGLING THE CARROT’ – UTILISING THE HUMAN PAPILLOMA VIRUS QUADRIVALENT IMMUNISATION PROGRAM IN A REMOTE COMMUNITY IN NSW, TO INCREASE STI SCREENING RATES AMONGST A PRIORITY POPULATION.

Lenton J1; Wray L2; Garton L1, 2; Knight V2, Burton L2
1 Sexual Health Services, Greater Western Area Health Service, NSW, Australia; 2 Sydney Sexual Health Centre, Sydney/Sydney Eye Hospital, Sydney, NSW, Australia.

Introduction/ Background
The Greater Western Area Health Service (GWAHS) covers 55% of NSW, with over half the area classified as remote. 7.9% of the population are Aboriginal. Communities located in GWAHS have poorer health status compared to NSW, especially the Aboriginal population. Age-adjusted population rates for chlamydia in GWAHS are almost double the NSW rate.

Sexual health outreach services have been developed to extend service delivery into remote communities. The NSW STI Strategy designates Aboriginal people as a priority for provision of sexual health services in NSW. The National Program for HPV quadrivalent immunisation began in 2007. In GWAHS, the sexual health program developed an initiative of linking HPV immunisation and chlamydia testing, to access the hard to reach population of 15 to 26 year old Aboriginal females no longer attending school. The project commenced in a remote Aboriginal community, 26/07/07.

Method
Uptake of chlamydia screening in Aboriginal females under 26 was reviewed prior to and after the introduction of the HPV immunisation program in this community.

Results
Two 12-month periods, one prior to and one post introduction of the HPV immunisation program, were examined. Pre-introduction 14 Aboriginal females < 26 years were screened with 5 chlamydia cases detected. Post introduction, 59 Aboriginal females < 26 years were screened with 21 chlamydia cases detected.

Conclusions
Introduction of the HPV immunisation program in a remote community has allowed greater access to a difficult-to-reach population and has led to increased STI screening rates and number of chlamydia diagnoses made. Therefore the carrot is working. Numbers are significant given that the estimated total population for this community is 600. Assistance by local Aboriginal health workers, to encourage immunisation and clinic attendance by the priority population, has also increased screening rates. This approach may in the longer term, improve health outcomes for these young women by decreasing chlamydia rates and increasing their STI knowledge.
P11
QI - QUITE IRRITATING OR QUITE IMPORTANT? - A PATIENT SATISFACTION SURVEY.

Keeley DL, Marshall, L
Infectious Diseases Department (B2 clinic), Fremantle Hospital, B Block, Alma Street, Fremantle, 6160, Western Australia.

Objectives- To evaluate the quality of service to patients attending an infectious disease department (incorporating sexual health and hepatitis services) via a patient feedback survey.

Methodology- A questionnaire, endorsed by the Patient Advisory Feedback Subcommittee, was provided to all patients of the Infectious Diseases Department at Fremantle Hospital over a fourteen week period. All general patients were given a questionnaire; those attending sexual health and hepatitis services were also given specialty-specific questions. Surveys were confidential, anonymous and colour coded to the specific area. Surveys were given to patients by the attending clinician and then returned to a box located in the reception area.

Summary of results – 111 questionnaires were given to new patients with a return rate of 97/111 (87%). Generally, the feedback was of a positive nature and most patients seemed satisfied with the services provided. Specifically, 81% of sexual health clients felt that tests were explained to their satisfaction, 81% felt their privacy was well maintained with a physical examination, 90% felt they were given opportunity to ask questions and 90% stated they felt their overall experience was good.

Conclusion – A QI survey is an important and valid method to obtain precise information on quality of services to patients and enable assessment of patients needs relating to service delivery. Positive feedback can also serve as a rewarding experience for employees. It is important to ensure feedback of the report is provided to all involved personnel and that ongoing surveys of a similar nature are conducted regularly.

P12
ORAL POSTER MONDAY 15 SEPTEMBER 1522 – 1530

SEXUAL HEALTH PROFFERED PAPERS - CHLAMYDIA: BEADS

CHLAMYDIA TESTING AND NOTIFICATION IN VICTORIA: MORE MONEY, MORE TESTS.

McNamee K, Fairley C, Hocking J

Objective: To examine the associations between chlamydia testing and notification and age, sex, socio-economic status and access to services for area of residence for the Australian state of Victoria in 2004.

Methods: Data on 72970 tests and 7109 notifications for chlamydia were obtained from government sources by age, gender and area of residence. Each of 78 areas of residence was assigned to a population weighted quartile of socio-economic advantage and was scored for access to services. Generalised linear modelling was used to analyse relationships between the variables.

Results: The odds of being tested for and notified with chlamydia increased by 28% (OR 1.28, 95% CI: 1.28-1.29) and 10% (OR 1.10, 95% CI: 1.08-1.13) respectively and the odds of a test being positive decreasing by 15% (OR 0.85, CI: 0.84-0.87) for each quartile increase in socio-economic advantage, when adjusted for access to services. This increased to 39% (OR 1.39, 95% CI: 1.38-1.41) and 25% (OR 1.25, 95% CI:1.20-1.29) respectively when only those aged 25 years and above were considered. The odds of a test being positive decreased by 15% (OR 0.85, 95% CI: 0.84-0.87) for each quartile increase in advantage. The highest proportion of any subgroup population tested was 8.1% in females aged 20 to 24 years living in the most advantaged quartile.

Conclusion: Access to Chlamydia testing is inequitable and favouring more advantaged areas who are also less likely to test positive than individuals from disadvantaged areas. Testing in the age groups at most risk, females aged between 20 to 24 years, was low even in those living in the most advantaged quartile. If Australia is to implement a chlamydia screening program through primary care, education should be particularly targeted to practitioners in more advantaged areas regarding the appropriate age group to screen.
P13
CHLAMYDIA: TIME TO TREATMENT

Porter SE, Ooi C.
Pacific Clinic Newcastle Sexual Health Service, Community Health Centre, 670 Hunter Street, Newcastle, NSW, 2300, Australia.

Objective:
To describe
1. Clients diagnosed with chlamydia at the Pacific Clinic.
2. Time duration between chlamydia testing and treatment.
3 Reasons for unsuccessful provider telephone contact of clients diagnosed with chlamydia.

Method: A retrospective audit using electronic SHIP database and manual data extraction was conducted for patients diagnosed and treated for chlamydia at the Pacific Clinic, Newcastle Sexual Health Services, from January to June 2006.

Results: Sixty six files were reviewed, 25 (25/66, 38%) were females whose mean age was 20yrs (range 15-26 years), the mean age of males was 26 years (range 19-44 years). Eight (8/66, 12%) identified as men who have sex with men, 7 (7/66, 11%) as injecting drug users, 2 clients were HIV positive (2/66, 3%), 2 (2/66, 3%) identified as sex industry workers and 1 client (1/66, 2%) was of Aboriginal or Torres Straight Islander background. Treatment was provided at the initial screening visit for 10 (10/66, 15%) females and 27 (27/66, 50%) males. The mean number of days for all clients, from testing to treatment of chlamydia was 3.9 days, in females 5.9 days (range 0-52 days) and males 2.8 days (range 0-22 days). In 34 clients (34/66, 52%) the initial contact by telephone for results was unsuccessful. Of these clients, in 23 (23/34, 68%) there was no answer (in one case the mobile was switched off, 1 client gave the wrong number). No reason for unsuccessful contact was given for 11 clients (11/34, 32%).

Conclusion: Service programmes should evaluate time to treatment of STI and follow up of clients with positive results. This audit enabled evaluation of existing processes and the implementation of change to current practice.

P14
URINARY TRACT INFECTIONS IN SEXUAL HEALTH- WHAT’S CHANGING OVER TIME?

Linehan J1 & Wray L2
1Medical Student, University of New South Wales, Sydney, Australia; 2Sydney Sexual Health Centre, Sydney, NSW, 2000, Australia

Symptoms of lower urinary tract infection (UTI) are a common presenting complaint to sexual health services. Since 1997 our clinic has monitored the changing patterns of antibiotic resistance in UTIs to ensure our prescribing guidelines reflect the likely antibiotic sensitivities of the causative organisms. Since 1997 our first-line antibiotic changed from trimethoprim to cephalexin, reflecting local resistance patterns.

We reviewed all diagnoses of UTI during 2007 and compare this to data from 2001 and 1997.

There were 109 episodes of UTI in 2007. 107 mid-stream urine samples were sent for culture. 59 (55%) samples were culture positive, of which 43 (73%) grew Eschericia coli, 8 (14%) bowel flora, 6 (10%) Staphylococcus saprophyticus, 5 (8%) Klebsiella species, and 5 others.

Of 53 organisms tested for cephalexin resistance, 4 (8%) were resistant. Of 57 organisms tested for trimethoprim resistance, 11 (19%) demonstrated resistance. 45 organisms were assessed for resistance to co-amoxyclav and 2 were resistant (4%). Of the 4 organisms resistant to cephalexin, 2 were also resistant to trimethoprim. Cephalexin was prescribed to 72 (75%) on initial visit who had no contraindication prior to culture and sensitivity results.

In 1997, no organisms were reported to be resistant to cephalexin. In our 2001 audit of 166 cases of UTI, 1.3% of positive samples showed resistance to cephalexin, and by 2007 this has increased to 8%. Although this trend has not yet breached the recommended level of 15-20% for changing first-line antibiotic, it demonstrates the need for ongoing audit of clinical practice.

Only 75% of patients were treated as per clinic protocol but greater than 90% of patients were given one of the 3 antibiotic regimens recommended by the National Prescribing Service. Clinics should be alert to locally changing patterns of antibiotic resistance to maximise effective treatment of this common condition.
**P15**  
**SYphilis & HIV**

Roth N, Nicolson J  
Prahran Market Clinic, 131 Commercial Road, South Yarra 3141, Australia.

**Background**  
Since ~2000, there has been a resurgence of syphilis, particularly in homosexual men (MSM) and in HIV positive men. With an apparent rise in the rate of new HIV infections (particularly in Victoria) there has been speculation that this signified a rise in risk-taking behaviour among MSM and/or confirmation that syphilis-associated ulceration and inflammation increases the risk of HIV acquisition.

**Objective.**  
Our clinic has a predominantly gay patient population, with a significant HIV caseload. We conducted a retrospective case review of all diagnoses of syphilis, with the aim of describing the differences, if any, between HIV positive and negative men in the presentation, treatment response and follow-up of syphilis cases.

**Methods.**  
The clinic uses a computerised medical record system (CMRS). All patients with positive syphilis serology were identified. By manual review, cases of previous treated syphilis were removed, focusing this study on de novo syphilis cases. The CMRS was then reviewed for all identified cases to identify the parameters of interest.

**Results.**  
185 diagnoses of syphilis were identified: 80 in HIV negative men, 105 in HIV positive men. Differences were found in the presentation, treatment regime, occurrence of Jarisch-Herxheimer reaction and adequacy of serological follow-up in the HIV positive vs negative groups. Response to treatment was the same in both groups. In 7 cases, a possible relationship was observed between the syphilis diagnosis and subsequent HIV seroconversion. Follow-up serology was significantly more consistent in HIV-positive patients.

**Conclusions.**  
The clinical presentation of syphilis in HIV positive men is associated with more florid clinical symptoms and signs and better clinical follow-up, but not in treatment response. Better documentation of a past history of syphilis in medical records is needed to optimise follow-up.

**P16**  
**WHAT FEMALE PATIENTS THINK ABOUT CHAPERONE USE WHEN SEEING MALE SEXUAL HEALTH PRACTITIONERS.**

Simanjuntak C1, Cummings RC2, Chen MY1,2, Williams H1,2,  
Snow AF2, Fairley CK1,2  
1School of Population Health, The University of Melbourne, Melbourne, VIC, Australia.  
2Melbourne Sexual Health Centre, Melbourne, VIC, Australia.

**Aim:** The aim of this study was to elicit the views of female patients about being offered chaperones for a genital examination when consulting with a male sexual health practitioner. **Method:** An anonymous self administered questionnaire was completed by female patients (n=201) following consultation with a male sexual health practitioner at the Melbourne Sexual Health Centre.

**Results:** Of the 201 who participated in the study, 167 were examined of whom 102 were offered a chaperone and 79 declined the offer of a chaperone. None (95% confidence interval, 0-5%) of those who declined a chaperone reported that they were uncomfortable saying yes to the practitioner. A small percentage of women who were offered a chaperone were made uncomfortable by the offer (n=8, 8%).

**Conclusion:** This demonstrates that the majority of women who declined a chaperone really did mean that they did not want a chaperone, rather than out of fear of creating a sense of mistrust with the practitioner.

van Lieshout TA, 1 Brisbane Sexual Health and HIV Service. 1/270 Roma Street, Brisbane, Queensland.

Objective: To examine the routine screening for gonorrhoea using Polymerase Chain Reaction (PCR) assays at urogenital and non-urogenital (throat and anal) sites in asymptomatic patients attending the BSHS in the following risk groups: Men who have sex with men (MSM), female commercial sex workers (CSW) and heterosexual women and men. To compare positive assay results with the “Gold Standard” of microscopy and culture.

Methodology: Data from Auslab, the Queensland Health and Scientific Services (QPATH) database, were collected over a three-year period from patients attending the BSHS. The clinical records of all positive PCR assay results for N. gonorrhoeae were reviewed. Patient risk group, clinical presentation (symptomatic or contact of known positive index case with either N. gonorrhoeae or Chlamydia trachomatis versus asymptomatic) and correlation with culture for N. gonorrhoeae were examined.

Summary of results: 10,302 (50.7%) males (M) and 10,032 (49.3%) females (F) attending the BSHS over the audit period were screened at various sites with a PCR assay for N. gonorrhoeae. Total positive results/total tests performed by test site: Cervix = 7/4,972 (0.14%); Rectum: M = 68/1,340 (5.1%); F = 2/236 (0.8%); Throat: M = 118/2,635 (4.5%); F = 9/2,237 (0.4%). First-pass urine (FPU): M = 86/6,217 (1.4%); F = 6/2,597 (0.23%). Asymptomatic patients with a positive N. gonorrhoeae PCR by site: Cervix = 2/7 (28.6%); Rectum-only: M = 12/36 (33.3%); F = 0/2 (0%); Throat-only: M = 47/80 (58.7%); F = 2/8 (25%); FPU: M = 0/86 0 (0%); F = 4/6 (66.7%).

Conclusion: There were low yields of positive PCR assays for N. gonorrhoeae in women. In both heterosexual and homosexual males, no FPU-positive PCR assay for N. gonorrhoeae occurred in asymptomatic patients. “Best practice” screening for gonorrhoea at each site with PCR assay &/or culture in asymptomatic patients in various risk groups attending BSHS are discussed.

P18 GARDNERELLA VAGINALIS SEPTICEMIA WITH INFECTIVE ENDOCARDITIS, SEPTIC EMBOLI TO BRAIN AND PYELONEPHRITIS IN AN IMMUNOCOMPETENT MAN.

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Gardnerella vaginalis, a gram-variable bacillus first described by Leopold in 1953, typically associated with bacterial vaginosis in women. A number of infections have been described in men including balanitis, urethritis, urinary tract infection and asymptomatic bacteremia, often in association with urological procedures or in patients with underlying urological problems such as prostate adenoma and urethral stricture. Severe infections previously described include septicemia, pulmonary abscess in an alcoholic and perinephric abscess following a kidney transplant. However, significant infection in a previously well man is rare. Here we report a case of G vaginalis septicemia with infective endocarditis, septic emboli to brain and pyelonephritis in an immunocompetent man.
P19
PREVENTION AND AWARENESS FOR JAIL INMATES

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District Jail Larkana

Target Area: Jail Inmates

Introduction:
High risks prevail due to limited/no access to STIs (Sexually transmitted infections), care and support, scarcity of information and awareness about the hazards and prevention measures against HIV/AIDS which make jail inmates vulnerable to HIV infection. This project aimed at increasing awareness and minimizing risks amongst jail inmates.

Objectives
- To increase the knowledge and awareness level on HIV & AIDS of the jail inmates
- To advocate for prevention measures and care about HIV/AIDS and STIs
- To train the peer educators to promote better life skills

Methodology
Methodology adopted in this study was the Behavior Change Communication through peer educators the method used was Stratified Random Sampling. This method was adopted in keeping in view of the project design to train the peer educators.

Summary of Result
- Jail Inmates received information and improved knowledge and improved about hazards and prevention of HIV & AIDS.
- Developed IEC (Information, Education and Communication) material related to the HIV/AIDS and STI transmission disseminated
- Five refresher trainings were conducted with jail inmates
- Pre baseline conducted and findings published
- Low literacy rates of jail inmates make it essential to adopt innovative BCC (Behavior Change Communication) strategies depending largely upon peer-education.
- Improved health seeking behaviors of jail inmates
- Referrals for STI treatment were made and healthy practices were up taken by jail inmates along with STI treatment

Conclusion:
There should be a corner set up in jail hospital for diagnosis, treatment and dissemination of awareness for STDs. If possible, screening should be done to identify more cases of HIV. IEC material should be distributed so that the myths and misconceptions about HIV & AIDS are cleared.

P20
WITHDRAWN
P21 SHORT-COURSE SELF-INITIATED FAMCICLOVIR AS EFFECTIVE AS A STANDARD 5-DAY REGIMEN FOR RECURRENT GENITAL HERPES IN HIV+ PATIENTS: SUBGROUP ANALYSIS OF THE FAST RANDOMISED CONTROLLED TRIAL

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The Famciclovir Short-course Herpes Therapy Study (FaST) established that a 2-day short-course regimen of famciclovir (500 mg stat then 250 mg 12-hourly) was non-inferior to the standard 5-day regimen (125 mg 12-hourly) for patient-initiated treatment of recurrent acute genital herpes. Endpoints studied were lesion healing, safety and tolerability, resolution of symptoms, functional impact, recurrences aborted, and time to the next recurrence.

Human immunodeficiency virus-positive (HIV+) patients were included in the study if they met eligibility criteria with a CD4 count of ≥ 500 cells/µL and/or CD4 cells ≥ 25% of total lymphocytes within the previous 3 months AND had been on stable management, with or without antiretroviral therapy, for at least one month prior to enrolment. Among 873 patients in the study (1038 recurrences, intent-to-treat analysis), 65 were HIV+ and experienced 93 recurrences. 41 recurrences were treated with a 2-day regimen and 52 with a 5-day regimen.

Compared to the general study population, there was no statistically significant difference in the HIV+ subgroup in the probability of not being lesion-free at 5.5 days (primary efficacy outcome) with a 2-day or a 5-day regimen (0.301 vs 0.315, respectively). There was also no statistically significant difference in the HIV+ population in the time between successive recurrences (a secondary efficacy outcome) with 2-day and 5-day regimens (mean 94 vs 85 days, respectively). This is similar to the findings in the general population for 2-day and 5-day regimens (72 vs 71 days, respectively).

These results are from a retrospective subgroup analysis in a small number of patients, but suggest that a 2-day regimen of famciclovir is as effective as a 5-day regimen in patient-initiated treatment of recurrent acute genital herpes in HIV+ patients.

P22 ADAPTATION OF TRADITIONAL MEDIA TO REDUCE HARM IN COMMUNITIES

Santosh Dahal – Nepal Red Cross Society

Background: Nepal constitutes more than eighty percent rural areas. In rural areas, illiteracy, poverty, and gender based crimes are widespread. Migration of young people to India and Gulf Countries is high. Awareness level among community people regarding reproductive health issues like HIV transmission, alcohol related harms and health and hygiene is limited.

Nepal Red Cross is working since decade on health programmes in 75 district of the kingdom.

Objectives

The communities are empowered and they can prevent themselves from HIV, gender and caste related reproductive health through trainings, orientations, advocacy sessions, income generation activities and dissemination through traditional singers.

Methods

Nepal is rich in traditional culture and entertainment approaches. Traditional entertainment approaches are very popular and well accepted in the communities. Project has adapted a traditional entertainment approach called Gandhaba - traditional roving singers Song to disseminate the information in the communities. For this purpose, the traditional singers are trained on the topics like reproductive health, HIV/AIDS, migration, demerits of alcohol, caste discrimination. The singers and project people jointly compose songs on topics mentioned above. Then the trained singers with composed songs are mobilized in communities to disseminate information.

Results

The Gandhaba having community acceptance visit community people spontaneously and participate in the singing songs.

The mobilization of traditional singers has supported to reduce stigma and discrimination attached to PLHIV. Information given through traditional singers regarding reproductive health, HIV/AIDS and sexual issues are more acceptable in the communities then through modern media. Further, dissemination through Gandhaba song has supported to create a supportive environment in communities to work for prevention of HIV/AIDS transmission.

Conclusions

This approach has been found sustainable because the singer who is trained is from local community and once trained may continue for longer times. Those singers use local language thus they are highly accessible and easily understood by the community people.
P23
SCHOOL BASED PREVENTION INTERVENTION RUN BY(PLWHA)

Karki A, Bhandari L

Issues: - A group of HIV Positive youths started a network of plwha in Nepal. There is an estimated 70,000 plwha across the country. Six out of ten sex workers and 1 out of 2 IDUs are infected with the virus and their age group varies from 13 to 39.

Description: - The national network of PLWHA in Nepal started a training of trainers (TOT) program among their members on the basic of HIV/AIDS. After two weeks of basic course the group of 20 was divided into two groups and went to school, colleges where they talked on living positive.

Lesson learned: - After completion of 3 days in each of the groups the members returned home happy. The immediate results was seen by pre-post test result which showed that the group succeeded since 80% of the participants did learnt a lot more than expected. Further to our surprise was that many school started their own HIV awareness clubs and the members became peer educators in their respective community.

Recommendation: - Our latter result showed that the student were interested in working in their community. Also that the members could earn some money for themselves to spend on their daily lives.

P24
‘ABOUT AIDS’ CD-ROM - INTERACTIVE LEARNING ABOUT HIV/AIDS FOR PEOPLE LEARNING ENGLISH AND/OR WITH LOW LITERACY

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In recent years there has been an increase in the number of HIV/AIDS notifications in NSW. A large portion of this increase has been within the culturally and linguistically diverse (CALD) heterosexual community. For this reason it was considered important that new arrivals to Australia be educated about HIV/AIDS issues at an early stage in their settlement process. In response to this need, About AIDS was designed to teach English using HIV/AIDS information, allowing students to learn and at the same time become aware.

In order to develop a culturally sensitive and user friendly resource consultations were conducted with twenty nine (29) ACL Auburn teachers, thirty two (32) ACL students, twenty six (26) community leaders/representatives from a range of cultures and ACL management. In addition HIV/AIDS information sessions were conducted with students and teachers. Overall the response to developing the resource was very positive.

In initial consultations with teachers concerns were raised about teaching HIV/AIDS to culturally diverse students in a mixed gender class setting. Later consultations and workshops directly with students revealed that they were interested in receiving the information and found the CDROM format to be appropriate and non-confronting.

About AIDS was designed for use with the support of a teacher, by students in a computer-based lesson. Using the format of an interactive CDROM allows students to work at their own pace, choosing information they feel comfortable with and to have their questions answered in a semi-private manner.

Without the involvement of teachers, students and community representatives in the different stages of the project, About AIDS could not have been produced. We are hoping About AIDS will increase the capacity building of English Language Providers, in relation to HIV/AIDS issues and their students, as well as inspire other projects that could utilise the resource.
P25
DISCORDANCE RATE AMONG CLIENTS RECEIVING ANTIRETROVIRAL THERAPY AT TASO UGANDA

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Background
The AIDS Support Organisation (TASO) was founded in 1987 to prevent HIV infection, restore hope, and improved the quality of life of persons and communities infected and affected by HIV/AIDS. TASO rolled out a home base HIV counselling and testing programme in 2004, targeting household members of clients enrolled on ART. The main objective was to identify household members who may be eligible for ART and start them on treatment on ART to avoid future drug sharing and to offer free counselling and testing in the homes.

Problem statement
Sexual partners and spouses of HIV infected individuals are at higher risk of being infected with HIV if they are of negative or unknown sero-status. The sero-Behavioral Survey (2004-2005) conducted in Uganda indicated that 1.1m Ugandans are living with HIV/AIDS, 77% of these are sexually active, 84% don't use condoms, 88% of married men have cheated on their wives as compared to 56% women, 58% of HIV positive individuals are have unprotected sex with a negative spouse i.e. are discordant, and majority don't know their status.

Methods
Routine analysis of HBHCT Programme data from the TASO Management Information System (MIS)
The data used in the study was from 6 TASO Centers Rukungiri, Mbarara in western, and Gulu in the northern, Masaka and Entebbe in the central, and Tororo, in the eastern part of Uganda.

Results
Of the total 679 spouses tested for HIV, 388 patients were discordant; this gives a discordant rate of 57% 95% CI [48.6, 65.9].

Conclusion
The national discordant rate 58% is statistically not different from the TASO discordant rate of 57%. Care and treatment programs should consider scale up of Home based HIV counselling and testing to promote partner testing to both ART and none ART clients for promoting risk reduction of acquiring HIV infection.

1 CI=Confidence Interval

P26
ART COUNSELLING: A CONTRIBUTOR TO ADHERENCE IN INDIA.

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Access to treatment for HIV is increasing in many parts of the world. However, information on adherence to antiretroviral therapy (ART) in developing countries is limited. This study was planned to assess levels of adherence to ART in HIV-infected adults and determine factors associated with suboptimal adherence.

Face to face interviews were conducted from February – March 2008 at a public ART clinic in India, where fixed dose combination antiretroviral medications were provided free of charge. Socio-demographic characteristics, HIV/AIDS knowledge, ART-related effects and self-reported adherence data were collected.

Of 279 participants, 197 (70.6%) were males and 82 (29.4%) were females. The most common age groups were 35-44 years for men (47% of men) and 25-34 years for women (56% of women). 50 (17.9%) had no formal education, 123 (44.1%) had been to school until at least 10 years of age and 193 (69.2%) were employed at the time of the survey. 114 (41%) reported spending more than 5 hours to reach the clinic and 133 (47.7%) had been on ART for two years or more.

Over the previous 4 days, 267 (95.7%) of participants reported 100% adherence, 10 (3.6%) reported missing 1-2 pills and 2 (0.7%) reported missing ≥3 pills. Over the previous 28 days 243 (87%) of participants reported adherence of 100% 30 (10.8%) reported missing 1-2 doses and 6 (2.2%) reported missing ≥ 3 doses. 28 (14.2%) of men and 15 (18.2%) of women had ever stopped treatment for more than 1 week.

Counselling about HIV treatment and adherence were significantly associated with good adherence over the previous 28 days. Hospitalization in the last year, commitment to taking medication and non-belief in treatment efficacy were significantly associated with stopping treatment for more than 1 week.

The appropriate use of counselling can result in excellent levels of adherence, even in resource-poor environments.
P27
HEALTH PROFESSIONALS IN STI CLINICS WILLINGNESS TO ASK SEXUAL IDENTITY (ADDIS ABABA)

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Background: In Ethiopia the prevalence of HIV/AIDS is 4.3% & 87% of the transmission is heterosexual. The transmission rate in homosexuals is not known.

Methodology: Anonymous questionnaire were provided & conducted (after pre test) for 100 health professionals working in the STI clinics.

Result: 70% of the health professionals do not ask sexual identity of their clients due to their own socio-cultural & religious aspects while other 22% do not ask due to socio-cultural & religious aspects of the society & clients. Only 8% of them do ask sexual identity.

Conclusion: There is lack of willingness of health professionals to assess’ sexual identity of clients.

Recommendation: An open discussion among health professionals & education of sexual preferences is critical.
Chlamydia and Gonorrhoea are the most reported notifiable sexually transmitted infections in Western Australia. The introduction of PCR testing has increased the sensitivity of detection of Chlamydia and Gonorrhoea and has allowed the use of urine as a diagnostic specimen. However, there is the potential to miss infection if testing is performed solely on urine. A retrospective analysis of the detection of Chlamydia trachomatis and Neisseria gonorrhoeae in patients presenting to Royal Perth Hospital in 2007 was performed to determine the necessity of multiple collection sites.

The analysis was conducted on sets of patient samples that included urine and a genital swab collected together with one or both producing a positive result. From 30 reported cases of Chlamydia infection in females, 21 were detectable in urine compared to 29 that were detectable in swabs. In males, 54 out of 57 positive cases were detectable in urine, whilst 48 were detectable in urethral swabs. Without the collection of a genital swab, 14% of infections would have remained undiagnosed. Positive Gonorrhoea results were obtained 3 out of 5 times in female urine samples compared to 5 out of 5 for genital swabs. Male samples showed similar results with 14 out of 17 positive urines and 17 out of 17 positive swabs. In this instance 23% positive Gonorrhoea cases would have been missed if a genital swab had not been performed. This data highlights the importance of swab collection to increase the rate of detection of Chlamydia and Gonorrhoea, especially where a multiplex assay is used. Expansion of this analysis to include results dating back to 2005 is expected to support these findings.

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### P29

**LOW POSITIVE PREDICTIVE VALUE OF A NUCLEIC-ACID AMPLIFICATION TEST FOR NON-GENITAL NEISSERIA GONORRHOEAE INFECTIONS IN HOMOSEXUAL MEN**

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**Objectives:** Nucleic acid amplification tests (NAAT) for the detection of Neisseria gonorrhoeae are only validated for use with genital samples. To determine the test performance of the BD ProbeTec assay for the detection of N. gonorrhoeae at non-genital sites, we performed supplemental testing using a previously validated assay targeting the gonococcal porA pseudogene on non-genital samples collected from participants in the community-based Health in Men (HIM) cohort of homosexual men in Sydney, Australia.

**Methods:** A total of 327 (289 oropharyngeal and 38 anorectal) samples initially reactive for N. gonorrhoeae DNA using the ProbeTec assay were tested on the porA supplemental assay. An additional 100 (50 oropharyngeal and 50 anorectal) samples negative on the ProbeTec assay for N. gonorrhoeae DNA also underwent supplementary porA testing.

**Results:** Of the 327 samples initially reactive for N. gonorrhoeae DNA on the BD ProbeTec assay, 88 of 289 oropharyngeal samples and 28 of 38 anorectal samples tested positive on the porA assay. The positive predictive value of the ProbeTec assay for the detection of N. gonorrhoeae DNA was 30.4% (95% CI 25.2-36.1%) in the oropharynx and 73.7% (95% CI 56.9-86.6%) in the anorectum. All oropharyngeal and anorectal extracts negative for N. gonorrhoeae DNA on the ProbeTec assay were also negative on the porA assay resulting in negative predictive values of 100% at each site.

**Conclusion:** Supplemental testing of reactive non-genital BD Probetec N. gonorrhoeae samples resulted in greatly improved accuracy of gonorrhoea diagnosis at these sites. More research involving a larger number of specimens is required to determine the performance characteristics of the BD assay on anorectal samples. However, our results indicate that a positive result of a single NAAT cannot be relied on for diagnosis of pharyngeal gonorrhoea in Australian homosexual men.
P30
WEIGHT CHANGE ANALYSIS OF PATIENTS ON STAVUDINE-LAMIVUDINE-NEVIRAPINE DRUG REGIMEN

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Objective: Weight loss of >10% from baseline is a major characteristic feature in the development of AIDS. The objective was to find out the impact of Stavudine-Lamivudine-Nevirapine drug regimen on body weight and to establish the relationship between weight gain and the baseline immunological status of the patient.

Methods: A retrospective study was conducted among 80 HIV positive antiretroviral experienced subjects treated with the Stavudine-Lamivudine-Nevirapine regimen who have completed at least 48 weeks of treatment. Of these 42 of them had CD4 count ≤150/mm³ and 38 had CD4 count >150/mm³ at baseline. The baseline weights of the two groups were comparable. Analyses also included factors like CD4 count, liver function tests, renal function tests and hemogram. Statistical methods included descriptive statistics and Wilcoxon Mann-Whitney U test.

Results: An overall increase in weight percentage was noticed during the course of treatment. The group of subjects with lower baseline CD4 count had a greater margin of weight gain at 48 weeks when compared to the other group (14.4 vs 8.0, p-value .005). The maximum increases in percentage weight were found during the first 20 week. The number of patients with ≥ 10% weight change was significantly higher in the lower CD4 count group at 48 weeks (65% vs 35%, p-value .01).

Conclusions: The study shows that greatest increases in weight were seen in those patients with greater degrees of immunocompromise at baseline. The study supports the usage of weight change analysis to assess the improvement of patients in resource poor settings.

P31
A GONOCOCCAL REAL-TIME PCR ASSAY COMPRISING TWO GENETIC TARGETS – TWO HEADS ARE BETTER THAN ONE

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Nucleic acid amplification tests (NAATs) have revolutionised laboratory diagnosis of sexually transmitted diseases and are now widely used by laboratories worldwide. However, NAATs for Neisseria gonorrhoeae continue to be plagued by false-positive results caused by cross-reactions with commensal Neisseria strains. In addition, recent data indicate that sequence-related false-negative results can occur in gonococcal NAATs, whereby target sequences are either absent or contain several mutations. In this study a duplex N. gonorrhoeae real-time PCR assay was developed targeting the gonococcal porA pseudogene and multi-copy opa genes. The assay used TaqMan chemistry for real-time PCR detection and was performed on the ABI7500 instrument; porA and opa PCR reactions were distinguished using FAM and Yakima Yellow fluorophores respectively. The duplex assay was validated by testing 596 clinical specimens including both uro-genital and extra-genital specimens, and the results compared to those obtained using a consensus reference standard comprising three individual gonococcal real-time PCR assays. Of the 596 clinical specimens tested, 41 provided positive results in all three singleplex assays and were considered “true-positive”. All 41 “true-positive” specimens were positive in the duplex assay providing an overall clinical sensitivity of 100%. Four specimens comprising two urine samples and two throat swab specimens were positive in the duplex assay but were not positive in all three reference assays. These were considered to be false-positive results in the duplex assay providing a clinical specificity of 99.3%. Overall the results show the duplex assay is suitable for routine screening for gonorrhoea. In addition, the two-target system of the duplex assay decreases the potential for sequence-related false-negative results and can provide simultaneous confirmation of positive results. Overall our experience suggests there is considerable benefit in the use of two-target PCR methods and that such assays may enhance the detection of other infectious agents.
P32
INFECTIOUS SYPHILIS PREVENTION FOR MSM – ARE WE GETTING IT RIGHT?
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Since the early 2000s, rates of infectious syphilis have been increasing exponentially in major cities across Australia, North America and Europe, with the majority of cases occurring among gay and other homosexually active men. Comparing and contrasting two prevention strategies developed in Toronto, Canada, in 2005-2006, and in Melbourne, Victoria in 2007-2008, this paper will examine whether prevention strategies founded on testing and treatment are sufficient to curb the infectious syphilis epidemic. The response in Toronto was a collaborative intervention between Toronto Public Health (TPH), the Hassle Free Clinic (HFC) and the AIDS Committee of Toronto (ACT) that utilized existing testing sites at sex on premises venues frequented by gay and other homosexually active men. The responses of the Victorian AIDS Council/Gay Men’s Health Centre and PLWHA (Victoria) by contrast dovetailed into an existing national general sexual health campaign for gay and other homosexually active men. The collaborative efforts in Toronto benefited from the shared resources of the three partner agencies – peer outreach from ACT, and clinical expertise from the HFC and TPH. In Melbourne, the health educators’ access to various media such as community radio allowed for more thorough dissemination of testing and prevention messages. We conclude that a successful response to an infectious syphilis epidemic requires a comprehensive and holistic approach that includes clinician offered and patient-requested testing and treatment as well as social marketing components supporting evidence-based prevention messages.

P33
THE THRILLS CHILLS AND SPILLS OF WORKING WITH SEXUALLY EXPLICIT MATERIAL IN HIV PREVENTION TARGETING GAY MEN
Colin Batrouney

This presentation will look at the implicit and explicit tensions that arise from working with sexually explicit materials that target homosexually active men in a culture that has shifted increasingly to what is euphemistically characterized as ‘the mainstream’. I will chart the difficult negotiation with public funders as well as critical attitudes from some in the gay community that reveal a deeply embedded fear that, in depicting or suggesting homosexual sex, many of our hard won social gains will be lost.

The presentation will examine the development and implementation of a recent campaign that addressed issues related to unprotected anal intercourse in casual settings, utilizing imagery from the gay porn industry.
IDENTIFYING YOUNG PEOPLE AT RISK OF SEXUALLY TRANSMITTED INFECTIONS USING AN INTERNET BASED RISK ASSESSMENT TOOL

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Objectives
a) To develop an assessment tool to assist GPs in identifying young people (16-24 years) at risk for chlamydia and other sexually transmitted infections (STIs) when they present for any reason;

b) To test the acceptability of the tool among patients and providers; and

c) To measure the effect of the tool on chlamydia testing rates.

Method
Patients aged 16-24 years attending three general practices in metropolitan Victoria were referred to an online sexual risk assessment tool, ‘Check Your Risk’ (www.checkyourrisk.org.au) for a period of 6 months. The effectiveness of the tool was assessed by comparing testing rates for chlamydia before and after its implementation in the practices and through semi structured interviews with GPs and practice staff.

Results
The implementation of an educational program and an online sexual risk assessment tool into general practice resulted in a minimal increase in chlamydia screening of young people aged 16-24 years. The percentage of women tested for chlamydia increased slightly from 7.6% to 8.1% (p=0.6) and for men decreased slightly from 4.0% to 3.4% (p=0.5). Overall the percentage tested for chlamydia remained stable, from 6.4% to 6.5% (p=0.9).

While GPs felt that chlamydia testing was very important, they did not have the time to refer substantial numbers of young people to the website during consultations. Whilst only a small proportion of the patients that were referred to CYR (24.1%), accessed it (13.5%), young people at risk for STIs were identified and provided with online information on STI testing. Of the young people who utilised CYR, 74.7% (47/63) female respondents and 58.5% (31/53) male respondents reported not using condoms all the time.

Conclusion
General practice does not appear to be the ideal place to promote a web based sexual risk assessment tool in order to increase chlamydia screening. Alternative avenues in which to promote such web based services need to be explored as do other interventions to increase chlamydia screening in general practice.
Objective: To describe the experiences of chlamydia infected individuals with regards to partner notification and to determine what supports might best assist them.  

Method: A structured telephone questionnaire was administered to men and women recently diagnosed with chlamydia from Victoria, the ACT and Queensland.  

Results: Of the 275 individuals approached to participate, 202 (73%) completed the telephone questionnaire.  Of those, 67 (33%) were men who reported sex with men (MSM), 67 (33%) were men who had sex with women only (non-MSM) and 68 (34%) were women.  MSM reported a higher median number of sexual partners in the prior six months (6, range 0-80) compared with non-MSM (4, range 0-50) or women (2, range 1-10).  The median number of partners who had been contacted was two for MSM, one for non-MSM, and one for women.  The most commonly cited reasons for informing partners was out of concern for them, 44% (88/202), or because it was ‘the right thing to do’, 37% (75/202).  Contacting partners by phone 52% (105/202), or face-to-face 30% (61/202), were the preferred methods.  Few experienced verbal or physical abuse/threats from partners, 5% (9/169).  Fifty six percent of participants indicated that they would have liked to have been given a dose of antibiotics to give to their partner.  Of those individuals, 68% (76/112) felt that it would have been more likely that their partner would have been treated if they had been provided with an additional dose of antibiotics.  Of the individuals who had not contacted all their partners, 31% (38/124) felt that the availability of resources such as web based tools would have led to them contacting more partners.  

Conclusion: Partner notification is being undertaken to some extent by chlamydia infected individuals; however, the availability of a range of tools and supports is likely to result in a higher proportion of partners being contacted.
P37
OUTCOMES OF THE STAMP OUT CHLAMYDIA PROJECT

Currie MJ, O’Keefe EJ, Bavinton T, McNiven M, Schmidt M, Davis BK, Baynes A, and Bowden FJ.

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Aims
Describe the education and screening outcomes of the Stamp Out Chlamydia (SOC) Project in the ACT (Australian Capital Territory).

Methods
Chlamydia health promotion and screening were offered to tertiary students (aged 16-25) on 8 tertiary campuses in the ACT (12/2/2007 - 1/5/2008). A community development model underpinned a range of activities. Chlamydia education was provided through written materials, the Internet, SMS and discussions with SOC staff. To participate, students provided verbal consent, a urine specimen for chlamydia testing and their phone number.

Results
Of the 17,500 eligible students on ACT campuses, ~15,000 were exposed to the SOC Project. In addition, ~42,300 young people viewed the SOC convenience advertising conducted on campus and at nearby licensed venues. 59 events were conducted during the study period and 2,380 urine specimens collected for chlamydia testing (1356 male; 969 female). 33 individuals (15 male; 18 female) were diagnosed with chlamydia from 37 tests (one male three times during a week-long event and another male tested positive in March and August 2007). 177/2380 participants were outside the target age group (range 14 - 46 years); and six (3.7%) were diagnosed with chlamydia. All cases (33) were contacted by SOC Nurses and informed of their results, offered free treatment and contact tracing was discussed. 32 positive cases (15 male; 17 female) were treated at Canberra Sexual Health Centre (30), in General Practice (1), at Sydney Sexual Health Centre (1).

Selected characteristics of cases

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No.</th>
<th>% of positives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>15</td>
<td>45.5</td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
<td>54.5</td>
</tr>
<tr>
<td>Reported overseas acquisition</td>
<td>6</td>
<td>18.8</td>
</tr>
<tr>
<td>Out of target age group (26-33yrs)</td>
<td>6</td>
<td>18.2</td>
</tr>
<tr>
<td>Pelvic Inflammatory Disease</td>
<td>4</td>
<td>12.1</td>
</tr>
<tr>
<td>Aboriginal or Torres Strait Islander (or partner of)</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>MSM</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Previous genital chlamydia infection with associated reactive arthritis</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>Other ST/BBV*</td>
<td>1 (Hep C)</td>
<td>3.0</td>
</tr>
</tbody>
</table>

*Old diagnosis

Conclusions
Chlamydia education and screening on tertiary campuses exposed a large number of students to information and enabled chlamydia screening. The prevalence of chlamydia in the study population was low, but this model is transferable to areas of higher prevalence.
P38
ORAL POSTER MONDAY 15 SEPTEMBER 1551 – 1558

SEXUAL HEALTH ORAL POSTER SESSION: PEARLS OF WISDOM

PROMOTING SEXUAL HEALTH AND ACCESS TO YOUNG PEOPLE USING A PARTNERSHIP APPROACH WITHIN A COMMUNITY BASED YOUTH SERVICE IN SYDNEY.

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Wilds S1, Pullen L2.
1 St George Youth Services; 2HIV/AIDS and Related Programs Unit, South Eastern Sydney Illawarra Health, NSW, Australia; 3Area Youth Health Coordinator, South Eastern Sydney Illawarra Health, NSW, Australia; 4Short Street Centre Sexual Health Clinic, South Eastern Sydney Illawarra Health, NSW, Australia; 5St George Division of General Practice, NSW, Australia.

Best practice indicates that creating supportive environments and raising awareness of health issues are key factors in increasing young people’s access to health services. Their access to mainstream sexual health providers may be limited by concerns about confidentiality, trust and embarrassment in disclosing sexual health issues.

The UpZone was established in 2005 as a pilot project by a range of agencies in the area. It is located in a non-government youth service and offers free integrated drop-in services, including access to general practitioners, a sexual health nurse and drug and alcohol services, to young people aged 12-25 years old in the St George area.

The project is a unique example of the way that strong partnerships between agencies can successfully build the capacity of a community to address an emerging need for young people when limited resources are available.

In October 2007 the UpZone received funding to promote the clinic more widely, and to develop sexual health promotion strategies including a youth peer education project. This work aims to increase knowledge of sexual health issues among young people and increase service accessibility. After five months, this has resulted in an increase of 50% in client attendance to the UpZone. A youth participation strategy has also been initiated with peer educators forming a youth reference group to provide input on resource development and various aspects of the clinic.

Evaluation of the UpZone is being conducted. This will provide data on clients’ demographics, primary reason for attendance, sexually transmissible infection diagnoses, referrals made to other services, and number and type of sexual health services provided.

This paper will outline the process of health promotion strategies, findings of the evaluation, and comment on the effectiveness of these strategies and the access of young people to the clinic.

P39
LONG-TERM NATIONAL SURVEILLANCE FOR GENITAL WARTS THROUGH AUSTRALIAN SEXUAL HEALTH SERVICES

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A national program using human papillomavirus (HPV) vaccines in Australian teenage girls and young women requires systems that can provide long-term surveillance for trends in HPV-related diseases, which include cervical cancer and pre-cancerous lesions (most due to HPV types 16 and 18) and genital warts (mostly types 6 and 11). Conditions related to HPV types 16 and 18 are largely detected by laboratories, thus enabling laboratory-based surveillance. However genital warts are predominantly diagnosed clinically, thus requiring clinical surveillance.

We are developing a genital wart surveillance system through Australian Sexual Health Clinics to monitor the impact of the introduction of an HPV vaccination program with the aim of addressing the following questions:
1. Is the relative rate of diagnosis of genital warts in young women declining over time?
2. Is the rate of decline in warts different depending on the type of vaccine given?
3. Is there evidence of a flow-on protective effect for their male sexual partners or young men in general?
4. Is there any evidence for a direct protective effect of HPV vaccination for young men, including men who have sex with men?

The methodology is an extension of the ACCESS (Chlamydia surveillance) model which involves collating de-identified data on priority populations attending the services: demographics, gender of sexual partners, and involvement in sex work. For the purposes of wart surveillance, additional data items of interest will be HPV vaccine status, sex overseas (possibly with unvaccinated people), sex with people from overseas, and a new diagnosis of ano-genital warts. All data will be extracted from routine clinical databases, thus minimising the imposition on the clinical services.

This is Australia’s first national collaboration for the surveillance of genital warts.
P40
ORAL POSTER TUESDAY 16 SEPTEMBER 1445 – 1452

SEXUAL HEALTH PROFERERD PAPERS: SOCIAL RESEARCH: CHAMPAGNE DIAMONDS

AUSTRALIAN MEN AND CHRONIC PELVIC PAIN (CPP): COMPARATIVE RESULTS OF THE NATIONAL INSTITUTE OF HEALTH CHRONIC PROSTATITIS SYMPTOMS INDEX (NIH-CPSI) AND THE CPP SCALE USING DATA FROM THE AUSTRALIAN LONGITUDINAL STUDY OF HEALTH AND RELATIONSHIPS.

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Objective: The NIH-CPSI has gained international recognition as a valid scale for male chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS). There exists no Australian data utilising the NIH-CPSI. This paper compares the NIH-CPSI against the CPP scale and, moreover, identifies the prevalence of chronic prostatitis in a representative sample of Australian men.

Methods: Using data from a representative household sample of Australian men 16-64 years who completed a computer assisted telephone interview.

Main Outcome Measure(s): The NIH-CPSI consists of 9 items addressing four aspects of chronic prostatitis – pain, urinary function, impact and quality of life - during the previous week. The CPP scale addresses pain associated with sexual intercourse (dyspareunia), urination, and any other pelvic pain during the previous 12 months.

Results: On the NIH-CPSI 8% of men indicated some form of genitourinary pain: 5% with a score greater than 5. Over 40% of men reported urinary problems: 4% indicating both voiding and frequency problems at least once. Almost 10% of men with pain or urinary problems indicated an impact on daily activities; 32% were less than satisfied if symptoms were to remain. Urination pain was reported by 2% of men; dyspareunia by 1%. With respects to the CPP scale 5.5% of men reported urination pain during the last 12 months with almost 8% reporting this occurred at every void. Dysparunia was reported by 5% of men: 5% indicating this occurred every time. Other pelvic pain was report by 12% of the sample.

Conclusions: The implementation of the NIH-CPSI in this study provides valuable information to professionals about male CP/CPPS: currently non-existent in Australia. However, unlike the CPP scale used which addresses symptoms over the previous 12 months and frequency the NIH-CPSI is more acute; questions only address the previous week.
HPV SURVEILLANCE: RESULTS FROM A PILOT PROJECT

Freedman E, Bateson D, Estoesta J, FPNSW, Ashfield, NSW 2131

Current Cervical screening guidelines recommend HPV testing as follow up after treatment for a high grade cervical lesion. However the practical implications of HPV testing as part of ongoing screening are not yet demonstrated.

From June 2006 to December 2007 at the Inner Metro Family Planning NSW clinic we tested 390 women for HPV DNA (Digene Hybrid Capture 2 Test) as part of cervical screening on the basis of previous high grade cervical lesions. The time from treatment to the HPV test varied from less than one year to 29 years (mean 12 years).

The positive rate for the initial HPV test was 9.0% (35/390). Twenty-six (74.3%) of the women testing positive for high risk HPV had a negative Pap test at this time. The mean age for testing was 43 years (22 to 69 years) and women who tested positive were significantly younger than those who tested negative (38 years versus 43 years, 95% CI). There was no difference in the time from treatment for women who tested positive compared with those who tested negative for HPV DNA.

It is known that most HPV infection is transient however it is possible that women who have had previous cervical lesions are at risk of developing new lesions, due to increased susceptibility to HPV infection or decreased immune clearance. Testing for HPV has been shown to be of some benefit in identifying women in whom treatment has failed but the usefulness of a negative HPV test within the year after treatment may not be predictive of long term outcome.

Longitudinal HPV DNA surveillance data such as this from routine clinical practice will help to refine the role of testing as part of cervical screening and will lead to the development of testing guidelines for women with a previously treated cervical lesion.

NEEDS OF FEMALE MEDICAL STUDENTS ABOUT REPRODUCTIVE HEALTH EDUCATION USING FOCUS GROUP DISCUSSION METHOD

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Women Affairs Office, Ministry of Health and Medical Education, Tehran, Iran

Reproductive health is a state of complete physical, mental and social well-being, in all matters relating to the reproductive system and to its function. Improvement of the women's health requires not only good health services, but also their cooperation. Educating people about the importance and details of health care are necessary to ensure the best individual cooperation. In order to plan an appropriate educational program, assessment of knowledge and insights of the target group is needed. In this project, thorough focus group discussion, insights of female medical students about reproductive health have been evaluated. A questionnaire was designed about reproductive health, and its questions were discussed by the 12 selected female medical students.

We concluded that although the students’ insight about reducing uncontrolled population was accepted but their information about family planning, sexually transmitted diseases and HIV were not significant. Most of them believed that our reproductive health education is neither enough nor appropriate, so they could not be good messengers of reproductive health in their society. In addition, theoretical, microbiological and demographic bases are more attended in these educational university programs and unfortunately operational aspects of reproductive health, family planning, sexually transmitted diseases and their ways of transmissions and prophylactic methods are less considered.

Many of the students believed that 20-25 and 24-28 years are the most suitable ages for marriage for the girls and boys respectively. Most of them suggested beginning reproductive health education in school. Considering the fact that marriage is delayed and because of our cultural background, today we need practical plans for answering to young people’s needs, also there is a need for discussions and recommendation of specialists and exports, in addition to find strategies to facilitating marriage by the government.
Notifications of chlamydia, the most common sexually transmitted infection (STI), continue to increase in Victoria and nationally, with the majority of infections found among young people. Previous studies have shown that a high proportion of young people are sexually active yet condom use is inconsistent, STI knowledge is poor and most do not have regular STI tests. New and innovative methods are required to reach this high-risk group to increase condom use and encourage regular STI testing in order to decrease the transmission of STIs. Text messages are a highly promising method of sexual health promotion as most young people own mobile phones, messages can be sent to multiple recipients simultaneously, are delivered immediately and are low-cost.

In January 2008 2552 young people aged 16-29 were recruited from a music festival. They completed a short questionnaire covering demographics, sexual health and risk behaviour and were asked to provide their mobile phone number. The average age of participants was 21.6 years; 89% had ever had sex and 39% reported multiple sexual partners in the past year. Almost two-thirds (60%) of sexually active participants had never had an STI test. Among the 49% with casual partners in the past year, 63% reported always using condoms with these partners.

Two thousand and forty-five participants provided a valid mobile number and have been receiving fortnightly text messages relating to sexual health and safer sex. To date, eight of the planned 12 messages have been sent with 279 (14%) participants choosing to withdraw from the messages. Most withdrawals (n=157, 56%) occurred in the first eight weeks. The final message and follow-up survey will be conducted in July 2008. The progress of this study suggests it is feasible to send sexual health promotion messages to a large group of young people with acceptable retention rates. Breakdown of withdrawals from valid numbers (in case you are interested)

<table>
<thead>
<tr>
<th>Withdraw Message</th>
<th>Withdraw Reason</th>
<th>Number Withdraw</th>
<th>Percent Withdraw</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Stop</td>
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</tr>
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<tr>
<td>3</td>
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<td>2.7%</td>
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<td>Stop</td>
<td>34</td>
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<td>34</td>
<td>1.7%</td>
</tr>
<tr>
<td>7</td>
<td>Stop</td>
<td>35</td>
<td>1.7%</td>
</tr>
<tr>
<td>8</td>
<td>Stop</td>
<td>20</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

2045 100.0%
Study Objective
There is little information available regarding the prevalence of Chlamydia Trachomatis in young men in the general population. The community based rate of infection is estimated to be 4.6%, but this is thought to reflect an over-representation of high-risk groups. The aims of this study were: 1) estimate the rate of Chlamydia infection in young men attending general practitioners in the Perth metropolitan area, 2) assess behavioural factors associated with having the disease, and 3) assess GP management of patients testing positive.

Methodology
Sexually active men (15-29 years) were recruited from 8 general practices in Perth, Western Australia. Participants were required to complete a questionnaire concerning their sexual orientation, history, behaviours and genital symptoms and provide a urine sample for PCR testing for Chlamydia. If a participant returned a positive PCR result, the treating doctor was contacted by a researcher 2 weeks following the test to assess patient follow up.

Results
401 men were recruited. 373 had urine results available. Of these, 3.8% (95% CI, 2.1-6.2) returned a positive PCR result for Chlamydia Trachomatis. There were no remarkable differences between the sexual practices and behaviours of positive and negative participants, although we cannot exclude sampling bias given the small number of positive participants. All patients were followed up by their treating doctor once results were received. Despite the small number of positive participants, there was little relationship between self-reported sexual behaviour or symptoms and incidence of Chlamydia in young men. Details of these findings will be provided at presentation.

The Conclusion
Given the asymptomatic nature, it may be appropriate to offer screening for at-risk individuals, thereby moving towards curbing the increasing infection rate for this disease.
Background Few data exist on pharyngeal gonorrhoea outside clinical settings and there have been no prospective studies of pharyngeal chlamydia. We examined prevalence, incidence and risk factors for pharyngeal gonorrhoea and chlamydia in the community-based HIM cohort of homosexual men in Sydney.

Methods From January 2003, all participants were offered annual urine, anal and pharyngeal testing for N. gonorrhoeae and C. trachomatis (“study visit diagnoses”) by strand displacement amplification (BD ProbeTec). All pharyngeal ProbeTec samples positive for N. gonorrhoeae underwent supplemental porA testing. At annual face-to-face visits, participants reported diagnoses of sexually transmitted infections (STIs) made in the previous 12 months (“interval diagnoses”) and history of recent sore throat. Sexual behaviour was reported every six months. For pharyngeal gonorrhoea, study visit and interval diagnoses were combined for incidence and risk factors analyses.

Results Among 1,427 participants enrolled, pharyngeal gonorrhoea prevalence was 0.57% on initial testing and combined incidence was 4.45 per 100PY. The prevalence of pharyngeal chlamydia on initial testing was 1.06% and incidence was 0.58 per 100PY. Neither infection was associated with sore throat. Pharyngeal gonorrhoea was independently associated with younger age, higher number of male partners, contact with gonorrhoea and insertive rimming with casual partners. Pharyngeal chlamydia was independently associated with receptive penile-oral sex to ejaculation with casual partners.

Conclusion Pharyngeal gonorrhoea infection was common in the HIM study and its association with rimming suggests a broader range of sexual practices may be involved in transmission of gonorrhoea to the pharynx than previously acknowledged. The incidence of pharyngeal chlamydia was much lower than for pharyngeal gonorrhoea. However, the high baseline prevalence relative to the low incidence suggests that infection may persist for long periods if left untreated. Occasional screening for pharyngeal chlamydia in homosexual men who frequently practise receptive oral sex to ejaculation may be warranted.
P47
ORAL POSTER MONDAY 15 SEPTEMBER 1710 – 1720

SEXUAL HEALTH PROFFERED PAPERS - PUBLIC HEALTH: CULTURED PEARLS

SEX AND SPORT: CHLAMYDIA SCREENING IN RURAL SPORTING CLUBS

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1. Macfarlane Burnet Institute for Medical Research and Public Health, Melbourne, VIC, Australia; 2. Key Centre for Women’s Health in Society, University of Melbourne, VIC, Australia; 3. Women’s Health Loddon Mallee, Bendigo, VIC, Australia.

Objectives: To determine the feasibility of a chlamydia testing outreach program among 16-25 year old males and females in rural Victoria undertaken at local sporting clubs, and to determine the prevalence of chlamydia and understand sexual risk behaviour in this population.

Methods: Young people were recruited after a night of sporting practice from the Loddon Mallee region of Victoria, between May and September 2007. Participants completed a brief questionnaire regarding risk taking behaviour and provided a urine sample. They were given condoms and health promotion materials about sexually transmitted infections (STIs). Those positive for chlamydia were managed by telephone consultation with the Melbourne Sexual Health Centre.

Results: Seven hundred and nine young people participated in the study; 548 (77%) were male; participation rate on recruitment nights was over 95%. Five hundred and forty six participants (77%) were sexually active and the chlamydia prevalence in this group was 3.9% (95%CI 2.6,5.7); (5.6% (95%CI 2.6,10.3) in females and 3.5% (95%CI 2.1,5.4) in males). Alcohol and drug use was common with approximately 60% of males and 20% of females having consumed alcohol at short term ‘risky’ levels at least weekly and 60% had used an illicit drug in their lifetime. STI knowledge was generally poor and only 25% used a condom the last time they had sex. Economic analysis suggests the program was more cost effective than standard opportunistic testing.

Conclusion: Sporting clubs represent a cost effective, feasible, acceptable and innovative community based setting to screen, treat and educate young people in a rural and regional setting, especially for males.

P48
PREVALENCE OF SYPHILIS AMONG ANTENATAL CLINIC ATTENDEES IN KARACHI, PAKISTAN

Shah S

Objectives: A cross-sectional multi-center pilot study was conducted to determine the prevalence of syphilis among pregnant women in Karachi. Methods: Data was collected through a structured questionnaire from antenatal clinics attendees at three hospitals of Karachi (1) the Civil hospital, (2) the Kharadar General Hospital Karachi, and (3) the Ibrahim HYDERI Hospital. Blood samples were drawn for syphilis serological tests after getting informed consent from study participants. Results: Among the 800 women enrolled in our study, the overall prevalence of syphilis was 0.9%. Women married to men with a lower educational background and women who declared having extramarital relations and who where drug users had higher syphilis prevalence and the difference was significant. None of the risk factors which originally qualified for inclusion in a multivariable model were found to be statistically significant. Conclusions: While this study reported overall low syphilis seroprevalence rates among ANC attendees which were comparable to several other existing population-based studies in Pakistan, the main worry for Pakistan remains the existence of bridge populations for syphilis (such as IDUs, who are often married, and Hijras who serve as receptive prostitutes) among whom the rates of syphilis are much higher. An interesting fact that came out of our study is that a majority of our syphilis cases were found among the attendees of the Ibrahim HYDERI Hospital among whom injection drug use is very common. Because of the dual risk of adverse perinatal outcome related to congenital syphilis and of the potential facilitation of HIV transmission (particularly among existing bridges populations such as IDUs and their dependants), we therefore highly recommend the implementation of universal antenatal syphilis screening toward the national efforts for prevention and control of STI and HIV/AIDS despite the current low prevalence in the general population.
P49
ORAL POSTER MONDAY 15 SEPTEMBER 1720 – 1730
SEXUAL HEALTH PROFFERED PAPERS - PUBLIC HEALTH: CULTURED PEARLS
COMMUNITY-BASED SURVEILLANCE OF SEXUAL BEHAVIOUR, 2005-2008
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With the prevalence of chlamydia and other STI rising in Australia, we need to determine whether there have also been changes in sexual risk behaviour. It is important to undertake behavioral surveillance in young people - the group at greatest risk of STI. We have conducted serial cross-sectional surveys of young people at a Melbourne music festival. From 2005 to 2008 over 5,000 questionnaires have been completed by people aged 16 to 29. Logistic regression, adjusted for age and gender, was used to determine trends in risk behaviours. We defined people being at risk of STI if they reported a new, casual or multiple recent partners and inconsistent condom use. The proportion of people at risk decreased from 33.8% in 2005 to 29.4% in 2008 (OR 0.92, 95% CI 0.87-0.97). There was no change over time in the proportion reporting multiple partners (OR 0.97, 95% CI 0.92-1.02) but consistent condom use increased in this group from 27.8% to 33.7% (OR 1.17, 95% CI 1.07-1.28). Having a new partner in the prior three months decreased significantly from 32.1% to 25.2% (OR 0.77, 95% CI 0.77-0.90), accompanied by an increase in consistent condom use from 50.0% to 56.7% (OR 1.21, 95% CI 1.05-1.39). The proportion of people reporting casual sexual partners increased from 46.2% to 55.1% (OR 1.25, 95% CI 1.15-1.35) although condom use with casual partners remained around 60% (OR 1.07, 95% CI 0.95-1.21). In multivariate analysis being at risk of STI was associated with recent drug use, regular binge drinking and being aged 20 to 29 years. Despite increases in STI notifications, risk behaviors (other than having casual partners) appear to be decreasing in this group. One possible explanation is that the increasing STI diagnoses are largely due to increased STI testing. An alternate explanation is that having casual partners is a greater driver of STI transmission than inconsistent condom use. The young people we surveyed reported risk behaviors at much higher prevalence than their age counterparts in other studies. Music festivals are a useful setting for monitoring trends within a high-risk subpopulation of young people.

P50
TRENDS IN CHLAMYDIA PREVALENCE AND RISK BEHAVIOURS AMONG YOUNG PEOPLE: VICTORIAN SENTINEL SURVEILLANCE
Lim M1,2, Goller J1, Guy R1, Hocking J1,2, McNamee K1, Gold J1, Fairley C1, Kelly N3, Henning D1, Timms J1, Hellard ME1,2
1Centre for Epidemiology and Population Health Research, Burnet Institute, Melbourne, VIC, Australia; 2Department of Epidemiology and Preventive Medicine, Monash University, Melbourne, VIC, Australia; 3Key Centre for Women’s Health, Melbourne University, Melbourne, VIC, Australia; 4Family Planning Victoria, Box Hill, VIC, Australia; 5Melbourne Sexual Health Centre, Carlton, VIC, Australia; 6Royal Women’s Hospital, Parkville, VIC, Australia; 7Royal Children’s Hospital, Parkville, VIC, Australia.

In Victoria and nationally, chlamydia diagnoses have steadily increased over time with most notifications among young men and women. These data arise from passive surveillance that is highly dependant on testing patterns. Most estimates of chlamydia prevalence and risk factors in Australia are from studies among clinic attendees, however these have generally been based at single clinics, focused on females and not repeated to determine time trends. To better understand chlamydia epidemiology in Victoria, a sentinel surveillance network based in 12 sexual health and primary health services was established in April 2006. At sentinel sites, clinicians offer demographic and behavioural questionnaires to all clients undergoing routine chlamydia testing. Questionnaire findings were linked with laboratory results. This paper describes chlamydia prevalence and risk behaviours among young heterosexuals in two time periods; April-December 2006 and January-June 2007 during which 6139 questionnaires were received from 9725 individuals tested (response rate 63%). In 2006, the median age of males was 28 years and 23 years for females, 37% of males and 14% of females had STI symptoms, 68% of males and 46% of females reported casual sexual partners in the last year and 66% of males and 61% of females reported inconsistent condom use with these partners. These proportions were similar in 2007. In males, 7.4% (95% CI=6.1-8.8) were diagnosed with chlamydia in 2006 compared to 8.4% (95% CI=6.8-10.2) in 2007. In females, chlamydia prevalence was 8.0% (95% CI=3.0-4.6) in 2006 compared to 4.8% (95% CI=3.7-6.1) in 2007. Chlamydia prevalence was higher in those aged 16 to 24, reporting STI symptoms, multiple sex partners or inconsistent condom use. Trends over time in testing will be presented. Results from this clinical-based sentinel network provide a more comprehensive picture of chlamydia epidemiology in Victoria that will be valuable to inform and evaluate public health interventions such as screening programs.
Factors Associated with STI among Young Women: Findings from the Australian Longitudinal Study on Women's Health

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Objective: This paper examined sociodemographic, health, sexual behaviour, relationship and health service use factors associated with self-reported sexually transmitted infection among Australian women in their twenties and thirties.

Methodology: Participants were 6840 women who participated in four mailed self-report surveys for the Australian Longitudinal Study on Women's Health. Women were aged between 18-23 years when first surveyed in 1996, and were surveyed again in 2000, 2003 and 2006. Four logistic regression analysis using backwards selection examined factors associated with ever reporting a STI at any survey, and reporting a recent STI.

Summary of Results: By Survey 4 around 16.8% of the women had ever reported a STI and of these almost 40% reported a recent STI. Reporting a STI at any survey was associated with having a university education by Survey 4, being out of the workforce at Survey 1, ever reporting partner abuse, having more male sexual partners and younger age at first sex, and being up to date with Pap tests. Reporting a recent STI was associated with being unpartnered and using condoms at Survey 4, not being up to date with Pap tests at Survey 1, having more male sexual partners and older age at first sex, reporting no sexual abuse at Survey 1 and having fewer pregnancies/pregnancy events at Survey 1 and Survey 4.

Conclusion: Women who are well educated and actively monitor their sexual health and attend for regular pap smears are likely to be diagnosed and treated if they contract an STI. Further examination of patterns of STI infection among women in their twenties and thirties are warranted.

Improving the Accuracy of Aboriginal and Non-Aboriginal Disease Notification Rates Using Data Linkage

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Routinely collected infectious disease surveillance data provide a valuable means to monitor the health of populations. Notifiable disease surveillance systems in Australia have consistently reported high levels of completeness of demographic data fields of age and sex, but low levels of completeness of Aboriginality data. Significant amounts of missing data associated with case notifications can introduce bias in the estimation of disease rates by population subgroups.

The aim of this analysis was to evaluate the use of data linkage to improve the accuracy of estimated notification rates for sexually transmitted infections (STIs) and blood borne viruses (BBVs) in Aboriginal and non-Aboriginal groups in Western Australia.

Probabilistic methods were used to link disease notification data received in Western Australia in 2004 with core population health datasets from the established Western Australian Data Linkage System. A comparative descriptive analysis of STI and BBV notification rates according to Aboriginality was conducted based on the original and supplemented notification datasets.

Using data linkage, the proportion of STI and BBV notifications with missing Aboriginality data was reduced by 74 per cent. Compared with excluding notifications with unknown Aboriginality data from the analysis, or apportioning notifications with unknown Aboriginality based on the proportion of cases with known Aboriginality, the rate ratios of chlamydia, syphilis and hepatitis C among Aboriginal relative to non-Aboriginal people decreased when Aboriginality data from data linkage was included.

Although there is still a high incidence of STIs and BBVs in Aboriginal people, incompleteness of Aboriginality data contributes to overestimation of the risk associated with Aboriginality for these diseases. Record linkage can be effectively used to improve the accuracy of estimated disease notification rates.
P53
SEXUALLY TRANSMITTED INFECTIONS IN A POPULATION OF AFRICAN REFUGEE WOMEN ATTENDING A SEXUAL HEALTH CLINIC IN NEWCASTLE, AUSTRALIA

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Objective
Sexually transmitted infections (STIs) are often perceived to be more prevalent in certain populations. This study examines the prevalence of STIs amongst a group of newly arrived refugee women from several African countries.

Method
From May 2006, quarterly sexual health clinics were conducted for refugee women in the Newcastle Area, following a successful pilot clinic in November 2005. Women were recruited via the migrant health service and local refugee settlement services. Recruitment was aimed at women who had arrived in Australia within the last 6 months, although no client presenting was denied service. Consultation was conducted with interpreters and full sexual health screening was offered.

Results
From November 2005 to September 2007, 54 refugee women were seen. Demographics and sexual history will be reported. Tests taken and results will be discussed.

Conclusion
Issues affecting testing and treatment will be discussed, including barriers to health care and cultural issues.

P54
SEXUALLY TRANSMISSIBLE INFECTION AND BLOOD-BORNE VIRUS HISTORY AND SEXUAL HEALTH KNOWLEDGE AMONG PRISONERS IN NEW SOUTH WALES

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Objective: To examine reported rates of various sexually transmissible infections (STIs) and levels of sexual health knowledge among prisoners in New South Wales.

Method: A random-sample survey of inmates in NSW prisons (1118 men, 199 women) was conducted by computer-assisted telephone interview.

Main outcome measure(s): Self-reported lifetime experience of a list of named STIs and other related conditions, HIV and hepatitis B and C. Responses to true/false sexual health knowledge statements.

Results: The most commonly reported sexually transmissible genital condition among men was pubic lice (21%) and among women ‘any other genital problem’ (21%). Genitoanal warts (7% men, 11% women), HPV on Pap smear (10%), chlamydia (5% men, 14% women) and genital herpes (2% men, 14% women) were also common. Rates for many STIs were up to several times higher than in the general population. Less than 1% of men and only one woman had HIV.

A high proportion reported having (or having had) hepatitis C: 25% men, 45% women, reflecting high rates of injecting drug use in the past (55% men, 77% women) and high rates of needle sharing in prison among those who continued to inject while in prison.

Knowledge about herpes was similar to the general population and knowledge of chlamydia was higher. Prisoners were almost all aware that AIDS did not affect only gay men and most knew that you could not tell by looking at someone whether they might have an STI.

Conclusions: Prisoners’ STI histories reflect the risky lives and poor health care that many inmates have experienced. Evidence does not support education as a useful response. We recommend expansion of intake screening and of access to sexual health care in prison.
Objective: Concurrency of sexual relationships has been found to be a significant driver of generalised STI epidemics. We examined the agreements between people in regular heterosexual relationships with regard to sexual exclusivity and whether (1) people adhered to their agreements and (2) their relationships survived.

Methods: A representative household sample of 8,656 Australians aged 16–64 years completed a computer-assisted telephone interview and were surveyed again a year later.

Results: At Wave 1, 97% of respondents in regular relationships said they expected not to have sex with anyone other than their partner, and 97% said they expected their partner not to have sex with anyone but them. Most people (men 52%, women 68%) had discussed this with their partner. Almost all who had discussed it (>95%) had come to a clear agreement. Among couples with an agreement expecting mutual sexual exclusivity, only 4% of men and 2% of women reported more than one partner at Wave 2, i.e. had had sex with someone else. The same was true of couples with no agreement. The situation of people without explicit agreements, or where they expected one partner but not both to have sex with other people, is more complex. Of 6677 relationships, 11% had ended by Wave 2. Relationships with exclusivity agreements were less likely to survive than those without.

Conclusion: People in long-standing relationships were less likely to have discussed exclusivity; perhaps sexual fidelity is assumed by people with traditional notions of marriage. Couples who fear they may disagree about exclusivity may avoid discussing it. Health promotion advice to engage openly with this question may be fruitless for many people, given Australia’s strong ethic against ‘two-timing’. STI prevention should focus on ensuring that new couples do not embark on unprotected sex without prior testing.

The prevalence of female gonorrhoea in urban Australian sexual health clinics is thought to be very low, leading to debate about the utility of routine screening for gonorrhoea in asymptomatic women. Identifying associated clinical behavioural and demographic variables of women diagnosed with gonorrhoea may allow more targeted screening practices to be initiated.

The Sydney Sexual Health Centre database identified women who were tested for cervical gonorrhoea between 1992 and 2007. Diagnostic, demographic and behavioural information were extracted to ascertain the prevalence of gonorrhoea and describe variables associated with gonorrhoea infection. Additionally, a case-control study was conducted of cervical gonorrhoea cases from January 2000 to December 2005, with 2 gonorrhoea negative women presenting on the same day selected as controls. A blinded researcher examined the medical records to determine identifiable risk factors for gonorrhoea. These included genital symptoms, being a contact of gonorrhoea, sex work, sex outside of Australia and injecting drug use.

Between 1992 and 2007, 158 women were diagnosed with Neisseria gonorrhoea. Results of the case-control study reveal that women with gonorrhoea were more likely to be a known contact of gonorrhoea (OR 86, p<0.01), have had recent sex overseas (OR 7, p<0.01), or with a partner from overseas (OR 8.8, p<0.01), be symptomatic (OR 11, p<0.01), or be a chlamydia contact (OR 11, p<0.05). Intravenous drug use and commercial sex work were not associated with gonorrhoea infection.

Very few cases of gonorrhoea were identified in asymptomatic women who were not known to be contacts of gonorrhoea. Further analysis will be conducted to determine the prevalence of female gonorrhoea and associated demographic and behavioural variables. A very low prevalence of gonorrhoea, particularly in asymptomatic women, decreases the reliability of positive NAAT test results. This has important implications for the screening of asymptomatic women presenting to urban sexual health clinics.
P57
PREDICTORS OF TRICHOMONAS VAGINALIS INFECTION IN WOMEN ATTENDING AN URBAN SEXUAL HEALTH CLINIC

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Asymptomatic women attending most Australian sexual health clinics for STI screening are tested for *trichomonas vaginalis* by vaginal wet mount microscopy. The increasing acceptance of STI screening with nucleic acid tests on self-collected samples reduces opportunities for microscopy including wet mount examination for *T. vaginalis*. The aim of this study is to investigate factors associated with *T. vaginalis* infection in women attending our clinic.

A retrospective, case-control study was performed on all cases of *T. vaginalis* infection diagnosed in female patients attending between January 1992 and December 2006. Controls were defined as the next two consecutive women who were negative for *T. vaginalis* on wet mount microscopy. Clinical, behavioral and socio-demographic parameters were collected to identify variables associated with *T. vaginalis* infection in women attending our clinic.

There were 106 cases of *T. vaginalis* identified. Preliminary results reveal that women with *T. vaginalis* were more likely to be symptomatic at presentation (OR 7.3, p<0.01) and be new clients (OR 2.4, p<0.05). Only 6 infections were diagnosed in women who were asymptomatic repeat clients (OR 10, p<0.01). Women with *T. vaginalis* infection were also significantly older and more likely to have had sex overseas, or with a partner from overseas, than control women, and to have never had a cervical smear.

Ceasing wet mount microscopy on asymptomatic women attending for repeat visits would miss very few cases of *T. vaginalis* infection. Given the extremely low prevalence of *T. vaginalis* in this urban sexual health clinic population, asymptomatic women at repeat visits do not require screening for *T. vaginalis* and can be screened using self-collected samples for other STIs.

P58
CHANGES IN SEXUALLY TRANSMITTED INFECTIONS TESTING AND DIAGNOSES IN MEN WHO HAVE SEX WITH MEN IN A SEXUAL HEALTH SERVICE

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The Australian and New South Wales sexual health strategies recommend sexual health clinics target high prevalence groups. In response to increasing rates of sexually transmitted infections (STIs) in men who have sex with men (MSM) in inner Sydney, STI testing guidelines were released in 2000-2001.

Objective
To describe trends in MSM attendances, number of STI tests performed, proportion of MSM tested, and positive yield of testing from 1996 to 2006 at a public sexual health service.

Method
The Sydney Sexual Health Clinic (SSHC) electronic database was searched for MSM attendances from 1996 to 2006. For each attendance the number of STI tests and STI diagnoses were recorded. The crude proportion of MSM tested and diagnostic test yield were calculated.

Results
Over the period 1996-2006 there was a 77% increase in the number of MSM attending SSHC. There was a large increase in the number of tests performed and an increase in the proportion of MSM tested. The increase in testing was greatest for rectal testing, with a 5-fold increase for both gonorrhoea and chlamydia. The number of STI diagnoses increased, with, the greatest a 40-fold increase in rectal chlamydia diagnoses. The percentage yield of testing increased from 1% to 5% for rectal chlamydia and decreased slightly for gonorrhoea. Syphilis yield increased from 0.1% to 1.3% while other infections remain stable or showed a slight decrease.

Conclusion
Our results demonstrate the successful reorientation of a sexual health clinic to respond to a local STI epidemic. Over the ten years to 2006 the number of MSM attending the clinic rose substantially and the proportion tested for STIs also increased. Despite this large increase in the number of tests performed the percentage yield remains high, and has even increased for rectal chlamydia. Increasing STI testing of asymptomatic MSM has increased the number of STIs diagnosed by Sydney Sexual Health Centre.
P59
ORAL POSTER TUESDAY 16 SEPTEMBER 1544 – 1551

SEXUAL HEALTH ORAL POSTER SESSION:
PEARLS OF WISDOM

CHANGES IN LIFETIME PROBABILITY OF
ABORTION FOR AUSTRALIAN WOMEN:
RESULTS FROM THE AUSTRALIAN
LONGITUDINAL STUDY OF HEALTH AND
RELATIONSHIPS

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Study’s objective: This paper aims to describe the rates
of pregnancy termination for different birth cohorts of
Australian women in relation to the legal status of the
procedure, social factors likely to influence the need for
terminations and availability of services.

Methods: We analysed data from the first wave of the
Australian Longitudinal Study of Health and Relationships,
a random sample of 4,374 Australian women aged 16-64
years, who completed a computer-assisted telephone
interview in 2005. Cumulative percentages of women
who had ever had a termination of pregnancy were
calculated in five-year age groups for each five-year birth
cohort from 1940-1944 to 1985-1989.

Results: Women born before or in 1949 were less likely
to have had a termination at any age than those born
later. Rates at each age increased for subsequent birth
cohorts up until the 1970-1974 cohort which recorded
the highest cumulative percentage of women to have
had a termination at each age. At age 26 – 30 years
this had reached 16%. For women born in 1975 or
later, cumulative termination rates have fallen for each
successive birth cohort.

Conclusions: Social changes that affect the legality and
accessibility of pregnancy termination services, as well
as those which have an impact on sexual practices, are
discernable in the reproductive histories of Australian
women of different generations.
P61
THE PUBLIC HEALTH APPLICATIONS OF LABORATORY TESTING DATA FOR SEXUALLY TRANSMITTED INFECTIONS

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Health authorities generally only collect positive results of tests for notifiable sexually transmitted infections (STIs), such as gonorrhoea and chlamydia. The notification rates calculated based on these data are known to be poor indicators for prevalence/incidence as they are substantially influenced by the amount of testing. Laboratory testing data for STIs (including all test results) supplied by pathology companies can provide denominator data and thus improve the understanding of STI epidemiology.

In addition, laboratory STI testing data can be used to monitor and assess the delivery of sexual health services to remote Indigenous communities; patterns of testing practice; yield of specific specimen collection methods; gonococcal culture rates and yield; and practice of disease notification by pathology companies. They can also be used in detecting possible changes in specificity and sensitivity of pathology assays.

De-identified STI testing data have been collected from some major pathology companies for a few years. In this presentation, we will demonstrate how such data can be used in the above-mentioned ways.

P62
SUN, SEA, SEX AND STATISTICS: ESTIMATING THE IMPACT OF BACKPACKERS FOR CHLAMYDIA INFECTION MIGRATION IN AUSTRALIA

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²Sydney Sexual Health Centre

Risk behaviour likely play major role on transmission of chlamydia infection in young heterosexual adults; however, potential impact of chlamydia migration through backpackers are unknown. Thus, we estimated the proportion of young men and women for which their risk to chlamydia infection is attributable to contact with backpackers relative to the other established risk factors. We included 13,192 men and women aged 18-30 years who attended Sydney Sexual Health Centre (SSHC) during the period of 1998-2006. We used logistic regression to estimate the relative risk of chlamydia infection by the odds ratio and estimated partial population attributable risk (PAR) using the method of Spiegelman et al, (2007). Overall, potentially modifiable risk factors such as consistent condom use and number of sex partners ≥ 3 and excess alcohol consumption, accounted for approximately 66% of the cases observed. Sex-specific analyses revealed not only differences between men and women also between backpackers versus not backpackers, suggesting that intervention measures may have to be gender-specific for backpackers and non-backpackers. In particular, the higher prevalences of excess alcohol intake and more than 3 sex partners in last three months among female backpackers accounted for gender differences in PARs. In this population, a few known risk factors account for a majority of chlamydia infection cases. In order to inform effective prevention responses there is a need to better understand the dynamics of chlamydia infection and the relative and attributable risk associated with specific risk factors and specific sub-populations such as backpackers.
P63
LEAPING INTO CHLAMYDIA AWARENESS

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Aim: To increase awareness of Chlamydia among young people in Tasmania

This project recruited young people (14-24 years old) individually or in small groups at public venues, at public events and in health promotion settings to discuss Chlamydia. The objective of these discussions was to:

- assess what young people in Tasmania understand about Chlamydia
- teach participants about the transmission, testing for and treatment of Chlamydia
- increase participants awareness of the potential consequences of Chlamydia
- develop a targeted response to ongoing Chlamydia awareness projects

Young people were invited to complete a simple questionnaire. Staff then thanked them for their participation with a Freddo frog and/or condoms and lubricant. The questionnaires, and token thank you, facilitated a discussion about Chlamydia and safer sex. This process has revealed that most young people know that Chlamydia is a sexually transmissible infection. The information gathered indicates that prior to the discussion young people are largely unaware of the potential consequences of Chlamydia; they believe it can be contracted through intercourse only and that older females in the cohort are more likely to have accurate information than other subgroups. This presentation will provide a summary of the knowledge that young people in Tasmania hold about Chlamydia and patterns relating to age, geography and gender. It will discuss the implications of this experience on future health promotion projects including the importance of age and gender specific messages, knowledge gaps and engaging young people.

P64
ORAL POSTER MONDAY 15 SEPTEMBER 1700 – 1710

SEXUAL HEALTH PROFFERED PAPERS - PUBLIC HEALTH: CULTURED PEARLS

MODELLING OPTIMAL SYPHILIS SCREENING PROGRAMS FOR MEN WHO HAVE SEX WITH MEN

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3: AIDS Council of New South Wales

The incidence of syphilis has increased in numerous cities in recent years, particularly in men who have sex with men (MSM). This is of concern due to the morbidity associated with syphilis infection but also because it is a significant cofactor for increasing the infectivity/susceptibility of HIV transmission.

We develop a biologically realistic mathematical model of male homosexual transmission of syphilis, incorporating sexual mixing networks between MSM who engage in low or high sexual activity or group sex. We calibrate the model to the Australian MSM population and use detailed biological, epidemiological, behavioural, and clinical data. The model is used to evaluate various intervention strategies, including different coverage levels, degree of synchronicity, and frequencies of testing and treating for syphilis. We also investigate the epidemiological impact and efficiency of targeting screening of different MSM subgroups. For each strategy we forecast the reduction in incidence and prevalence of syphilis over 10 years.

We find that there is a complex relationship between coverage, frequency, and synchronicity of testing for syphilis in determining the relative reduction in incidence. The more targeted the synchronicity of testing (that is, the closer in time all people are tested) the greater the population-level reduction in incidence. If the coverage level for testing is sufficiently high (i.e., greater than ~70% of the gay population test for syphilis per year) and it is maintained for 10 years then it is theoretically possible to eradicate syphilis. However, more targeted interventions, such as screening 25% of men who engage in high activity 2-3 times per year could have the same reduction in overall incidence.

Our analysis highlights the importance of high activity MSM in sustaining syphilis transmission and suggests that targeting these subgroups, particularly those infected with HIV, could be a highly-effective and efficient public health strategy.
In New South Wales, incidence rates of bacterial STI among men who have sex with men (MSM) increased dramatically since 2000. STIs play an important role in HIV transmission. To be effective for STI/HIV prevention, STI testing should be comprehensive, based on the clients’ sexuality and risk practices. However, achieving this is difficult in some contexts.

We used data from the Sydney Gay Community Periodic Survey and explored trends in and factors associated with STI testing among gay men during 2003-2007. HIV testing was more common than STI testing and remained stable during 2003-2007. Use of swabs and urine samples increased significantly, and so did the frequency of testing in a year preceding surveys. Blood testing for STI other than HIV changed little. However, a steady one-third of men had not been tested in the previous year. Significantly, some men missed opportunities for comprehensive testing: one in five HIV-negative or unknown-serostatus men who undertook HIV testing in a year before survey were not tested for other STIs, and about 23% of those who were not tested for HIV in that period had sexual health testing for STI other than HIV. Sexual behaviors (higher number of partners, having casual partners and engaging in unprotected anal intercourse with them) were associated with STI testing. HIV-positive men tested for STI more often than those not HIV-positive.

STI testing among men who were not HIV-positive has improved significantly in gay men in NSW, mostly due to the STI testing guidelines, provided by general practitioners and public sexual health services, and education campaigns. However, it remains inadequate for STI control and HIV prevention. For STI screening to deliver any significant sexual health dividend, appropriate and comprehensive screening is essential. In the context of increasing STI incidence among MSM locally and globally, this should not be taken for granted.
SOCIAL RESEARCH

P66
HOW MANY IS TOO MANY? GAY MEN’S PERCEPTIONS OF NUMBERS OF SEXUAL PARTNERS: FINDINGS FROM THE QUICKIE PROJECT

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Aims:
Educational materials promoting testing for sexually transmissible infections (STIs) often encourage gay men to seek testing when they have ‘high’ rates of partner change or ‘more’ partners, yet it is rare for these materials to define what is meant by a ‘high’ number. We asked gay men in Sydney what they thought was a ‘high’ number of sexual partners and how they defined their own rate of partner change. The aim was to understand the range of ways in which men interpret messages about partner numbers and to identify any problems with the use of non specific definitions of partner numbers.

Methods:
31 sexually active, gay-identified men living in the Sydney were recruited and interviewed in 2007-8 for the Qualitative Interviews Concerning Key Issues and Experiences (QUICKIE) project and a second round of interviews is currently underway. Interviews were conducted in locations convenient for participants around key topic areas (such as sex, relationships, drugs and community) and were digitally recorded. A thematic analysis of men’s accounts is presented here.

Results:
QUICKIE participants described their sexual activity and numbers of sexual partners in relation to what they perceived as ‘high’ or ‘low’ (or ‘normal’ or ‘unusual’) levels of sexual activity among gay men. Men interpreted terms like a lot of sexual partners in a range of ways e.g. (some considered two a week as reasonable such as Octavio “I think two different people a week, that’s fine, but if you have two different people every week that starts to worry” whereas others suggested that three a week or in sex venues could be a lot such as Ray “If you were to say 1000 per year that’s three per day. If you go to a back room………you could have ten people go through past your glory hole: have you had sex with ten people? As opposed to a one on one session that’s easily definable!”). Therefore, men who reported having similar numbers of partners over similar periods of time could perceive and describe their level of sexual activity quite differently to each other.

Conclusions:
Gay men may interpret educational messages about numbers of sexual partners in a range of ways, especially if those messages do not specify how many partners is regarded as a ‘little’, ‘average’ or ‘a lot’. This means that messages may be seen as irrelevant by some of the men they are supposed to target. For gay men to perceive educational messages as relevant to them, and to understand the intent of messages about STI testing and other sexual health promotion strategies, it is preferable to clarify ambiguous terminology about partner numbers.

P67
YOUNG PEOPLE AS RESEARCH COLLEAGUES—USE OF PEER RESEARCH ASSISTANTS TO INVESTIGATE PEER BASED PROGRAMS

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Peer based youth health promotion programs outside of the school setting have had limited in-depth evaluation. A barrier has often been the capacity of research to track and engage with marginalised youth involved in the programs.

The MY-Peer (Marginalised youth: participation, engagement and empowerment research) project aims to contribute to the establishment of good practice standards and evaluation in peer based health promotion programs targeting marginalised youth. The research is a collaboration between the Western Australian Centre for Health Promotion Research (WACHPR) and a range of peer based programs being conducted by youth agencies. A core value of the programs is genuine participation from young people aged 16 to 25.

The research methodology incorporated a strong youth participation basis and included the recruitment of “Peer Research Assistants” - paid positions recruited from the young volunteers within the programs and trained to undertake adapted qualitative and quantitative research with their peers. The peer research assistants were an active part of the research team, and were involved in the development of instruments, data collection and analysis.

The approach required careful planning around training, boundaries, confidentiality, expectations and roles. However the benefits of peer research assistants and their impact on the research culture far outweighed the challenges. The youth participation achieved was significantly higher than previous approaches and resulted in significant changes in the researchers assumptions and plans for the study. The influence was far more than would have resulted from focus groups and resulted in significant changes in the researchers assumptions and plans for the study. The influence was far more than would have resulted from focus groups and representation on committees alone. However supervision, support and rapport with peer researchers required particular emphasis and results were mixed across programs.

WACHPR will be looking at expanding the approach to other areas of intervention research. If implemented appropriately this approach can achieve more relevant research outcomes for interventions and young people.
P68 HIV RISK PERCEPTION AND SAFER SEX DISCOURSE*: A PERSPECTIVE OF CHALLENGES TO HIV/AIDS PREVENTION AMONG POVERTY DRIVEN FEMALE SEX WORKERS- A PREPOSTEROUS OR PRAGMATIC QUEST!

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Background: In contemporary societies, “safe sex” practice is important to everyone who is sexually active. Safer sex practices reduce the risk of contracting sexually transmitted infections including human immunodeficiency virus (HIV). Since the advent of HIV, safer sex discourse has intensified yet global HIV infections continue to rise and more rapidly among women primarily through unprotected sexual intercourse. In many developing countries, heterosexual contact has been the predominant mode of transmission with high rates reported among female sex workers. I set out to investigate female sex workers’ level of knowledge of HIV/STI, how they perceive risk, what forms their risk perception took and if these perceptions translate into protective behaviors and to assess the challenges to “safer sex” phenomenon in the sex industry. Method: One hundred and seventy two female sex workers from fourteen different sites within the National Capital District in Papua New Guinea were interviewed through face to face in-depth interviews and focus group discussions about issues of HIV transmission, risk behaviors, risk perceptions and the factors that impact on safer sex practices and protective behaviors. Tape recorders were used to record discussions and responses from study participants. Additional information was recorded in field notes which were later transferred to activity grids. Each day, findings from the research questions asked were analyzed on the basis of the types of responses given to each individual question and using thematic analysis categorized responses under recurring themes. Data was validated through triangulation and presented on a 3 page interview summary sheet. Results: All study participants demonstrated basic knowledge of HIV but their knowledge on the role of STIs in HIV transmission was considered poor. They showed high HIV risk perception but admitted their vulnerabilities rarely translate into protective behaviors. Most study participants were swift to indicate unprotected sexual intercourse, inconsistent condom use and illicit drug and alcohol use as significant risky behaviors, these risky behaviors were common but expressed difficulties beyond their capabilities to modify them. Most sex workers when asked about condom use, 42% of the respondent said sometimes, 37% said condom use is not necessary when having sex with regular partners, 15% responded never and only 6% of the total study participants indicated being able to use and insist on condom use all the time. Reasons for not always using condoms, 40% respondents said their partners dislike sex with condoms, 35% said they trust their regular sexual partners, 22% said they are unable to negotiate condom use and 3% said it is not fun to use. Most agreed that the notion of safer sex practices is ideal but 100% condom use is unachievable. One participant said “our clients know we are desperate for money so they pry on our weaknesses”. Conclusions: High HIV risk perception does not necessarily translate into protective behaviors and safer sex practices. Identified factors are intertwined into a combination of structural, environmental and social constraints under which circumstance female sex workers are left with limited powers and opportunities to adopt or negotiate safe sex practices.
A GEOGRAPHICAL MAPPING AND SIZE ESTIMATION OF FEMALE SEX WORKERS IN PORT MORESBY, PAPUA NEW GUINEA

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Background: Information on the size of female sex workers, where they congregate and operate is important. Precise locations and actual size estimation is vital for conducting research, behavioural surveillance surveys, situation analysis etc. And for programmatic purposes, ample information and understanding of the size, typology and locations of sex workers is paramount for planning and implementation of comprehensive interventions. In Papua New Guinea (PNG), reliable data on the number of sex workers is dearth given the illegal status and clandestine nature of sex work in addition to issues related to stigma. In order to understand the operational typology of female sex workers, assess the magnitude of the epidemic and to calculate effective means to curb it, this study attempts to map popular locations and estimate the number of sex workers in Port Moresby.

Methods: Geographical mapping, direct observation and actual counting approaches were employed to estimate the number of sex workers. Geographical mapping was carried out to locate vicinities where sex workers solicit their clients. Sex workers were recruited to take part in the study. Additional information was sought from key informants, gatekeepers and relevant sex workers social networks. Several locations were identified and mapped, actual contacts were made with a number of sex workers and others were only observed according to informants’ reports. At each of these locations, sex workers were manually counted and then aggregated to estimate total number of sex workers in all the sites visited. Target sample size for each site was set, however sometimes selection of respondents continued until the point of saturation whilst minimizing double counting as much as possible. Triangulation method was employed to deduce reliable statistical information. Results: This exercise identified and mapped 14 sites around Port Moresby, the National Capital District. Those identified were settlements, urban villages, peri urban slums, ports, water front/ wharf, motels, guest houses, hotels, “pamuk houses”, bars, discos, night clubs etc. The study concluded that there is an estimated 550 sex workers in the 14 locations and were of the “2 Kina” and “Disco Meri” categories. Of the total 550, actual personal contacts were made with 212 respondents and 293 through observation and informants reports. Sex workers and local informant’s reports confirmed additional sex worker sites but designated “no go zones” and therefore avoided.

Conclusions: More systematic techniques are required to reach hard to reach populations to yield accurate estimations and to avoid over or under representation of study findings.

Key words: Qualitative, Ethnography, Female Sex Workers, Mapping, Size Estimation, Port Moresby, Papua New Guinea.
P70
EXPLORING LESBIAN SEXUAL HEALTH PRACTICES

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It is a commonly held belief that lesbians are at low or no risk of sexually transmitted infections (STIs) regardless of their sexual practices. Consequently, many lesbians and their general practitioners make the assumption that lesbians do not need to be screened for STIs. Is this assumption correct? What do we really know about the sexual practices of lesbians?

The bi-annual Sydney Women and Sexual Health (SWASH) survey is a cross-sectional survey of women in contact with gay, bisexual and lesbian communities. Women are recruited at the Sydney Gay and Lesbian Mardi Gras Fair Day and at other groups, venues and clinics. Results from SWASH have indicated that 26% of respondents had had sex with gay or bisexual men (6% in the last 6 months), which raises the possibility that many lesbians may be exposed to STIs including HIV that are more common in the gay community.

The study also showed high rates of drug and alcohol use, high rates of tobacco smoking and relatively low rates of sexual health screening.

Using results from the 2006 and 2008 SWASH surveys, this presentation will explore the sexual health practices of lesbians and same sex attracted women, with particular focus on attachment to the GLBT community, sexual identity, sexual practice, drug use, health behaviour and knowledge. It is anticipated that conference attendees will gain a better understanding about lesbian sexual health and practices and what this means in terms of general lesbian health.

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P71
INFORMING YOUNG PEOPLE IN THE TERTIARY SECTOR ABOUT CHLAMYDIA

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Aims
Describe strategies used to engage and inform tertiary students about chlamydia during the Stamp Out Chlamydia Project (SOC) conducted in the Australian Capital Territory (ACT) - 12 February 2007 and 1 May 2008.

Methods
A community development approach was used to facilitate engagement with tertiary students aged 16-25 years on eight campuses. Three models of engagement were tested - Private Participation, Incentive Based and Altruistic models. A range of strategies was used to engage the target group: posters; advertisements in student diaries and newspapers; incentives and convenience advertising. Health promotion and chlamydia screening were offered at sporting, music and social events and in student accommodation. Outcome measures include approximate numbers of students exposed to the project and the number of urine specimens obtained on campus. A Private Participation Model offered reluctant students the capacity to participate without engaging with staff. Students were awarded points towards their scores at Scavenger Hunts and Trivia Nights.

Results
32,000 students were reached through advertisements in their diaries; approximately 42,300 young people were exposed to the convenience advertising campaign; 10,300 students were exposed to SOC during 12 events where cash incentives were offered, of these 1043 received the cash incentive. 5,000 students attended 41 events where no incentives or non-cash incentives were offered. Private Participation resulted in 184 specimens collected at 3 events. The number of specimens collected was greatest when cash incentives were offered, or when students were actively engaged by their peers.

Conclusions
The community development model assisted engagement with the students and may be one way the project could be sustained. A range of methods to interact with students is important to reach sub-populations among the target groups. Convenience advertising and advertisements in diaries has the capacity to reach a large number of students. Peer engagement and financial incentives maximised engagement of the target population.
P72
YOUTH PEER EDUCATION AND BEHAVIOURAL DATA COLLECTION VIA OUTREACH IN SYDNEY

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Sexual health education via youth peer education outreach activities has been delivered in Sydney for over 10 years, with the simultaneous collection of descriptive behavioural data occurring in 2004, 2006 and 2008. Data from 2004 / 2006 surveys on sexual health and alcohol and other drug use in Sydney collected from peer education reveals the most common age of first sexual encounter is 14 years, that young men were more likely to report a higher number of sexual partners than young women and that approximately 30% of young people (16-25 years) reported using condoms every time they had sex. Peer education outreach conducted with a slightly older age range (18-30 years) in backpacker pubs and clubs reveals a similar percentage of condom usage. The most common reasons given for not using condoms for both the younger and older target groups were being affected by alcohol and/or other drugs at the time of sex, as well as condoms reducing sensation. Survey results from 2004 indicate that the most commonly used drug amongst these young people (16-25 years) was cannabis while in 2006 it was ecstasy. In 2004 51% of young people had a Medicare card and in 2006 the figure was only 25%. Findings from 2008 will be available by August 2008, and a descriptive analysis of data collected across the 3 periods will be compared.

P73
SEXUAL BEHAVIOUR OF INTERNATIONAL AND DOMESTIC STUDENTS ATTENDING BRISBANE TERTIARY CAMPUSES.

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Over a two year period, the Sexual Health Program of the Ethnic Communities Council of Queensland conducted a sexual behaviour survey of university students during Orientation Week activities at several Brisbane campuses. A convenience sample was surveyed, and a mix of domestic and international students were approached opportunistically and invited to participate. Translated versions of the survey were offered to Chinese students. Surveys posed questions concerning country of birth, language, current sexual relationships, numbers of partners, condom usage, access to various health services, injecting drug use, intoxication during sexual activity and presentation of symptoms suggestive of an STI.

Surveys were analysed according to country of birth with respondents placed into broad categories: Australian (n=310), East Asian (n=255), Other Asian (n=90), European (n=46), and African (n=30). 286 males and 445 females completed surveys.

Significantly 21-22% of East Asian male and female students reported same sex partnerships compared with 3-7% reported by Australian and other international students. More Australian students (49.7%), African students (46.7%) and European students (45.7%) report being in a regular sexual relationship compared with Other Asian (34.4%), and East Asian (27.2%) students. Between 40-45% of all student groups reported using condoms the last time they had sex. More African students (46.7%) and European students (45.7%) reported having had a sexual health check with Asian students reporting the lowest rates (12-13%). Again more African students (63.3%) reported having had an HIV test with Asian students reporting the lowest levels (20-22%).

More Australian and European students reported being intoxicated while having sex when compared with Asian students for the previous month (15.8%, 15.2%, 1-2% respectively). For all other time periods, Australian students reported more instances of intoxication while having sex.

Further results of the survey will be reported and implications for service provision considered.
P74
SEX WORK, RISK AND SAFETY IN A REGIONAL AUSTRALIAN SETTING

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The aim of the research was to explore the health and lifestyles of sex workers in a regional city in Australia. Eleven females who identified themselves as sex workers were interviewed during a four week period. Transcripts were transcribed verbatim and analysed by the two authors applying thematic analysis. Key themes identified included client violence, mental health, Sexually Transmitted Infections (STIs) and Hepatitis C, drugs and alcohol, public censure and intra-work conflict. These key themes are further analysed and the implications for risk and safety are discussed.

P75
CONDUCTING SEXUAL HEALTH RESEARCH WITH YOUNG ABORIGINAL PEOPLE USING PERSONAL DIGITAL ASSISTANCE TECHNOLOGY

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Introduction: The Aboriginal Health & Medical Research Council of NSW and the National Centre in HIV Social Research are currently undertaking a research project to assess levels of knowledge and risk practices for sexually transmitted infections and blood borne viruses of Aboriginal people in NSW aged 16-30. This research project is significant in itself by translating research into policy and practice by using innovative first of its kind technology in Australia through the administration of surveys on Personal Digital Assistance. The trialing of data collection using hand-held Personal Digital Assistance (PDA), Hand Held Device was chosen to determine the suitability of using IT with young people in health research.

Methods: Young people are being recruited through survey stalls at major Aboriginal cultural events and are asked to complete a questionnaire using a PDA. Trained recruiters give participants the option of using the hand-held device or a paper based survey. Audio recordings of the survey questions and responses are available on the PDAs via headphones at participant’s request. Eight HP iPAQ hand-held devices were loaded with a specialised program to administer the survey.

Results: To date 338 surveys have been collected using the PDAs. Very few surveys were administered through paper surveys. This method has a number of advantages over traditional paper based questionnaires. The participants have required little instruction or help in using the hand-held device, participants move through the survey faster as there are default skips built into the system, administration of the survey is perceived to be more confidential than a paper survey, and the option of listening to the survey and responding may address literacy problems.
THE SUBURBAN SHAG BAG

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Objectives: The sex industry in eastern Sydney has been well characterized. However, little is known of the sex industry elsewhere in Sydney. Western Sydney comprises of 14 Local Government areas, with an estimated population of 1.84 million. A rapidly growing region, it includes people from diverse ethnic and cultural backgrounds. Furthermore, recent demographic and legislative changes suggest that a review of current sex worker (SW) activities might be helpful in informing the development of sexual health services for this particularly vulnerable group.

We therefore sought to study self-identified SWs attending Parramatta Sexual Health Clinic (PSHC) and its outreach facilities at Mount Druitt (MD), both located in western Sydney.

The objectives were to describe the socio-demographic characteristics, sexual practices, testing patterns and sexual health of the SW population attending these sites.

Methods: Self-identified SWs presenting to PSHC and MD between 1st of April 2007 and 31st of March 2008 were identified using the clinic database. A retrospective review of case notes was then undertaken.

Results: 330 individuals attending PSHC and MD during the study period were coded as SWs. Majority (85.8%) of the SWs were female, with a mean age of 35.9 (range 19 to 73 years). Data concerning shifts per week, clients seen per shift and condom usage will be presented. Screening/testing frequency, symptoms and distribution of sexually transmitted infections will also be presented.

Conclusion: Our data provides a snapshot of current SW activity in western Sydney. Clearly these figures are only representative of those SWs who are sufficiently informed and motivated to attend existing sexual health services. It is possible that those not currently accessing services are at an even higher risk of sexual health problems. Modifying services in the light of these findings may help improve the sexual health of SWs in western Sydney.
P78
FACTORS INFLUENCING SEXUAL RESPONSE MODEL OF MALAY WOMEN IN MALAYSIA: A QUALITATIVE STUDY

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Women’s sexual health has received attention by health professionals and researchers in Malaysia. Study by Sidi and colleagues in 2007 found that majority of Malay women support Basson’s circular model of female sexual response. Objective of this paper is to present reasons behind this issue. Two Malay women, one newly married and another for more than 15 years, were interviewed face-to-face at their home. Subjects were asked regarding their sexual experience, marital relationship and sexual problems that they may had. Religious teaching, cultural factors and inadequacy of sex education were among few reasons found to influence their sexual functioning.

P79
SOCIO-CULTURAL PRACTICES INFLUENCING HIV/AIDS IN SUB SAHARAN AFRICA; REVIEW OF CURRENT STATE

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Description of problem
Around 69% of People Living with HIV worldwide are in Sub Saharan Africa (SSA). At the end of 2007, an estimated 22.5 million adults and children were living with HIV in SSA. While efforts with the aim of checking the rate of new infections are ongoing, existing socio-cultural practices in SSA greatly exacerbate the pandemic.

Methods
This paper reviews the available research evidences that link socio-cultural practices in SSA with increasing infections of HIV/AIDS and gives recommendations on how to address these issues.

Results
Poverty is a leading cause of increased HIV infections in SSA, its four predictors being Teenage marriages, Migration, Sexual trade and Polygamy. Teenage marriages occur because parents, eager to recover their investment in a daughter, have her married in exchange for dowry, often to an older man with a history of multiple partners. Immigrants resulting from famine or civil war, example in Sudan indulge in commercial sex as a means of survival. Traditional practices such as spouse sharing, widow inheritance, polygamy and genital mutilation are widespread in SSA. Among the Okun of Nigeria, sexual relations between men and wives of their male kin are accepted. Widow inheritance is widely practiced by the Luo of Eastern Africa. Stigma hinders prevention efforts since those who are infected may be reluctant to adopt behavior that might signal their HIV-positive status to others. In SSA, not breastfeeding is highly stigmatized; making it difficult for HIV positive women to protect their children.

Conclusion
Evidently, socio-cultural practices in SSA greatly exacerbate the AIDS pandemic. A multifaceted approach that includes women’s education and economic empowerment as well as modifying legal and social structures that contribute to the spread of HIV in SSA are necessary additions to intervention programs.
P80
ORAL POSTER TUESDAY 16 SEPTEMBER 1605 – 1612

SEXUAL HEALTH ORAL POSTER SESSION:
PEARLS OF WISDOM

WHAT HAS SEX GOT TO DO WITH IT?
RECONSIDERING VULNERABILITY BASED
ON FINDINGS OF A RETROSPECTIVE CHART
AUDIT OF UNDER 16 YEAR OLD ATTENDEES
AT FAMILY PLANNING QUEENSLAND (FPQ)
CLINICS.

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Since 2005, in Queensland, legislative and policy changes
have placed greater emphasis on health care provider’s
responsibilities in assessing vulnerable young people at
risk of neglect and abuse. Striking a balance between
these obligations and the need to provide confidential
sexual health services for young people has raised ethical
and medico-legal questions for the staff involved in their
care. A retrospective chart audit of all under 16s attending
FPQ clinics during 2007 was conducted to:
• Review attendance patterns & characteristics of young
people under 16 attending FPQ clinics
• To evaluate quality of assessment of young people
following implementation to legislative and policy
changes
• To identify how often issues of concern are identified
and frequency of notification to Department of Child
Safety and other welfare services

Altogether, 311 under 16 year olds attended during the
study period: 246 of these young people were sexually
active. While many of the attendees were in similar
age, consensual and ‘regular’ relationships a number of
other health and social issues were identified that raised
concern about the actual or potential well being of the
young person. A significant number of the attendees
were accompanied to the clinic with a parent or guardian
raising further considerations around consent to
treatment and the provision of confidential services for
young people.

The results of the audit has provided greater clarity for
staff at FPQ about the ‘risk of harm’ decision making
process that needs to be applied when working with
early adolescents who are sexually active. The framework
that has been developed to assist this process places an
equal emphasis on supporting healthy sexuality as much
as it does in identifying those vulnerable young people
needing support beyond the capacity of family planning
or sexual health agencies.

P81
ORAL POSTER TUESDAY 16 SEPTEMBER 1612 – 1619

SEXUAL HEALTH ORAL POSTER SESSION:
PEARLS OF WISDOM

REAL CHOICES: WOMEN, CONTRACEPTION &
UNPLANNED PREGNANCY

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Objective:
The objectives of conducting the research were to:
- survey women who had experienced at least one
unplanned pregnancy;
- investigate attitudes about and awareness of different
contraceptive methods;
- investigate women’s contraceptive use currently and at
the time of their unplanned pregnancy;
- look at the constraints on women’s decisions when they
face an unplanned pregnancy and what they thought
would expand their options at this difficult time; and
- set women’s experiences, understandings and decisions
in the context of their lives, and the broader social context
in which they make their decisions.

Methodology:
The research was conducted online by WebSurvey using
the database of Pureprofile. Invitations were extended so
as to obtain weighted samples with regard to age and
residency by state as ascertained by the Australian Bureau
of Statistics.

Results:
- Of the 2,041 women who commenced the study, 1,033
women confirmed having experienced an unplanned
pregnancy, and 60% of those were using at least one
form of contraception at the time.
- At the time of their unplanned pregnancy, the largest
group of women using contraception were on the pill
(43%), while 22% were using a condom.
- Nearly half of all women do not take into consideration
protection against sexually transmitted infections (STIs)
when choosing their method of contraception.
- 21% of the women using contraception at the time of
their unplanned pregnancy were using more than one
method.

Conclusion:
There is an urgent need to increase the range of
contraceptive options in Australia, invest in research
to improve contraceptive efficacy and implement a
dedicated contraceptive user education campaign.
P82

A SOCIAL MOBILISATION CAMPAIGN ON THE PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV

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Issue Statements: Many HIV-positive pregnant women in Malawi are not aware of how to prevent mother-to-child HIV transmission. To combat this, the Story Workshop (SWET) in Malawi has involved women in a number of activities to educate them about VCT and how nevirapine works.

Description Statement: To help prevent MTCT, SWET conducted training with local people on how prospective parents can prevent HIV infection and how to prevent transmission if they are infected and pregnant. The communities were also given funds to start small scale businesses with the aim of helping poor mothers purchase formula milk. These activities were implemented in the six districts. 1,800 women went for VCTs after participating in the project.

Lessons learned:
• Audience numbers exceeded expectations; SWET reached 8000 people. Community leaders took an active role in the mobilization campaign, while other communities agreed to discuss the issue further locally.
• Women are afraid to go for testing because they are afraid of losing their marriages if they are found to be HIV positive. This forces the women to stop visiting Anti Natal Clinics once found to be positive.
• Men are reluctant to take part in PMTCT.
• A lot of women are still giving birth with Traditional Birth Attendant and most of them are not trained.

Conclusion:
• There is a need for civic education to help communities understand the concept of PMTCT.
• Positive mothers who can’t afford formula milk should receive free formula milk or assistance from the community and international aid agencies.
• Pregnant women should be empowered to visit a VCT site even if their husbands refuse them.

P83

AN ASSESSMENT OF PREMENSTRUAL SYNDROME AND PREMENSTRUAL DYSPHORIC DISORDER IN YOUNG ADULTS AT TEHRAN UNIVERSITY OF MEDICAL SCIENCES

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Menstruation is an important biological phenomenon and studies concerning menstruation need to take into account lifestyle and cultural and psychosocial factors that define the meaning, values and behavior associated with this phenomenon. The objective of the current study was to evaluate the prevalence of a potential premenstrual syndrome (PMS) and premenstrual dysphoric disorder (PMDD) during one menstrual cycle, in a representative sample of young medical university students of Tehran, according the Pennsylvania University criteria. On the other hand, a questionnaire, available from the author, was used to explore socio-demographic data. 72 students were interviewed that the mean age of them was 21.20 years, 34 met the criteria of a potential PMS (47.21%), 20 of them showed PMDD (27.77%) and 25% of them had no complications in this area. During the premenstrual phase the following symptoms were found among the proportion with PMS and PMDD (74.98%): marked depressive mood (81.48%); difficulty of concentration (33.33%); being nervous and anxious (24.07%); irritability and anger (75.92%); marked increase in appetite (48.14%); moodiness, sadness (48.14%); hypersomnia or insomnia (51.85%); sense of being overwhelmed (25.92%); lethargy, excessive fatigue (53.70%) and physical symptoms including breast tenderness, swelling, headache, joint or muscular pain, and a sensation of bloating and weight gain (72.22%). On the other hand, 53.70% of the sample had a disturbance in their socio-professional lives as a consequence to the psychological disturbances. Just 18.51% of these women consulted a physician, and 24.07% used drugs (mostly herbal ones). Exactly half of them experienced painful periods and 37.03% reported irregular ones. Some of these students expressed a lot of stress and tension in their study and relationships, 40.74% had the wrong food habits. Unfortunately 83.33% of them didn’t exercise enough. These data confirms that these disorders are common and have a bad impact on mental health and on quality of life of the women, when the mental health and quality of life at the same time affect the prevalence of these disorders.
COMMON MYTHS AMONG WOMEN ABOUT SEXUAL RELATIONSHIPS IN PREGNANCY

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Background: There are a variety ideas and beliefs among women about sexual relationships in pregnancy period. Identifying taboos and making clear the rights and wrongs could be useful for the mental health of couples.

Aim: The aim of the study was in discovering and exploring the beliefs of pregnant women about having sex during pregnancy.

Method: The open ended interviews were conducted with 51 pregnant women who were referred to the teaching clinic in Gorgan. All of the interviews were tape recorded and transcribed line by line. The data were coded and categorized as it usual in qualitative methods.

Finding: Two main themes in the study are 1) Damage, 2) Feeling guilty. Fear of abortion, fetus suffocation, fetus abnormality, rupture of fetus hymen, and concern of the harm of the mother are some of myths among our participants. We put the myths in three categories including “benefit, right, wrong, and harmful”.

Conclusion & Discussion: There is no necessity to emphasis the importance of the sex life among couples. Since some of believes are harmful and could have negative an impact on relationships, the role of an evidence based education in providing a healthy life should be considered.

Key words: Believes, Sexual relationship, Pregnancy, Women, Gorgan

A GLANCE AT BEHAVIORAL AND SEXUAL RELATIONSHIPS A GROUP OF IRANIAN COUPLES DURING PREGNANCY

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Introduction: Pregnancy has been identified as a time of crisis for many couples and little research has explored the Iranian couples during this life-changing event.

Aim: The aim of this study was to explore the common changes of sexual and affective relationships of the couples during pregnancy.

Methods: The open ended interviews were conducted with 51 pregnant women who were referred for their routine health check up to a teaching clinic in Gorgan, Iran. All of the interviews were tape recorded. The data were coded and categorized as it usual in qualitative methods.

Results: The data indicated the pregnant women experience several changes in terms of affective and sexual relationships. Some of them are due to common myths among couples such feeling guilty of sex in pregnancy period. Nearly all of the participants stated while they feel more love to their husbands and need more kindness of them however they are not so interested in sex and try to avoid of that. To cope with some of physiological changes for having sex during pregnancy, the couples could find some solutions such a change in their sex positions. The common position was lateral one. Fear of abortion and harm to the fetus, pain, personal discomfort were some of the women concerns. In our study none of the couples met a health care provider for counseling about their sex questions.

Conclusion: Obviously, there is a need to place emphasis on the role of counseling for the couples in making clear the common myths and discussing non-answered questions. It seems counseling is a missed and ignored part in our health care service.

Key word: women, pregnancy, behavioral and sexual relationships, Iran
P86
SEXUAL ACTIVITY DURING PREGNANCY AND IMPORTANCE OF COUNSELING: A MISSING PART OF OUR HEALTH CARE
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Background: Pregnancy is a distinct period in the life of all of women that lead to hormonal and physical changes. The changes with cultural and religious influences, could affect sexuality and sexual activity during pregnancy.

Objective: The aim of this study was to explore women sexual relationships during pregnancy.

Method: The open ended interviews were conducted with pregnant women who were refereed to the teaching clinic in Gorgan. All of the interviews were tape recorded. The data were coded and categorized as it usual in qualitative methods.

Result: 73 percent of the women reported low libido during pregnancy. All of the participants refused from having intercourse during pregnancy for many reasons, such as ‘concern about their baby’s health, feeling sin, fatigue, pain and discomfort due to a big abdomen, nausea and vomiting’. Most of the participants made some changes in their coitus position. Fashionable position for 45 percent of them was ‘rear position’. None of the women were seeking neither counseling nor obtaining information from a doctor or midwife due mainly to shyness in talking about sex.

Conclusion: Many women are experience some problems in their sex life during pregnancy, which can contribute to significant emotional distress. However, women may not seek professional expertise in their attempt to alleviate this condition. It is important to assess the beliefs and experiences of all women, including pregnant ones.

Key word: sex, pregnancy, counseling, woman

P87
“MOTHERS ARE NOT MACHINES” PERSPECTIVES OF RELIGIOUS LEADERS, HEALTH PROFESSIONALS AND COMMUNITY LEADERS ABOUT FAMILY PLANNING IN PAKISTAN.
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This study describes perceptions of opinion leaders; the religious, health, and community leaders and the barriers they both identify and create for family planning among the reproductive age group in slum areas of Karachi, Pakistan. A qualitative study using semi-structured interviews and a purposive sample of 20 opinion leaders (8 religious leaders, 6 health professionals and 6 community leaders) was conducted. Thematic analysis was used to generate themes. All leaders supported the central theme, that ‘mothers are treated as machines’ by the husbands and in-laws, and disapproved of consecutive pregnancies. Islam does not approve of acts of subjugation upon the weak, especially mothers. Further themes identified by opinion leaders include ‘mutual decision making in childbirth and family planning as valued’; the benefits of family spacing and planning’; and ‘willingness of the people to accept new ideas and ways of treatment’. Some religious leaders viewed ‘spacing as conditional and considered family planning as a sin and a Western conspiracy’ against Muslim people. Condom use was supported by religious, health and community leaders but context varied. Nevertheless, building capacity for understanding and cooperation between opinion leaders was reported as a way resolve issues of family planning. Genuine ‘opinion leaders’ in Pakistani society play a powerful role as advocates for reproductive health and family planning programs. Cooperation among religious leaders and health professionals in Muslim communities for the provision of information, counselling and advocacy on this issue may be an achievable way forward. These findings may be applicable to working with Muslim countries in Australasia.
P88
ADOLESCENT'S SEXUAL HEALTH AND HIV/AIDS VULNERABILITIES IN PAKISTAN-KAP STUDY FINDINGS

Toor Z

Issues: Cultural and religious restrictions limit adolescent boys’ and girls’ access to knowledge, services and prevailing myths on HIV/AIDS and sexual health.

The Study’s Objective
Understand knowledge, attitude and perceptions on sexual health of adolescent boys and girls aging 11-13, 14-16, 17-19 years in Chakwal, Vehari and Mansehra Districts of Punjab province.

Background
Pakistan is high risk and emerging prevalence country with 63% youth population having limited political, societal and religious leadership to confront epidemic. Recent studies showed concentrated epidemic for HIV/AIDS in Intravenous drug Users (IDUs) and growing evidence on Men have Sex with Men. Inadequate sexual health services and limited access to information on adolescent sexual and reproductive health increasing the vulnerability to HIV/AIDS and Sexually Transmitted Infections (STIs).

Methodology
Knowledge Attitude & Practices (KAP-qualitative/quantitative) study, social mapping, tools pre-testing, focus group discussion, especially designed questionnaire on sexual health and HIV/AIDS was administered.

Summary of Results
None of girls aging 11-13 have knowledge on sexuality. 4.2% were involved in sexual activities; boys aging 17-19 have higher level of knowledge and 10.6% were involved in sexual activities. 38% had heard the word sex and only 9% knew safe sex practices; 4.5% girls have information on safe sex.

Conclusions:
• Lack of information on safe sexual practices, prevailing myths, and misperception making youth at risk
• Restricted access to knowledge on adolescent sexual and reproductive health and HIV/AIDS
• Adolescent do not perceive HIV/AIDS as threat to their lives believing HIV as West’s problem.
• Design early, age specific peer education to equip young people with knowledge, life skills, access to information and services
• Involve parents for supportive social environment for adolescent
• Sensitize print and electronic media
• Promote STIs and HIV/AIDS education in curriculum

P89
GENERAL PRACTITIONER SEXUAL AND REPRODUCTIVE HEALTH KNOWLEDGE. RESULTS OF THE QUEENSLAND 2008 SURVEY.

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In 2008 a survey on sexual and reproductive health knowledge and education needs of General Practitioners in Queensland was conducted by the HIV & HCV Education Projects, School of Medicine, The University of Queensland and Family Planning Queensland. The survey was sent to 6,791 General Practitioners who are registered through the Medical Board of Queensland. At the time of abstract submission, 890 surveys have been returned.

The rationale for this survey originated in the education in sexual health provided by the HIV & HCV Education Projects in Queensland was conducted by the HIV & HCV Education Projects, School of Medicine, The University of Queensland and Family Planning Queensland. The survey was sent to 6,791 General Practitioners who are registered through the Medical Board of Queensland. At the time of abstract submission, 890 surveys have been returned.

The survey asked 15 basic knowledge questions on sexual and reproductive health and 3 questions on education in sexual health. These being: Where have you obtained information about sexual health? What is your preferred mode of delivery of information on sexual health? Reasons for not participating in education in sexual health? Aligned to each of these questions was a series of responses to tick.

The data and analysis of this survey will be presented, concentrating on the basic knowledge questions.
P90
LIVING SPHERE: GUIDE TO HERPES

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Living Sphere is a support website for people with genital herpes and their partners, family and friends. Living Sphere enables people to share information, resources, personal stories and experiences and aims to increase public awareness of genital herpes.

In September 2008, Jeannie May, founder of Living Sphere, will launch the book Living Sphere: Guide to Herpes. Co-authored by Dr Stuart Aitken from the Gold Coast Sexual Health Service, the book contains a combination of factual information, real life stories, advice, tips and recommended resources to assist people recently diagnosed with or living with genital herpes. The book is based on Jeannie’s experience as a member of the herpes community and a peer support provider as well as the experiences of other members of this supportive community.

Living Sphere: Guide to Herpes will provide healthcare professionals involved in caring for people with genital herpes an intimate insight into the daily challenges of living with the condition and highlight the psychological impact of living with genital herpes.

Jeannie May will share her story and abstracts from Living Sphere: Guide to Herpes to illustrate what it is like to be diagnosed with genital herpes and experience the journey from shock, anger and depression through to acceptance, hope and positive action.

Dr Stuart Aitken will examine this journey from a healthcare professional perspective and outline the strategies that healthcare professionals can adopt to support their clients along this journey.

“I have gone through shock, anger, denial, depression, shame, fear, and even felt suicidal at times. But with time, as with most things, you do learn to adapt, to cope, to heal and to forgive.”

Excerpt from Living Sphere: A Guide to Herpes

P91
“YOU’VE GOT MAIL” EVALUATION OF AN EMAIL LINK FROM A SEXUAL HEALTH WEBSITE FOR GENERAL PRACTITIONERS

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The Sexual Health in Western Sydney website was developed as one aspect of the GP/Sexual Health Liaison Project 2003-2005, funded by NSW Health. Developed in partnership with local General Practitioners (GPs), the website is consistent with the NSW Health focus on developing partnerships and building capacity of GPs to support their sexual health service provision. The website aims to provide access for GPs to current sexual health information. As well, an ‘Email a Clinician’ link was established. This allowed GPs with electronic access to communicate remotely with Parramatta Sexual Health Clinic specialists, enabling them to access quality, individualized, specialist opinion.

After initial establishment and promotion of the website, an evaluation of the email link to a clinician was conducted for a 12-month period in 2006. Results showed that despite 324 emails to the clinician link, the majority were spam, or unsolicited bulk emails, usually of either a commercial or sexually-explicit nature. Genuine enquiries comprised less than 10% of the total emails, and enquiries from health care workers comprised less than 1%. There were no emails from the GPs who were the target audience of the website. As a result of the audit and the amount of time spent by clinicians in sorting through the junk emails, the email link was removed from the site.

Possible reasons why GPs did not access the link will be discussed, including evidence of the reluctance of Australian doctors to use electronic fora in direct patient care. Due to the conclusion of the project, it was not possible to survey the relevant GPs directly.

With the new generation of medical graduates and GP registrars entering the Australian workforce, who can be expected to be skilled and comfortable with electronic medical communication, this option may be worth revisiting in the future.
P92
ORAL POSTER TUESDAY 16 SEPTEMBER 1626 – 1630
SEXUAL HEALTH ORAL POSTER SESSION: PEARLS OF WISDOM

SEXUAL HEALTH NEEDS OF YOUNG PEOPLE WITH PSYCHOSIS

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People with mental illness report significantly higher rates of sexually transmitted infections than people from the general population. It is suggested that people with schizophrenia are at greatest risk of contracting HIV. Sexual risk taking behaviour is identified as unprotected sex, early age at first sexual intercourse, multiple partners, and sex trading, and engagement in such poses the highest risk of HIV/STI infection. It is well known that risk-taking behaviour is very prevalent among adolescents and young adults, however there have been few investigations into the sexual health of young people with mental health problems. The current study aimed to investigate the rate of sexual risk taking behaviour, level of HIV/STI knowledge, attitudes towards condoms, and self-efficacy to use condoms, in a sample of young people aged 18-29 years with a history of psychosis. In comparison to a sample of matched control participants, young people with psychosis reported significantly higher levels of risk taking behaviour, particularly unprotected sex and sex trading (p<0.05). Level of HIV/STI knowledge, attitudes towards condoms, and condom use self-efficacy were similar in the two samples. These results suggest that young people with psychosis are at significantly higher risk of contracting HIV/STIs than young people from the general population. This issue could be addressed through the provision of interventions that enhance young people’s capacity to protect themselves against infection with HIV/STIs. It is imperative that we acknowledge this area of need and address this problem early given their heightened risk of further morbidity.

P93
THE DIAGNOSIS OF BREAST CANCER AND THERAPEUTIC TREATMENTS ON WOMEN’S SEXUALITY AND QUALITY OF LIFE: OUR OBSERVATIONS

Buda F

A diagnosis of breast neoplasia causes in women a great vulnerability with presence of psycho-sexual problems (decrease of desire, changes in physical reactions, troubles in in-couple communication). If they aren’t detected and treated on time, they can affect the patient’s life quality and relations.

References: Subject to informed agreement, the impact of breast neoplasia diagnosis and applied treatments (surgery, radiotherapy, chemotherapy, hormonal therapy) on relational and sexual-emotional life has been evaluated on 200 women from September 2000 and March 2004, and in follow-up until March 2006. 47% was in menopause (average age: 46.04 years old); 53% was in post-menopause (average age: 62.3 years old). 80% of them was married/cohabitant; 15% separated/divorced; 5% single. 21% was professional/manager; 35% worker/clerk; 44% housewives. Each of them was given a specific anonymous survey of 36 questions with multiple choice answers, in order to investigate about their relational and emotional-sexual life before and after the diagnosis. The survey was handed back by the entire sample.

Results: The data reveal that the impact of both, diagnosis and treatment, can be attributed to different areas: social-relational field, family, couple. Social relations haven’t changed for 23% of women; but for the remaining 71% they have, whether the initiative was taken by them (33%) or by the partner (26%). In the working circle, relations remained the same for 25% of women; on the other hand, they have changed for the 75%. The awareness about the diagnosis produced a greater intensity in the relationship with the family of origin, especially with children (100%) and with the mother (32%), going decreasing in 34.5% of cases. This reaction can be a response to affection and safety needs; or even a withdrawal, as a consequence of past anxiety and depression. Likewise, the way to face other people has changed, becoming whether more pretentious (44%); or more complaisant (27%); it was unvaried for 26%. Relations with friends appear to be quite stable (68%), while there is a decreasing interest in one’s body care (60%). Similarly, there are significant alterations in interests and hobbies (83%). As far as the life as a couple is concerned, if for 23% of women the relationship with the partner got better/became stronger, for 37.5% there were some variations in terms of less time given (5.5%), communication (6%) and physical-emotional closeness with the partner. The greatest impact in the couple points out a significant awkwardness in showing one’s...
own body (44%), affecting sexuality with a considerable drop of desire and sexual fantasies (decreased or ceased in 91% of cases); likewise, there is uneasiness in seizing the partner’s desire (71%).

Conclusions: These data can be read with reference to past emotional experiences of different nature (anxiety, depression, shame, anger whose effects should be investigated also in the partner) the woman lives, independently on how old she is when she is told the neoplasia diagnosis. This confirms how the cancer diagnosis and treatments produce a sense of final change in the patient’s feminine image and function, affecting every part of her relational and emotional life.

P94
THE CHECK WAS IN THE MAIL: PARTICIPANT PERCEPTIONS OF THE USE OF A SELF COLLECTION KIT FOR CHLAMYDIA TESTING

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Objectives
In Queensland a novel self-collection kit for Chlamydia trachomatis testing was piloted in 2007/2008 to lower barriers to testing. The present study evaluated the clients’ perceptions of the new testing approach.

Methodology
A self-collection kit consisting of all necessary items and instructions to obtain a sample for chlamydia testing was developed. The kit contains a standardised questionnaire. During the pilot phase about 3,000 kits were distributed by mail or through partner organisations which were in contact with the target population (16 to 25 year olds and the socially and geographically isolated). Interim results are presented in this abstract.

Results
A total of 294 samples were returned of which 98.0% (n=288) were accompanied by a completed questionnaire. Of the respondents 71.3% were female and median age was 22 years (inter-quartile range 19 to 26). Main reasons for testing were health concerns (46.2%) and convenience of testing (24.1%). All respondents said that they would use the kit again and 99.2% said they would recommend the kit to a friend. Of all participants 30.8% responded that they would have done a chlamydia test anyhow, 41.1% said that they would get tested for chlamydia by their GP and 40.5% would use hospital services.

Conclusions
The piloted kit demonstrated high acceptability by the target group. The kit attracted clients who would otherwise not have been tested. It therefore provides a promising additional option for chlamydia testing.

This project was funded by the Commonwealth, as part of a National Chlamydia Pilot program.
P95
A LITTLE GEM: AN INNOVATIVE APPROACH TO RETESTING A GROUP AT HIGH RISK OF CHLAMYDIA REINFECTION

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Those previously infected with Chlamydia Trachomatis present with a higher risk of re-infection. This study will seek to demonstrate that providing a recall system that mails out a ‘self collection kit’ (in the form of a repeat test for Chlamydia) and manages the results from a central location is an acceptable means of providing systemic, regular follow-up of these high risk clients.

Participants were recruited through 4 different sites, a regional and urban sexual health clinic, a regional family planning clinic and the Chlamydia Home Testing Trial. Recruitment commenced in January 2007 and was completed in March 2008. Home collection kits were mailed out systematically to each participant approximately 3 months after initial recruitment with the last mail out to take place in June 2008. A total of 129 kits were mailed out. By 19 May 2008, 32 recruits had returned kits (24.8%). Mean age is 23.8 (SD=4.2) and 71.9% of kits returned were from females. One returned sample tested positive giving a prevalence of 3.13% with a 95%CI = [0.08%, 16.22%]. The length of time taken for participants to return kits varied between sites and ranged from 2-115 days.

These are interim results only and the final analysis will be presented that will show that this method of retesting is an acceptable option in this high risk group.

This project is part of the trial of a home self-collection kit for Chlamydia testing in various settings and is supported by the ‘National Chlamydia Pilot Program’ funding of innovative Chlamydia projects.

P96
REQUESTING A CHLAMYDIA CHECK: WOULD YOU LIKE A KIT WITH THAT ORDER? ACCEPTABILITY OF USING THE INTERNET AND PHONE TO OBTAIN A SELF COLLECTION KIT

Gordon R1, Buhrer Skinner M1,2, Debattista J3
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In Queensland a novel self-collection kit for Chlamydia trachomatis testing was piloted in 2007/2008 to lower barriers to testing. The present study evaluated the acceptability of the kit offered via a website and a free call 1800 phone number.

Health promotion materials, including a website, were developed to raise awareness of chlamydia and the availability of the self-collection kit. The posters and leaflets were placed at locations frequented by the target population (16 to 25 year olds, socially and geographically isolated). Requests for a kit were directed to a centralised position from where kits were mailed out, samples received and results managed. Interim results are presented in this abstract.

A total of 192 requests were made via the website and 28 via the 1800 number. The return rates for the website requests and phone requests were 27% and 50% respectively. The mean age of respondents was 24.65 years (Standard Deviation 5.74) and 70.8% of returned kits came from females. Of the total of 64 samples six tested positive for chlamydia giving a positivity rate of 9.38% with a 95% Confidence Interval of [3.52%, 19.30%].

The study showed that confidential chlamydia testing using a mailing kit offered via a website and 1800 phone number is acceptable to the target population and that the management of such requests can be organised through a centralised position.

This project is part of the trial of a home self-collection kit for Chlamydia testing in various settings and is supported by the ‘National Chlamydia Pilot Program’ funding of innovative Chlamydia projects.
P97
USE CONDOMS AND ENJOY YOUR FREEDOM: SOCIAL MARKETING CAMPAIGN

Grose M

The Aboriginal Health & Medical Research Council of NSW has been funded by the NSW Department of Health to develop and deliver a state-wide multi-media campaign.

The campaign aims to reduce the risk of sexually transmissible infection (STI) and human immunodeficiency virus (HIV) transmission within New South Wales Aboriginal communities through raising awareness of safe sex practices and early detection and treatments.

The presentation will give an overview of the campaign, including the innovative creative concepts, findings of the consultations and outline the purpose and format of the workforce development sessions.

The main aim of the presentation will be to present what we have learnt and the impacts of this on the development of future safe sex campaigns for Aboriginal communities in New South Wales.

P98
SEXUAL BEHAVIOURS AND DRUG ABUSE AMONG THE STREET CHILDREN

Pokharel P, walia I, Kumar R, Kaur B, Lamsal S
Department of Community Health Nursing

The present study was carried out in the markets of two sectors and a resettlement colony of Chandigarh (U.T.), Northern India, during the month of January and February, to describe the health profile of the street children. Among the 100 conveniently chosen street children, 74 were Indians and 26 were Nepalese.

Ninety-one children were Hindu, 80 were above 12 years of age with the mean age and SD 14.74±2.77, 72 had some education, 54 children at present worked as hawkers and servants at shops and 69 had a daily income between Rs. 30-90.

Forty-two subjects had sexual exposure at various age with either girlfriend or prostitute in which two subjects were homosexual. Seventy subjects were substance/s abusers, which included 49 alcohol abusers, 48 smokers, 42 tobacco chewers, 3 injectable drug abusers and 51 various other types of substance/s abusers. Majority of the children were uncertain about the amount and frequency of the substance/s they abuse except the tobacco chewers where majority i.e. 28 chew one or two packets of tobacco per week.

It is recommended to establish “condom corners and street children help line” and “de-addiction centre” in the city and urban slum areas and undertake action research on their health.
P99
WHAT DO NEW SOUTH WALES PUBLIC SEXUAL HEALTH SERVICES LOOK LIKE?

1 New South Wales Sexually Transmissible Infections Programs Unit; 2 Sydney Sexual Health Centre, PO Box 1614 SYDNEY, NSW, Australia

The New South Wales (NSW) Sexually Transmissible Infections (STI) Strategy 2006-2009 provides a state-wide framework for sexual health programs and identifies the reorientation of publicly funded sexual health services toward priority populations and strengthening the capacity of general practitioners to manage STIs within the primary care setting as two key strategies. The Strategy focuses on increasing access to services for Aboriginal, men who have sex with men, sex workers, injecting drug users, people with HIV and youth populations.

We aimed to map publicly funded sexual health services (SHS) across NSW as a baseline for measuring progress of the NSW STI Strategy 2006 – 2009. Information was sought through site visits, email and telephone interviews from clinical directors and programs managers on staffing levels, service delivery, client numbers, priority population groups, triage practices, outreach services and general practice education programs.

There are 32 NSW SHS with 202 full time equivalent staff of which 32% are nurses. Services range from multidisciplinary to single nurse services. The range of proportion of priority populations attending SHS varies from 21% Aboriginal clients in rural/remote areas to 41% MSM in an urban setting. Many services are challenged servicing a large and poorly defined youth population.

Strategies used by SHS to prioritise access include triage, outreach services, designated clinics and targeted health promotion campaigns. SHS education and support to general practice to enhance their capacity to manage STI has traditionally been ad hoc; however there is increasing focus on improving strategic collaboration between general practice and SHS.

While contextual differences preclude direct comparison between SHS, tracking effective strategies and sharing experiences contribute to the effective implementation of service reorientation. This baseline snapshot of the current situation in NSW publicly funded SHS enhances the development of strategies to improve access by priority populations.

P100
ORAL POSTER MONDAY 15 SEPTEMBER 1522 – 1530

SEXUAL HEALTH PROFFERED PAPERS - SYSTEMS: BAUBLES

A STATE-WIDE STANDARD OPERATING PROCEDURE MANUAL FOR SEXUAL HEALTH SERVICES IN NEW SOUTH WALES – NOT RE-INVENTING THE WHEEL.

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The NSW Sexually Transmissible Infection (STI) Strategy 2006-2009 identifies publicly funded sexual health services (SHS) as centres of expertise for detection, treatment and care of STI. A key strategy is to promote best practice standards within publicly funded sexual health clinics. Currently there is no state wide guideline or manual and despite similarities across services, separate Policy & Procedure Manuals are developed and maintained by each individual SHS. So, the NSW STI Programs Unit is facilitating the development of state-wide policies and procedures for SHS.

A technical group of senior sexual health nurses was convened representing all 8 NSW Area Health Services. The group developed a terms-of-reference and has met quarterly to standardise SHS operating procedures. The nurses initially identified which procedures were generic and site specific. A template was developed and the procedures were divided between the nurses for drafting into the template. A timeline for ongoing review was developed and the final document will be endorsed by relevant state bodies to assist in standardisation and benchmarking.

The outcomes will be a standard operating procedures manual endorsed by NSW Health that can be used and adapted by SHS across the state as a benchmark for best practise service delivery. The manual index and draft contents will be presented.

The manual will provide standardised guidance for new nurses, doctors and other staff; ensure consistency in practice between SHS and will free overall nursing hours. The process of collaboration between the senior nurses also promotes increased networking and partnerships between services to support high quality service operations.
**P101**

**DEVELOPMENT OF A SEXUALLY TRANSMISSIBLE INFECTION TESTING TOOL FOR GENERAL PRACTICE IN NEW SOUTH WALES**

Murray C1, Moore S1, Poetschka N1, Bourne C1

1New South Wales Sexually Transmitted Infections Programs Unit, Sydney Sexual Health Centre, PO Box 1614 SYDNEY, NSW, Australia.

General practice (GP) is the main provider of sexual health primary care in New South Wales (NSW). Fifty-five percent of Australians diagnosed with a sexually transmissible infection (STI) or blood borne virus received treatment during the previous year through GP compared to eight percent through publicly funded sexual health services. Relying only on testing symptomatic presentations is not likely to result in treatment for the majority of STI which are asymptomatic. The NSW STI Strategy 2006-09 aims to increase the quality of sexual history taking and the amount of targeted STI testing conducted within general practice.

A Working Group for STI services in GP identified the need for an STI testing tool to support General Practice staff to increase the amount of sexual history taking and opportunistic testing conducted within general practice patients.

The STI testing tool aims to provide increase access to STI information and education resources, particularly those focused on sexual history taking, testing and treating uncomplicated STI, notification, contact tracing and appropriate referral for GPs. The Australasian Chapter of Sexual Health Medicine’s *Clinical Guidelines for the Management of Sexually Transmissible Infections among Priority Populations* were used as a reference and key organisations and general practices from across NSW were consulted about content and useability.

The testing tool, its development and outcomes of feedback on its use in general practice will be presented.

**P102**

**HIV/AIDS AND PUBLIC HEALTH**

Panda B

Human Development Foundation

Introduction: HIV/AIDS after three phases of planning in India and particularly in Orissa is yet to be recognized as a public health issue rather considered as an issue of medical intervention. It is not a problem of poor people but flourishes among the conditions of poverty. Like any other public health viz, malaria, TB and leprosy the initiatives taken in its prevention and control lacks organizational commitment and priority.

Objective: To assess the perception of the planners and policy makers on the issue of HIV/AIDS in the state of Orissa.

Results: As HIV/AIDS prevalence in Orissa is below as prescribed by the National standards and in spite of high vulnerability it is given less importance. Amidst other communicable diseases, in a resource constraint state like Orissa it loose its importance to be considered as a public health issue. The future implication and public understanding need to be geared up to address the issue in a meaningful manner. People’s participation and community involvement are hardly given weight age for public intervention. Health Promotion is hardly taken up. Public private partnership is in its infancy in the state leaving any scope for fruitful intervention.

Conclusion: Considering its future implications on general population and some of the special population groups, not compromising cultural and traditional values, intervention may be taken up on health promotion. If the issue is addressed with Political commitment with bureaucratic passion we can save the entire race before it explodes like an atom.
P103
DOUSING FIRES AT THE STATION
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Objective:
Over the past seven years the B2 Clinic has provided a nurse lead outreach sexual health service to youth aged 12-24 at The Station youth health service in Rockingham, which is 45kms south of Perth. This presentation aims to demonstrate how this model of service provision is responsive to the needs of young people, has been successful in building partnerships with other organisations, has provided effective health education and promotion activities and is delivered in a youth friendly environment by youth friendly staff.

Results:
As a result of this model the occasions of service have risen from 138 in 2002 to 192 in 2007, a 74.5% increase. This has enabled increased screening and an increased opportunity to improve the knowledge of the young people about sexual health. With the increase in the number of clients attending we are seeing an increase in the amount of disease, particularly chlamydia. In 2007 1 in 7 females tested were positive as were 1 in 5 males.

Conclusion:
The outreach service has been successful at reaching young people who are an underscreened group for sexually transmissible infections and the most at risk by providing a service they feel comfortable attending. Due to the increase in attendances, an extra clinic has been initiated.

P104
A CROSS SECTIONAL STUDY TO HIGHLIGHT THE ROLE OF CLIENT EXIT INTERVIEWS IN ENHANCING PERFORMANCE MANAGEMENT WHEN OFFERING HIV/AIDS SERVICES-TASO MASAKA EXPERIENCE
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Background: The AIDS Support Organization (TASO) mission is to contribute to the process of prevention of HIV infection and improving the quality of life of people/communities infected and affected with HIV/AIDS. Therefore ensuring good quality of service delivery is a prerequisite that organizations needs to put into consideration. For proper monitoring of services, organization requires periodic feedback on the quality of services delivered to clients. TASO Masaka is one of the 11 service centers located in South Western part of Uganda.

Methodology: The data was collected using an interview administered questionnaire. Data was entered using Epinfo 2002, and analyzed using SPSS. Double entry system was employed to ensure data integrity and cleaning. Sampling units were selected using systematic random sampling of 140 respondents during the clinic's. Respondents were selected from both outreach and general/ART clinics.

Results: A sample of 140 clients was sampled for the study, 48 clients from Kyazanga outreach and 92 from general/ART clinic. Majority of the respondents spent between 4 to 6 hours at both the general and outreach clinic. The minimum and maximum time spent at the clinic was 2 and 10 hours respectively. There is a significant difference between time spent at the outreach and general clinic (P=0.00, Chi-square value=26.48, degrees of freedom=4 at 95% level of Confidence). Out of 91(65%) clients who never saw the counselor, 39(42.9%) had no plan to see the Counsellor, some clients were told to see the only the doctor through Counsellor Triage. Out of 49 respondents who saw the Counsellor, 47(96%) had their issues addressed, 2 clients noted that there issues were not addressed. 138(98.6%) who turned up for medical services were happy with the way the Doctors handled them. 1 client confessed that she was not happy because she did not see the doctor, 1 had no response. 99(70.7%) of all the respondents sampled got all the prescribed medicines, 41(29.3%) were not given the prescribe medicines. 37 reported that the drugs were out of stock, 1 had to first be visited by staff, 2 had file missing, and 1 was given a new appointment date. There is no significant
difference between clients being attend to immediately soon after they have arrived at the clinics ($P=0.679$, Chi-square value=0.1716, Degrees of freedom=1 at 95% level of confidence). Generally 139(98.6%) were satisfied with TASO services. Satisfaction of TASO services at general and outreach clinics is not statistically different ($p=0.473$, Chi square value=0.515, degrees of freedom=1 at 95% level of confidence)

Conclusions: With the help of client exit interview, the center was able to establish the above findings that highlight area of achievements and area that need improvement in performance management during the provision of HIV/AIDS services.

Recommendation: Client exit interviews could be taken up by HIV/AIDS Service organizations to improve on the monitoring and evaluation of the quality of services provided to PLHIV.

Key Words: Client: is a patient who has tested HIV Positive and has registered with TASO.
ORAL PRESENTATION ABSTRACTS
WEDNESDAY 17 SEPTEMBER 2008
HIV PREVENTION RESEARCH

Gita Ramjee
South African Medical Research Council HIV/AIDS Lead Programme

The HIV Prevention field has faced a number of setbacks in the past year. Currently we have the ABC option of abstinence, being faithful and condomize (male and female), behavioural change and treatment of sexually transmitted infections. More recently, three randomized control trials showed that male circumcision is likely to reduce the risk of female to male transmission of HIV by up to 60%. With the rising infection rates in many countries, the current efforts for HIV prevention are clearly not adequate.

Our recent efforts to expand HIV prevention options through a variety of technologies (microbicides, vaccines, HSV2 suppressive therapy, and vaginal diaphragm) have had no success and in some cases there was a potential of the intervention to increase the risk of HIV acquisition. One of the challenges in the field has been in that the theoretical concepts that have been scientifically sound with adequate support from observational studies for many of these novel intervention technologies, are not supported by the same outcomes in randomized control trials. With growing infection rates in many parts of the world especially subSharan Africa, scientists in the HIV prevention field need to come together to strategies and ascertain why theoretical concepts and observational studies are not proven effective in randomized control trials, giving up on HIV prevention is not an option.

TO\n
TOWARDS AN HIV VACCINE - WHAT IS PROTECTIVE IMMUNITY AGAINST HIV INFECTION?

Sarah Rowland-Jones, Nuffield Department of Medicine, Oxford University, John Radcliffe Hospital, Oxford OX3 9DJ, UK

Following the disappointment experienced after the failure of the STEP HIV phase II vaccine trial last year, questions have bee raised about whether or not an effective vaccine to prevent HIV-1 infection can ever be achieved. Some have contended that the trial should be seen as a product failure rather than a failure of the entire T-cell vaccine concept, and that clinical vaccine studies should continue on an empirical basis. Others have suggested that there needs to be a return to basic science in order to define genuine correlates of protective immunity against HIV-1 infection. This presentation will review the current efforts towards HIV vaccines and discuss our understanding of the requirements for a successful HIV-1 vaccine. Relevant studies of HIV resistance or control of infection from studies in Kenya and West Africa will be presented to provide support for the concept of protective immunity.
WOMEN RISK HIV – INTERNATIONAL

11.00am – 12.30pm

A NOVEL APPROACH TO ANTENATAL RISK ASSESSMENT IN VERY LOW HIV PREVALENCE SETTINGS IN RESOURCE-POOR COUNTRIES

Holmes WR, Centre for International Health, Burnet Institute, Melbourne, VIC, Australia

In very low HIV prevalence settings in resource-poor countries the relative cost-effectiveness of routine provider-initiated offer of HIV testing for all pregnant women is low. A strategy of offering the test to pregnant women who may be more vulnerable to HIV infection is problematic because it is difficult to identify pregnant women at greater risk. Women at risk because of their partner’s behaviour are often unaware of their risk, and undertaking risk assessment is a sensitive task for busy antenatal care staff to conduct in a confidential, inoffensive and non-stigmatising manner.

However, there are often opportunities to reach expectant fathers with information and risk assessment. These opportunities may include pre-conception couple visits, antenatal couple visits, and ‘parentcraft’ classes for pregnant women and expectant fathers.

We have developed a novel risk assessment quiz for expectant fathers in the entertaining style typical of women’s magazine personality quizzes. Because the men do not need to fill in a checklist or questionnaire they can be completely honest in their answers because no one will know the result except themselves. The quiz includes ‘comments’ for each risk category. Those in the ‘low or no exposure risk category’ are congratulated and encouraged to continue their safe behaviours to protect themselves and their families. Those in higher exposure risk categories are informed that if they find they are HIV positive it is possible to protect their wife from infection if she is not yet infected, and that if she is already infected the risk of transmission to their baby can be greatly reduced. This provides a strong motivation for the father to request a confidential HIV test. A commitment to disclose a positive result to his wife would be obtained during the pre-test counselling.

It is planned to evaluate the risk assessment quiz for expectant fathers in Sri Lanka, where HIV prevalence remains very low.

ADDRESSING GENDER-BASED VIOLENCE IN SETTLEMENT AREAS OF PORT MORESBY

Ofasia E1, Duffy SM2
1World Vision Pacific Development Group; 2World Vision Australia

Gender-based violence (GBV) is prioritised in Papua New Guinea’s (PNG) National Gender Policy and Plan on HIV/AIDS 2006-2010. Various studies indicate an association between GBV and Human Immunodeficiency Virus (HIV). High incidence of GBV in PNG is associated with rapid social, cultural and economic change, social dislocation and erosion of the wantok system, especially in Port Moresby’s informal settlement areas. Victims of physical and sexual violence exhibit higher rates of HIV and sexually transmitted infections. The National AIDS Council estimates nearly 60% of new HIV infections in adults in 2007 occurred in women. Alarming rates of domestic abuse (two out of three married women) and sexual violence (over 50% of women) have been recorded in PNG. In addition to HIV transmission caused directly by violent sexual contact, GBV is symptomatic of disempowerment and denial of a woman’s right to exercise control over sexuality, and to sustain safe sexual practices.

In 2007 World Vision commenced implementation of the Ol Meri Igat Numba project to reduce GBV and HIV transmission in four settlement areas. The project takes an appreciative, rights-based and collaborative approach, encouraging positive attitudes and behaviours as well as challenging abusive ones. Project strategies combine behaviour change communication (BCC), engagement with service providers, and community forums. BCC activities include theatre, dance, media campaigns, and information, education and communication (IEC) materials developed in partnership with women and men in settlement areas. BCC messages raise awareness of HIV, safer sex, rights, health and welfare services, and strategies for action against perpetrators of GBV. Community forums provide opportunities for women to express concerns about GBV to men, community leaders and service providers. To lessen women’s economic dependence, women receive training in vocational and business skills.

Project methodology and early project results will be discussed, including successes and challenges. Anecdotal evidence indicates that real change has occurred in both men’s and women’s attitudes, but suggest long-term engagement is required for sustainable change.
TRIBAL FIGHTING, VIOLENCE AGAINST WOMEN AND GIRLS AND HIV IN PAPUA NEW GUINEA

Kupul M1, Mek A1, Kepa B1, Kelly A2
1Papua New Guinea Institute of Medical Research, Goroka, Papua New Guinea; 2National Centre in HIV Social Research, UNSW, Australia

There are many drivers of the epidemic and in the Highlands of PNG tribal fighting may be one. While killing men, tribal fighting creates a breeding ground for many form of violence against women and girls. Women and children are forced to be refugees in other ethnic areas, women and girls are exchanged for guns and/or forced into marriage and are raped and murdered. Women and children go without food, girls are denied education because they are refugees and pregnant women are deprived of antenatal care during pregnancy and labour. In these contexts women and girls are more vulnerable to HIV.

Concerned with such high rates of violence in Melanesia and East Timor a research of best practices was commissioned by AusAID and carried out by Program for Appropriate Technology in Health (PATH) utilizing local researchers. Drawn from the PNG country evaluation, which using participatory research methods, this paper addresses how two communities in Chimbu Province effectively addressing violence against women and girls by first combating tribal fighting.

The success of these communities indicates that in order for social change to occur there must be the desire for such change. There must also be ownership of the problem and solutions. These communities and other which want to change must also be prepared and supported to challenge cultural norms including violence, leadership and relationships within and between men and women and across ethnic groups. Two community organisations have initiated gender equity training, community policing by both men and women, and the involvement of women in decision making.

Where communities are working to help themselves, efforts must be made to help make them sustainable. To address violence against women and girls, gender relations need not be the direct entry point. Addressing other social issues such as tribal fighting can lead to change in gender relations and a reduction in violence against women and girls which in turn will make them less vulnerable to HIV. Communities have the power to transform themselves providing sanctuaries for women and girl from both violence and HIV.

FEMALE SEX WORKERS IN SRI LANKA: WHY ARE WOMEN WHO WORK ON THE STREET MORE LIKELY TO USE CONDOMS COMPARED WITH WOMEN WHO WORK IN OTHER LOCATIONS?

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Sri Lanka has a low-level HIV epidemic. The first large scale behavioural surveillance survey (BSS) in Sri Lanka was conducted in 2006/2007. More than 7,000 people were sampled from six sub-population groups: female sex workers; factory workers; drivers of three-wheel taxis; men who have sex with men; beach boys; and drug users. This paper is focussed on female sex workers.

Sampling female sex workers (FSW) was done according to the type of work context: streets, brothels, massage-parlours, casinos, and karaoke bars. There were exactly 900 FSW who had vaginal intercourse with a paying client in the previous twelve months, 488 of whom were working on the street. (Note: anal intercourse is not included in these analyses as it was rarely practiced).

In comparison with all other categories of FSW, women working on the streets were more likely to have always used condoms for vaginal intercourse in the last twelve months (82.0 % versus 62.3 %, p=.000) and on the last occasion (95.1 % versus 85.0 %, p=.000). These findings were contrary to expectation and prompted further analyses to explore the possible reasons why street-based FSW are more likely to use condoms for vaginal intercourse.

Multiple logistic regression analyses were conducted to examine the factors that distinguished FSW working on the street from other FSW. The final model showed that street FSW were more likely to: carry condoms with them; have found out about HIV through government health services; decide themselves how much the client pays for sex; and accurately believe that people can protect themselves from getting HIV sexually by using a condom every time they have intercourse. Street FSW were less likely than other FSW to: read and write; and to have found out about HIV through television.

Although less educated, FSW working on the street are better prepared to prevent HIV transmission by the use of condoms. These women are accessing important health information from government health services and appear to be taking greater responsibility for their health. Why these women have better access to government health services requires further exploration.
ALCOHOL CONSUMPTION, HIV TRANSMISSION AND IMPLICATIONS FOR WOMEN IN SOUTH AFRICA

Ghaly S

The aim of this paper is to examine the HIV epidemic in South Africa and to explore the role that alcohol consumption plays in HIV transmission. The paper will include a critical appraisal of various interventions that aim to reduce alcohol abuse and in so doing, reduce HIV incidence.

In several studies, alcohol consumption has shown to negatively impact on HIV prevention and treatment programs in South Africa. High levels of alcohol consumption are often attributed to factors such as unemployment, abuse and as resistance against oppression. High alcohol consumption was found to be one of the predominant causes of risky sexual behaviour, and a correlate of increasing levels of violence. The association between increased risky sexual behaviour and high levels of alcohol consumption has been demonstrated through studies conducted in South Africa by the South African Community Epidemiological Network on Drug Use (SACENDU).

After working with local HIV clinics in townships with the Organisation Friends of Africa, it became evident that underdevelopment, high unemployment, lack of recreational activities and the access to illegal alcohol outlets impacts on the risk of disease transmission, rape, teenage pregnancies and other forms of violence against women, all of which may contribute to increasing HIV rates. Intervention strategies such as the 2003 National Liquor Act have been established to reduce levels of alcohol consumption, by including a liquor outlet policy; regulating the physical availability of alcohol; and placing restrictions on alcohol marketing. Increasing employment opportunities and the availability of recreational activities are strategies that can also aid in reducing alcohol misuse and high risk sexual behaviour. However, many of these strategies have not yet been implemented. Consequently alcohol remains the highest abused substance causing irreversible social and physical damage for people living in South Africa.

This paper reports on the effects that the misuse of alcohol can have on the increasing rates of HIV and the fact that women are predominantly affected and provides a critical appraisal on some of the current alcohol related interventions aimed at reducing HIV/AIDS transmission in South Africa.

ENABLING HIV PREVENTION OUTCOMES FOR SEX WORKERS, PAPUA NEW GUINEA

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When sex work is criminalised sex workers ability to access justice and services are reduced including: HIV prevention, testing, treatment and care; general sexual health. Laws regulating sex work in Papua New Guinea have been interpreted to mean sex work per se is illegal. This paper reviews the Papua New Guinea laws and reports on the impact of stigma and discrimination on HIV prevention along with the direct impacts on individuals. Anecdotal evidence collected during a three year capacity development project working directly with Papua New Guinea sex workers has identified the need for enabling legal environments for the success of future HIV prevention, testing, treatment and care services for sex workers in Papua New Guinea.
TOWARDS VACCINES ELICITING BROAD NEUTRALISING ANTIBODY RESPONSES BY SELECTING FOR HIV-1 ENV IMMUNOGENS THAT PROMINENTLY EXPOSE CONSERVED NEUTRALISATION EPITOPES


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The recent failure of HIV vaccines eliciting potent T-cell responses in humans has highlighted the need to also stimulate broadly neutralising antibodies against HIV-1 envelope protein (Env), but this has proven a difficult task. While antibodies can be non-neutralising or enhancing for HIV infection, the desired broad neutralising antibodies bind conserved conformations such as the CD4 receptor and chemokine coreceptor binding sites on Env oligomers. We hypothesised that environments where target cells display low levels of receptor/coreceptor and negligible neutralising-antibody levels may select for HIV isolates that highly expose neutralisation-sensitive Env structures required for viral entry. We sought to rationally screen a panel of oligomeric Env for candidate neutralising-antibody immunogens by ranking them for binding affinity for soluble CD4 receptor (sCD4) and affinity for a reference panel of broadly neutralising monoclonal antibodies (mNAb). We assessed Env from two sources: 1) the brain, where antibody levels are typically low and 2) blood from late-stage AIDS patients when HIV-specific antibodies diminish. In general, Env from brain-derived clones showed higher affinity for mNAb and sCD4 than did Env from control clones derived from matched patient spleen. While some Env variants from late AIDS patients showed high affinity for sCD4 or mNAb this was not consistently different compared to Env derived from pre-symptomatic patients in the same cohort. A group of 6 Env clones with higher affinity for mNAb and/or sCD4 were selected for a DNA prime with a recombinant soluble gp140 oligomeric Env protein boost immunisation trial in mice. Most mice developed high anti-Env specific antibody titres measured by ELISA. Sera were pooled within groups and assessed for the ability to neutralise virus pseudotyped with Env derived from the AD8 (CCR5-restricted, relatively neutralisation resistant), 89.6 (dual CCR5/CXCR4 tropic) and NL4.3 (CXCR4-
UNDERSTANDING SUSCEPTIBILITY TO CMV IMMUNE RESTORATION DISEASE AND THE IMMUNOLOGICAL CONSEQUENCES OF EXTREME IMMUNODEFI CIENCY

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CMV disease is a common complication of late-stage HIV disease and recurs as immune restoration disease (IRD) in some patients. Here immunological and genetic factors assayed by our group are used to profile patients who experience CMV disease. CD4 T-cell responses were assessed by IFNγ ELISpot assay and antibody was quantitated by ELISA using a whole CMV antigen.

We tested all available samples from patients who had begun ART with advanced immunodeficiency (nadir < 50 CD4 T-cells/µl) in Perth (1996-8) and achieved a sustained virological and immunological response (n=50 patients). These criteria imply selection of patients on the basis of survival before ART and a favorable outcome thereafter. Although CD4 T-cell counts increased during the first year on ART, IFNγ responses to CMV were low before ART, rose slowly and never reached levels seen with cells from uninfected donors. Within this patient cohort, the lowest nadir CD4 T-cell counts associated with persistently low CD4 T cell IFNγ responses to CMV antigen, higher IFNγ responses to an NK-cell target (K562) and characteristic TNFA and IL12B genotypes. In a broader cohort, the TNFA genotype and high numbers of activating KIR genes were associated with a history of CMV as an AIDS-defining illness.

Patients who developed CMV IRD (retinitis or encephalitis, n=7) had a history of CMV-AIDS. Their CMV IRD paralleled a rise in anti-CMV antibody and markers of immune activation (eg: plasma IL-6). Longitudinal studies of IFNγ responses were not possible, but responses were low 2-3 years after the IRD. CMV IRD patients all had very low nadir CD4 T-cell counts and the characteristic TNFA / IL12B and KIR genotypes. These genotypes may promote extreme immunodeficiency and/or CMV-AIDS or may allow patients to survive these conditions to experience an IRD and join our study. Activating KIR may promote an NK response able to compensate for poor CD4 T-cell responses to CMV. A corollary of this model is that CMV IRD may not be a T-cell cytokine storm, as implicated in IRD associated with mycobacteria.

A different scenario emerges in Kuala Lumpur. Patients beginning therapy with <200 CD4 T-cells all experienced a rise in CMV antibody and CD4 T-cell IFNγ responses. Associations with CMV IRD are now under investigation.

PRE DICTING NEUROPATHY RISK BEFORE STAVUDINE PRESCRIPTION: AN ALGORITHM FOR MINIMIZING NEUROTOXICITY IN RESOURCE-LIMITED SETTINGS

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Sensory neuropathy (SN) is a common, disabling complication of stavudine (d4T) therapy, with prevalence rates >40% reported from d4T-treated cohorts of patients with HIV. Despite its toxicity, d4T is an effective, relatively inexpensive HIV treatment and remains important in resource-limited centres. Methods of predicting SN risk are needed to guide antiretroviral prescribing in countries where some use of d4T remains an economic necessity.

We undertook SN screening programs in Melbourne (low d4T use), Kuala Lumpur (intermediate d4T use) and Jakarta (routine d4T use) in 2006 to describe SN risk factors among HIV patients in our region. SN was defined by the presence of symptom/s and sign/s on the AIDS Clinical Trials Group Brief Peripheral Neuropathy Screen. Patients' height, age and weight were recorded and demographic, laboratory and treatment data were obtained from the medical file. Statistical analysis using Stata 9.2 defined factors associated with SN. The role of patient demographics in predicting SN was then assessed in patients who had ever used d4T.

294 patients were assessed (100 Australians, 98 Malaysians and 96 Indonesians). Prevalence rates of SN were 42%, 19% and 34% respectively and 32% overall. In addition to treatment exposures, increasing age (p=0.002) and height (p=0.001) were independently associated with SN risk. Receiver operating characteristic analysis suggested “cut-offs” of ≥170cm and/or ≥40 years for predicting patients at risk of SN. These were applied to the 181 d4T-exposed patients, yielding an SN risk of 20% in younger, shorter patients, 33% in younger but taller patients, 38% in older but shorter patients, and 66% in those older than 40 years and taller than 170 cm.

Stavudine is infrequently prescribed in Australia due to high rates of toxicity, but remains an important HIV treatment in our region. Rates of SN, a common d4T toxicity that impairs quality of life and may reduce patients’ ability to work, vary with patient age and height. These data support prioritizing patients taller than 170 cm and/or older than 40 years (factors measurable at no extra cost) for access to antiretrovirals other than d4T.
BIOLOGICAL CHARACTERIZATION OF NOVEL HIV-SPECIFIC ACTIVITY

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Human Immunodeficiency virus type-1 has led to global AIDS pandemic. Currently, there are 40 million people infected with HIV and with 14,000 new infections occurring each day. Although there are several lines of anti-retroviral drugs available in the market and have provided better life standards to HIV-infected individuals, there are continuing problems associated with these drugs—such as toxicity and emergence of resistance. All HIV vaccines have failed to date. Thus, fresh approaches and strategies are needed for controlling HIV. Recently, we have discovered a novel HIV-specific cellular differentiation activity in the soluble factor secreted by the CD4+ T cells from a unique HIV+ elite controller. This cellular differentiation activity leads to the induction of CD14+ monocytes to their differentiation to antigen presenting cells displaying CD40, CD86, CD11b and CD14 markers. This activity was observed to occur in both autologous and non-autologous fashion. This new approach has shown promise on cells from HIV+ positive individuals with low viral loads, suggesting its possible future use as a therapeutic vaccine in conjunction with currently prescribed therapy. The biology of these findings will be findings will be discussed in detail.


**RESULTS FROM THE 2008 PERIODIC SURVEY OF NSW NEEDLE AND SYRINGE PROGRAM ATTENDEES**

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In April 2008, the NSW Department of Health requested that staff at Needle and Syringe Programs (NSPs) collect demographic and drug use data from clients of NSP services. The National Centre in HIV Epidemiology and Clinical Research (NCHECR) was commissioned to analyse and report on the results. All clients attending participating NSPs during a two week period were asked to provide information on their gender, age, ethnicity, age of first drug injection, last drug injected, frequency of injecting, syringe disposal and where syringes were obtained.

A total of 6047 data collection forms were returned from the 52 NSPs who participated in the data collection. Of these, 3197 were clients who had not previously attended the NSP during the two week period. The number of repeat clients was 2009 giving an overall repeat ratio of 1.6. The median age of non-repeat clients was 36 years, 66% were male, 5.9% were from a non-English speaking background and 13% self-identified as Aboriginal and/or Torres Strait Islanders. The median duration of injecting drug use was 15 years and the most common drug last injected was heroin (33%), followed by methamphetamine (28%). Approximately 41% of clients reported injecting daily or more frequently.

This project provides an important snapshot of the NSW NSP client base and a useful mechanism for comparing the characteristics of clients across different geographic areas in NSW, as well as guiding estimates of the total IDU population in NSW for service coverage evaluation.
CONTINUED INCREASES IN SYRINGE DISTRIBUTION ARE REQUIRED TO RESTRAIN VIRAL TRANSMISSIONS AMONG INJECTING DRUG USERS IN AUSTRALIA: RESULTS FROM A MODELLING STUDY

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Sharing syringes by injecting drug users (IDUs) is an important mode of worldwide transmission of blood borne viruses, such as HIV and HCV. In Australia, the current coverage of sterile syringes is approximately 50% and annually there are ~30-40 HIV notifications and ~9,500 cases of HCV due to syringe sharing by IDUs.

We address the following research questions: (i) what are the driving behavioural factors in differential HIV and HCV incidence among IDUs in Australia? (ii) What impact will changes in needle-syringe programs (NSPs) have on HIV and HCV incidence? (iii) How much reduction in the proportion of injections that are shared and number of time a syringe is used before disposal is required in order to theoretically eradicate HIV and HCV epidemics among IDUs?

These questions are addressed through the development of a novel mathematical model based on risk equations, calibrated to the Australian population of IDUs. Differential incidence rates for the two epidemics are due to differences in transmission probabilities but also because syringe sharing behaviour and syringe distribution in Australia are at levels that sustain high levels of HCV incidence but not HIV. We provide predictions of the changes in incidence of both epidemics due to changes in intervention strategies.

If Australia had not implemented NSP from the late 1980s, then HIV notifications could have increased substantially and moderate increases in HCV would also have been observed. We predict that interventions due to NSP are very effective in reducing HIV and HCV. An increase of in the coverage rate to 90% could theoretically eradicate HCV transmission among IDUs. Alternatively, if the proportion of injections that are shared decreased from 15% to 2.5% then the HCV epidemic among IDUs could be eradicated. This research highlights the large benefits of NSPs and recommends that increased coverage can result in significant reductions in viral transmissions among IDUs.

THE ROLE OF NEEDLE SYRINGE PROGRAMS IN PREVENTING TRANSMISSION TO INJECTING BY YOUNG PEOPLE

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There is evidence that drug users in Australia are making transitions to injecting at younger ages. Needle and syringe programs (NSPs) play important roles in services for injecting drug users (IDU), and have the potential to assist in prevention of transition to injecting methods. However, their potential to access young people at risk of initiating injection is affected by the reluctance of young people to use health services.

How can NSPs be better accessed by young people and play a role in prevention? What are the issues around young people accessing NSPs?

To answer these questions, a literature review and key informant consultations were conducted. Using this research, an overview of existing and potential strategies and an outline the significant issues for NSPs in implementing such strategies will be presented. Issues include concerns about exposure of young people to drug users, normalisation of drug use, and NSP workforce capacity to work with young people and implement interventions.
A GAP ANALYSIS OF PEOPLE WITH A HISTORY OF INJECTING DRUG USE WHO ARE NOT CURRENTLY ACCESSING HIV AND SEXUAL HEALTH SERVICES IN SOUTH EASTERN SYDNEY ILLAWARRA AREA HEALTH

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People with a history of injecting drug use are documented as one of the priority groups in the NSW HIV/AIDS Strategy 2006-2009 and receive special reference in the NSW Sexually Transmitted Infection Strategy 2006-2009. Despite this, access to specialist HIV and sexual health services by people who inject drugs remains low.

This paper describes a gap analysis commissioned by South Eastern Sydney Illawarra Health to identify characteristics and needs of people with a history of injecting drug use and who are not accessing HIV/AIDS and STI services; and to identify service support strategies for how SESIH services can better target these populations to improve access.

The paper describes innovative strategies used to contact key informants, the role of informatics in analysing service utilisation data and the development of service re-orientation processes to increase access to not only HIV and sexual health promotion, screening, prevention and testing services but also to treatment and care services.

INCREASING HEPATITIS C TREATMENT UPTAKE BY INJECTING DRUG USERS FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS: OUTCOMES OF A PILOT STUDY OF INDOCHINESE INJECTORS

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Background: There has been limited research exploring hepatitis C (HCV) treatment-seeking from the perspective of injecting drug users (IDUs), particularly those from culturally and linguistically diverse backgrounds.

Methods: Between 2003 and 2007 ethnographic fieldwork and in-depth interviews were conducted with Indo-Chinese IDUs in South Western Sydney (n=72) recruited using theoretical and snowball sampling. Eligibility criteria for the pilot study (n=23) included being aged 18 years and over, ability to complete interviews in English, being of Cambodian, Lao or Vietnamese cultural background and having injected drugs in the last six months. Following a baseline interview about HCV, a culturally-informed brief intervention about HCV treatment was provided and participants offered facilitated referral to a tertiary liver clinic. Participants were followed up and interviewed again at three and six months.

Results: At baseline, most participants were unclear about what treatment involved and its potential outcomes. Participants responded to the brief intervention with numerous, detailed questions but while most expressed interest in having treatment at some stage, few (n=3) attended the clinic. Factors influencing treatment-seeking included the cultural significance of “curing” HCV, perceived capacity to adhere to treatment in the event of experiencing side effects, patterns of injecting drug use, precarious personal circumstances and lack of support, imprisonment and past experiences with health services.

Some participants experienced difficulties accessing the liver clinic, particularly with the system for making appointments. Those who accessed the clinic and disclosed current drug use felt that they were discouraged from initiating treatment until they stopped injecting drugs. Cultural factors influenced interactions with clinic staff, particularly disclosure of drug and treatment-related concerns.

Conclusions: Findings suggest that the brief intervention increased participants’ knowledge levels and interest in seeking treatment at some stage in the future. However, in addition to raising awareness of treatment, issues
identified regarding the assessment process and options for assistance and support during treatment, need to be addressed to promote treatment uptake by this group. Models of service delivery in tertiary settings need to include staff capacity to address drug dependence issues, streamlined referral and assessment processes and mechanisms for linking clients with culturally-appropriate support.
TISSUE-SPECIFIC ADAPTIVE CHANGES IN V3 OF GP120 ENABLE PERSISTENCE OF MARAVIROC-SENSITIVE R5X4 HIV-1 IN BRAIN

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Most neurotropic HIV-1 strains are CCR5-restricted, but R5X4 variants have been identified infrequently in brain. In this study, HIV-1 Envs were cloned from R5X4 primary viruses isolated from brain (n=6) and spleen (n=6) of subject MACS1. Single R5X4 Envs cloned from brain and blood of another subject were included (aBR01, aBL01). Envs were sequenced and structural modeling was performed to analyze amino acid variants. Env fusogenicity was tested in fusion assays with wild type and mutant coreceptors. Sensitivity to inhibition by the CCR5 and CXCR4 inhibitors, Maraviroc and AMD3100 respectively, was tested in single-round entry assays. MACS1 brain (M1br) and the brain-derived aBR01 Envs were more fusogenic than Envs from matched spleen or blood in cells expressing CD4/CCR5, whereas MACS1 spleen (M1sp) and the blood-derived aBL01 Envs were more fusogenic than Envs from matched brain in cells expressing CD4/CXCR4. Entry assays showed brain/spleen R5X4 Envs had preferential usage of CCR5/CXCR4 for entry, respectively. Studies with coreceptor mutants showed that, compared to M1sp Envs, M1br Envs had reduced dependence on residues in the CCR5 N-terminus (Y15), ECL1 (H88), and ECL3 regions (E262, F264) for CCR5-mediated fusion. Compared to M1br Envs, M1sp Envs had reduced dependence on residues 4-36 in the CXCR4 N-terminus and R183 in the ECL2 region for CXCR4-mediated fusion. Sequence analysis identified R306 in the V3 loop of 6/6 M1sp Envs and S306 in 6/6 M1br Envs. Mutagenesis studies showed R/S306 was solely responsible for the spleen/brain phenotypes, respectively. Whilst entry of spleen R5X4 Envs was not inhibited by the CCR5 inhibitor Maraviroc, entry of brain R5X4 Envs was potently inhibited by Maraviroc; a phenotype also conferred by R/S306. Thus, tissue-specific adaptive changes resulting in altered mode of coreceptor usage may enhance the tropism of compartmentalized R5X4 strains for cells expressing CCR5 in brain and CXCR4 in lymphoid tissues. Furthermore, the results suggest CCR5 inhibitors may be effective in suppressing certain R5X4 HIV-1 variants.
HIV DNA LEVELS IN PBMC DECLINE IN PATIENTS RECEIVING INTEGRASE INHIBITOR COMBINATION THERAPY

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HIV DNA can persist for years in circulating cells from patients on successful anti-retroviral therapy and presents a circulating latent reservoir of virus. New drugs to treat HIV infection are targeted at the HIV integrase (IN) enzyme. We assessed changes in HIV DNA in patients treated with an IN inhibitor, to assess if these new drugs can clear this circulating reservoir.

PBMC were isolated from patients recruited for Raltegravir (Ral) combination therapy based on special access guidelines, DNA extracted and HIV DNA quantitated (1). HIV DNA sequence was obtained by consensus sequence analysis. HIV DNA was detected in all patients prior to Ral therapy and declined to undetectable levels within 4 wks in 5/6 patients and 8 wks in the 6th patient. Patients concurrently showed a rise in CD4+ cells and a decline in circulating plasma viral load. The increase in CD4+ cells without accompanied increased HIV DNA, indicates reconstitution with HIV negative cells and prevention of further re-infection of these cells. Successful therapy was maintained for at least 6 mths. A minor transient viremia was observed in one patient with a brief treatment intermission at 3 mth post-therapy which was accompanied by an increase in HIV DNA. Ral-induced drug resistance mutations in the IN gene were not observed in either the circulating virus or PBMC DNA.

In conclusion, Ral combination therapy successfully and rapidly reduced HIV viral load and cellular DNA and increased CD4+ without drug resistance. Prevention of HIV DNA integration may promote decay and clearance of unintegrated latent HIV DNA forms, while the turn-over of cells harbouring integrated DNA without re-population of new infected cells may subsequently purge the HIV DNA containing reservoir. Thus, IN inhibitor therapy may reduce the circulating HIV reservoir above that seen with traditional protease and RT inhibitor based combination therapies.

This work was supported by funding from ACH2


INHIBITION OF HIV BINDING TO LANGERIN ON LANGERHAN'S CELLS AS A STRATEGY FOR MICROBICIDE DEVELOPMENT

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The interaction of HIV with immature Langerhans cells (ILCs) in the female genital tract is of key importance for sexual transmission, as these cells are the major cells able to transport virus through epithelium to T cells in the submucosa or lymph node. HIV binds initially to langerin on ILCs. Then the virus is probably either endocytosed or cause true infection. Therefore inhibition of HIV binding to langerin is likely to be a successful strategy for prevention of infection by microbicides (but probably requires combination with an inhibitor of the HIV fusion receptor (CCR5)).

To test this hypothesis we initially used skin/mucosa derived immature (i)ILCs but yields were too low for screening inhibitors, only for final validation of results. However with the model ILCs, Mutz 3 cells, derived from acute myelomonocytic leukaemia (5) and cultured in GM-CSF, TNFα, TGF-β, 99% expressed Langerin and <2% DC-SIGN and mannose receptor (MR), after cell sorting to deplete DC-SIGN/MR+ cells. 80-95% of these cells also expressed CD4 and 25-30% expressed CCR5. They were infectable by HIV at similar levels to iILCs.

Meanwhile parallel studies on the oligomeric status of langerin on the surface of langerin transfected QT6 and Mutz3 cells showed Langerin to equilibrate between monomeric and tetrameric states and that HIV gp120 trimer bound more strongly to the tetramer. The first inhibitors tested were the generic C Type Lectin Receptor inhibitor, mannan, and also blocking monoclonal antibodies to the carbohydrate recognition domain (CRD) and/or full extracellular domain (ECD) of langerin. All inhibited gp120 monomer/trimer binding to langerin as a monomer but not as a tetramer, indicating the need to develop inhibitors of gp120-langerin oligomer interactions, such as soluble langerins. The latter were tested for toxicity to monocyte derived DCS, Mutz 3 cells and keratinocytes and shown to be toxic only at high concentrations of >25μg/ml, using trypan blue dye exclusion or, for DCS in an antigen presentation assays. We will now examine the efficacy of soluble langerins in inhibiting binding of gp120 to langerin (oligomers) on Mutz 3 cells and iILCs, infection of these cells and finally transfer of HIV from these cells to CD4 lymphocytes.
AN HLA-C*0702 RESTRICTED T-CELL RESPONSE DIRECTED AGAINST AN IMMUNE ESCAPED HIV NEF KY11 EpIToPE EXHIBITS HIGHER FUNCTIONAL AVIDITY BUT LESSER CYTOLYTIC ACTIVITY WHEN COMPARED WITH THE ANTI-WILD TYPE RESPONSE


HIV-1 mutational escape from a suppressive epitope-specific T-cell response has been well described. Analysis of HLA allele associated HIV polymorphism in population-based studies (n>800) suggests that HIV may also adapt to favour induction of certain epitopes that actively enhance viral replication. We therefore sought to investigate the presence and functionality of the HLA-restricted T-cell responses driving one such adaptation identified by the genetic analysis (Nef D108E in the HLA-C*0702 restricted Nef KY11 epitope).

Cryopreserved PBMC samples from 32 HIV-infected patients with HLA-C*0702 allele were assayed for IFN-γ production upon stimulation with the adapted and non-adapted (‘wild type’) KY11 peptides by ELISpot assay. The functional avidity of wild type and variant-specific T-cell directed responses were compared using serial peptide dilutions. Autologous epitope sequences were determined from contemporaneous plasma samples in patients with detectable HIV viral load (n=4). CTL killing of peptide-pulsed EBV transformed B-cells was determined using the Chromium release assay.

IFN-γ was detected in PBMC samples from all patients after stimulation with anti-CD3 or CEF. IFN-γ responses to the wild type or adapted KY11 epitopes were detected in 13 patients. The adapted epitope induced IFN-γ responses in 11 HLA-C*0702 patients (median-500, range 150-1110 spots/million cells). In 3 samples from 2 cases, the adapted peptide-specific response had greater functional avidity than the wild type peptide. Autologous sequence contained the D108E adaptation in 1 patient who concurrently demonstrated IFN-γ responses. In initial assessments of T-cell killing, HLA-C*0702 B-cells pulsed with wild type peptide were killed more readily by adapted peptide CTLs than wild type peptide CTLs.

Despite modest levels of epitope-specific IFN-γ responses overall in this treatment-experienced patient group, HLA-
ROBUST NK-CELL MEDIATED HIV-SPECIFIC ANTIBODY-DEPENDENT RESPONSES IN HIV-INFECTED SUBJECTS

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Antibody-dependent cellular cytotoxicity (ADCC) is a potentially effective adaptive immune response to HIV-infection. The study of ADCC responses has been hampered by the lack of simple methods to quantify these responses and map effective epitopes. We serendipitously observed that standard intracellular cytokine assays on fresh whole blood from a cohort of 26 HIV-infected subjects identified non-T lymphocytes expressing IFN-γ in response to overlapping linear peptides spanning HIV-1 proteins. The effector cells were CD3-4-8-14-2+56+/- NK lymphocytes and degranulated Granzyme B and Perforin in response to antigen stimulation. Serum transfer assays demonstrated that the specific response was mediated by IgG. Fresh blood samples from half of the HIV-infected cohort demonstrated robust HIV peptide-specific IFN-γ expression by NK cells; predominately to Env, Pol and Vpu HIV-1 proteins. Responses were readily mapped to define minimal epitopes utilizing this assay. Antibody-dependent, HIV-specific NK cell recognition, involving components of both innate and adaptive immune systems, represents a novel and potentially effective immune responses to induce by vaccination.

CMV-SPECIFIC EFFECTOR MEMORY CD4+ T-CELLS IN HIV PATIENTS ON LONG-TERM ART ARE PREDOMINANTLY ‘CD28 NULL’ IMMUNOSENESCENT CELLS

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HIV-infected individuals who achieve a long-term virological response to combination antiretroviral therapy (ART) experience variable recovery of CD4+ T-cell responses to the antigens of opportunistic pathogens. This does not reflect current CD4+ T-cell numbers but is particularly evident amongst individuals who had a low nadir CD4+ T-cell count before ART. Using cytomegalovirus (CMV) as an index antigen, we examined markers relevant to the activation or regulation of CD4+ T-cell interferon (IFN)-γ responses in HIV patients on ART.

Study groups comprised male, CMV-seropositive HIV patients (n=18) and healthy controls (n=10). HIV patients were selected to fit three criteria; (1) nadir CD4+ T-cell counts <50 cells/µL, (2) at least 3 years on ART and (3) plasma HIV RNA <50 copies/mL for at least 2 years. IFN-γ responses to a crude CMV antigen were measured by ELISpot and were shown to arise from CD4+ T-cells. Flow cytometry was used to assess expression of CD57, CD28, cytotoxic T-lymphocyte antigen (CTLA)-4 and programmed death (PD)-1 on CD4+ T-cells.

Expression of CTLA-4 on CD4+ T-cells was higher overall in HIV patients compared to controls (p=0.03) but was not correlated with IFN-γ responses to CMV (r=-0.17). The expression of PD-1 on CD4+ T-cells in HIV patients extended over a wider range than controls (median (range) 4.9% (0.2-13.1) vs 2.3% (0.4-4.5), respectively) but was also not associated with IFN-γ responses to CMV (r=0.26). The majority of CD4+ T-cells expressed CD28 in both patients and controls (median of 90% and 93%, respectively) and CD28 expression inversely correlated with IFN-γ responses to CMV (r=0.54, p=0.02) in HIV patients. CD4+ T-cells that did not express CD28 expressed high levels of CD57. The proportion of CD57+ CD28- T-cells was directly correlated with IFN-γ responses to CMV in HIV patients (r=0.56, p=0.01).

These data suggest that a substantial proportion of CMV-specific effector memory T-cells in previously immunodeficient HIV patients receiving long-term effective ART are immunosenescent ‘CD28 null’ CD4+ T-cells, a situation similar to some autoimmune diseases. IFN-γ responses to CMV do not appear to be limited by CTLA-4 or PD-1.
PHENOTYPIC ANALYSES OF FOXP3-EXPRESSING CD4+ AND CD8+ T CELLS IN HIV-INFECTED PATIENTS

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Proportions of CD25+CD4+ regulatory T (Treg) cells are increased in HIV-infected patients. In untreated HIV disease, the proportion of CD4+ Treg cells in blood and tissue may be associated with the level of immune activation driven by HIV replication. Furthermore, populations of CD4–CD8– and CD8+ cells expressing FoxP3 are increased in the blood, particularly in patients with very low CD4+ T cell counts.

FoxP3+ cells have not been extensively phenotyped in HIV-infected individuals. We assessed the expression of various markers of activation and co-stimulatory molecules on FoxP3+CD4+ and FoxP3+CD8+ cells by flow cytometry, and compared the expression of these markers between untreated and treated patients.

FoxP3+ cells have not been extensively phenotyped in HIV-infected individuals. We assessed the expression of various markers of activation and co-stimulatory molecules on FoxP3+CD4+ and FoxP3+CD8+ cells by flow cytometry, and compared the expression of these markers between untreated and treated patients.

The proportion of CD4-negative FoxP3+ cells was greatest in the most immunodeficient patients. This population included CD8+ and CD4–CD8– double negative cells. A greater proportion of FoxP3+ cells from untreated patients (n=20; 5–1,400 CD4+ T cells/µL) exhibited the memory (CD45RO+) or activated (HLA-DRHI or Ki-67+) phenotype when compared with patients on ART (n=20; 50-1,250 CD4+ T cells/µL) and uninfected donors (n=14). When FoxP3+CD4+ and FoxP3+CD8+ T cells were compared in treated/untreated patients and untreated donors, expression of both CD28 and CTLA-4 was higher in the CD4+ subset, whereas expression of PD-1 and CD57 was higher in the CD8+ subset.

The data demonstrate major phenotypic differences between FoxP3+CD4+ cells and FoxP3+CD8+ cells. Proportions of CD4+ Treg cells and the FoxP3+CD8+ phenotype are directly related to the level of immune activation. A “re-balance” of FoxP3+ cells from the CD8+ to the CD4+ compartment may occur in treated patients who are able to successfully reconstitute their CD4+ T cell compartment and maintain virological control.

IDENTIFICATION OF HUMAN ANTIGEN-SPECIFIC REGULATORY T CELLS, PHENOTYPING AND FUNCTIONAL ANALYSIS

Nabila Seddiki1,2, Kai Brown1,2, Chansavath Phetsouphanh1,2, David Cooper1,2,3, John Zaunders1,3 and Anthony Kelleher1,2,3
1Centre for Immunology, St Vincents Hospital, Darlinghurst, NSW 2010, Australia; 2National Centre in HIV Epidemiology and Clinical Research, University of NSW, Kensington, NSW 2052, Australia; 3HIV, Immunology and Infectious Diseases Clinical Services Unit, St Vincents Hospital, Darlinghurst, NSW 2010

CD4+CD25+CD127lowFoxp3+ regulatory T cell (Tregs) have a role in maintaining tolerance to self-antigens and coordinating immune responses to pathogens. More recently, there has been increased interest in antigen-specific Tregs as they have potential as a novel immunotherapeutic agent in the treatment of autoimmune disease and cancer and may also have therapeutic role in transplantation and vaccine regimes. Using recall responses and a new gating strategy for which includes Foxp3, CD134 and CD39, we aimed to identify, phenotype and study the function of Tregs responding to re-stimulation with epitopes from CMV pp65. In healthy CMV+ donors we found that 1.41% ±0.37% (mean±SEM) of peripheral CD4+ T cells were specific for pp65. Surprisingly, a majority of these cells (70.80%±1.00%) were bona-fide Foxp3+ antigen-specific Tregs. This subpopulation was isolated by FACS and studied in suppression assays. Antigen-specific CD39+Foxp3+ Tregs were found to be better suppressors than CD39- Foxp3+ Tregs. To determine the source of these Tregs, the TCRβ CDR3 region of these subsets and other subsets of effector/memory cells is currently being amplified for clonotypic analyses. The results will determine whether antigen-specific Tregs are derived or not from effector/memory cells, which then undergo clonal expansion when encounter antigen.

WEDNESDAY 17 SEPTEMBER 2008: 3.30PM – 5.00PM
REGULATORY T CELL ABNORMALITIES ARE ASSOCIATED WITH ABERRANT CD4+ T-CELL RESPONSES IN PATIENTS WITH IMMUNE INFLAMMATORY SYNDROME (IRIS)

Nabila Seddiki1,2, Chansavath Phetsouphanh1,2, Kai Brown1,2, John Zaunders1,3, David Cooper1,2,3, Anthony Kelleher1,3
1Centre for Immunology, St Vincents Hospital, Darlinghurst, NSW 2010, Australia; 2National Centre in HIV Epidemiology and Clinical Research, University of NSW, Kensington, NSW 2052, Australia; 3HIV, Immunology and Infectious Diseases Clinical Services Unit, St Vincents Hospital, Darlinghurst, NSW 2010

Up to 30% of patients with HIV commencing antiretroviral therapy (ART) late in the disease, restore a pathogen-specific cellular immune response that is immunopathological and causes disease referred as immune reconstitution inflammatory syndrome or IRIS. We report that in HIV-infected patients who developed IRIS to mycobacteria, a large expansion of CD4+ T-cells specific for M. avium complex (MAC) antigens producing high levels of IFN-γ and IL-2 (P<0.01) was observed. Surprisingly, we found an even larger proportion of expanded CD127loFoxp3+CD25+Tregs in these patients compared to healthy controls (17.8%±2.51% c/w 6.81%±0.35%, p<0.05) or to HIV+ patients before commencing ART (4.3%±1.2%, p<0.01) or 4 weeks after starting ART (4.3%±1.61%, p<0.01). However, these Tregs are defective in their ability to suppress effector T cell proliferation and production of inflammatory cytokines (IL-6, TNF-α). This may explain the aberrant immune responses observed in these patients. To further investigate the suppressive dysfunction, we assessed CD39 and CD73 expression and function. These two ecto-enzymes have been reported recently to play a major role in Tregs function. Interestingly we found that, although CD39 expression was elevated in IRIS patients compared to controls (12.48%±2.069% c/w 2.67%±0.38%, p<0.05), CD73 expression was very low or absent compared to controls (1.045%±0.18% c/w 5.028%±1.18%, p<0.01). The imbalance in expression of these 2 regulatory ecto-enzymes that normally work in tandem may help explain the observed defect in suppressive function of Tregs, allowing the excessive proliferation and inflammation in IRIS. Experiments are in progress attempting to delineate a possible role for CD73 dysfunction in the immuno-pathology of IRIS.
A CRITICAL ANALYSIS OF THE QUALITY AND TRANSFERABILITY OF ECONOMIC EVALUATIONS OF HIV INTERVENTIONS FOR AUSTRALIAN DECISION-MAKING

Anderson JS1, Carter R2, Cooper DA1.
1National Centre in HIV Epidemiology and Clinical Research, Darlinghurst NSW 2010.
2Health Economics, Deakin University, Burwood, Victoria.

There have been few economic evaluations of HIV healthcare and prevention interventions in Australia. Decision-makers developing guidelines may use existing studies from the pre-HAART era or overseas. However findings from these studies may not be valid or relevant in an Australian population. This study aimed to examine the published literature of economic evaluations in the post-HAART era to assess their quality and transferability.

The peer-reviewed literature was searched using standard methodologies for publications (post 1996) related to economic evaluation of HIV interventions in high income countries. A second stage filter was applied which assessed the interventions on a number of criteria including impact on health and costs; evidence-based; on the policy agenda; options for incremental increase or decrease in funding; clear program logic for the intervention; temporal relevance. Finally the EURONHEED consensus instrument, developed by health economists, was used to score the quality and generalisability of the studies.

123 peer-review articles were available (1996-2007). Over 90% were published from North American studies with one published study from Australia. 58 related to healthcare and 62 prevention (including biomedical prevention). 19 focused on the prevention of perinatal transmission and 13 on the diagnosis, prevention and management of opportunistic infections. Quality and transferability scores ranged from 96% to less than 50%. Key issues in quality and transferability were perspective, study population, model design, measurement and valuation of benefit and cost data, and statistical analyses.

While there is extensive published literature on economic evaluations, most of it comes from North America and some of the findings appear less relevant to clinical management and policy making. Study populations may differ from an Australian population and values for costs and outcomes may not be valid for Australia in 2008. Decision makers need to consider both the internal and external validity of economic evaluations of HIV interventions in the post-HAART era.

COST EFFECTIVENESS OF SCREENING FOR ANAL CANCER IN HIV+ MSM

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Anal Squamous Cell Carcinoma (ASCC) occurs at rates of approximately 30 - 92 cases/100,000 in HIV+ MSMs. Despite surgery, chemotherapy and radiotherapy, the 2004 overall five year survival in Australia is 64% (lower in HIV+). This compares to 2002 rates of cervical cancer among the general Australian female population of 6.9 cases/100,000, and a five year survival of 74%.

Similarities exist between ASCC and cervical cancer. For example, both cancers occur in transitional tissue, both are caused by sexual transmission of certain genotypes of Human Papilloma Virus and they have similar cytological and histological features. Using cervical cancer screening as a model, we therefore sought to compare the estimated cost parameters of a theoretical anal Pap smear intervention to detect anal cancer, with those of the existing cervical Pap smear programme.

The total number of HIV+ MSM in Australia is approximately 12,700. It can therefore be estimated that 7.5 (range 3.6 - 11.7) cases of anal cancer will develop per year in these men. Anal Pap smears are reported as being 81% sensitive. Thus, if all 12,700 HIV+ MSM in Australia were screened, 81% of 7.5 cases = 6 cases would be detected. In this manner, each case of anal cancer would require 12,700/6 = 2,116 HIV+ MSM to be screened.

In comparison, the New South Wales Pap Register recorded 681,306 cervical Pap smears in 2005, when the incident cervical cancer rate was 238 cases per year. Thus 681,306/238= 2,862 Pap tests were performed on women for each case of cervical cancer detected.

A U.S.A. paper in 1999 estimated the cost per QALY for anal cancer screening in HIV+ MSM every 2 years was $13,000. In comparison, the most recent Australian figures indicate that the cost per QALY for cervical screening is significantly higher, at $21,707.

Our preliminary calculations therefore suggest that an intervention targeting HIV+ MSM with anal Pap smears to screen for anal cancer would be of comparable value and costs to that of the existing cervical cancer screening program. A number of assumptions were made in the above calculations, and further work is required to refine these figures.
EFFECTIVE PARTNERSHIP AND ADEQUATE INVESTMENT UNDERPIN A SUCCESSFUL RESPONSE: KEY FACTORS IN DEALING WITH HIV INCREASES

Diana Bernard¹, Susan Kippax¹, Don Baxter ²
¹National Centre for HIV Social Research (NCHSR); ²Australian Federation of AIDS Organisations (AFAO)

Background:
Australia has mounted an effective prevention response to HIV/AIDS by investing in policy informed by evidence, strong partnerships and adequate investment. Recently, in response to increases in HIV in some Australian states, the New South Wales (NSW) Department of Health set up a 'Think Tank' to examine state-based differences.

Methods:
The National Centre in HIV Social Research (NCHSR) undertook key informant interviews with major stakeholders to complement behavioural/surveillance data. It was hoped to identify how members of the partnership (government, non-government organisations, researchers, gay community) in NSW had collaborated to keep HIV notifications in NSW stable compared with increases in Victoria and Queensland. In parallel, the Australian Federation of AIDS Organisations (AFAO) analysed the strategic contexts, government responses and investments in prevention of HIV in all jurisdictions in Australia.

Results:
There were significant differences between NSW, Queensland and Victoria in the way the HIV partnership functioned and was resourced. Whilst the strong partnership in NSW enabled a planned, evidence-based response, the response in Queensland was hampered by competitive tendering that pitched partners against each other. In Victoria diminished funding, the inability of partners to work together, an inadequate strategic framework and a more rigorous application of the purchaser-provider model inhibited collaborative planning and the optimal resource allocation necessary for an effective response. Prevention campaigns in Queensland and Victoria were also subject to greater government censorship than NSW campaigns.

Conclusions:
Since the Australian strategic response to HIV/AIDS has been one of the most successful in the world, an understanding of Australian partnership arrangements is highly relevant for other countries addressing the challenge of HIV/AIDS. Any interpretation of, and response to, increases in HIV notifications and unsafe sexual practice needs to be cognisant of the crucial nature of strategic partnerships and adequate resourcing for successful prevention.

Keywords: HIV transmission, evidence based policy, partnership

MODELS OF ACCESS AND CLINICAL SERVICE DELIVERY IN AUSTRALIA TODAY

Dr Jan Savage, ASHM
Mr Peter Canavan NAPWA, Ms Jo Watson, NAPWA, Ms Levinia Crooks ASHM

Determining the appropriate nature, level and mechanism for delivering care to people living with HIV has been a constant challenge in the Australian environment. Since the early recognition of HIV and the management of opportunistic infection through to the development and delivery of very effective antiretroviral agents there has been a shifting understanding of what is best, what is appropriate, what is manageable and what is affordable care.

In Australia much care is provided to PWHIV by general practitioners in the community setting. But this care is provided in the context of there being a very dispersed HIV population nationally. At the same time our health workforce is over stretched and asked to take on increasing levels of complex management.

The Models of Access and Clinical Service Delivery Project is a joint initiative of NAPWA and ASHM. It is supported by DoHA and the States and Territories via AHMAC arrangements. The project is exploring the changing needs of PLWHA, the range of service models available generically to manage chronic care as well as the changing nature of HIV management.

The presentation outlines the methodology undertaken and presents preliminary data being collected as part of the project. It will also act as a discussion point for attendees to put forward issues which they see as important in the delivery of services to PLWHA as we enter the third decade of HIV management.
REDUCED RISK OF HIV SEROCONVERSION AMONG CIRCUMCISED HOMOSEXUAL MEN WHO REPORT A PREFERENCE FOR THE INSERTIVE ROLE IN ANAL INTERCOURSE

Templeton DJ1,2, Jin F1, Mao L3, Prestage GP1, Donovan B1,4, Imrie J1, Kippax SC3, Kaldor JM1, Grulich AE1

1National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney NSW, Australia; 2RPA Sexual Health, Royal Prince Alfred Hospital, Sydney NSW, Australia; 3National Centre in HIV Social Research, The University of New South Wales, Sydney NSW; 4Sydney Sexual Health Centre, Sydney Hospital, Sydney NSW, Australia

Circumcision substantially lowers the risk of HIV acquisition among heterosexual men in Africa, but there are few and conflicting data addressing circumcision status as a risk factor for HIV among homosexual men. We examined circumcision status as an independent risk factor for HIV seroconversion in the community-based Health in Men (HIM) cohort of homosexual men in Sydney, Australia.

Between 2001 and 2004, 1,426 initially HIV-negative men were enrolled. Circumcision status was self-reported at baseline and was validated by clinical examination during study visits in a sub-sample of participants. All participants were tested annually for HIV. Demographic information was collected at baseline and detailed information on sexual risk behaviours was collected every 6 months.

At baseline, almost two thirds of participants reported being circumcised; mostly as infants. There were 53 HIV seroconversions in the HIM cohort, an incidence of 0.78 per 100PY. On multivariate analysis controlling for behavioural risk factors, being circumcised was not associated with HIV seroconversion (HR 0.76, 95% CI 0.41-1.41, p=0.381). However, among those with a preference for the insertive role in anal intercourse, being circumcised was associated with a significant reduction in HIV incidence when controlling for age and number of insertive unprotected anal intercourse (UAI) acts with HIV positive or status unknown (sero-nonconcordant) partners (HR 0.15, 95% CI 0.03-0.80, p=0.026). In these men, a median 100% (IQR 92.1-100%) of UAI acts with sero-nonconcordant partners were in the insertive position and reported preference for the insertive role was remarkably constant over time.

Overall, circumcision was not associated with HIV incidence in the HIM cohort. However, being circumcised was associated with a significant reduction in HIV incidence among those participants who reported a preference for the insertive role in anal intercourse. As most HIV infections in homosexual men occur after receptive anal sex, circumcision is likely to have a limited impact as an HIV prevention intervention in Australian homosexual men. However, circumcision may have a role in those men who are predominantly at risk of HIV seroconversion through insertive rather than receptive anal intercourse.

Circumcision
5.15pm – 6.15pm

WEDNESDAY 17 SEPTEMBER 2008 5.15PM – 6.15PM
SMALL POPULATION HEALTH BENEFITS ON HIV BY CIRCUMCISING MEN WHO HAVE SEX WITH MEN

Londish G1, Templeton DJ2, Regan D2, Kaldor JM2, Murray JM1,2
1School of Mathematics, University of New South Wales, Sydney, NSW, Australia; 2National Centre for HIV Epidemiology and Clinical Research, Sydney, NSW, Australia

Men who have sex with men (MSM) suffer a disproportionate burden of HIV in the developed world. The recent success of circumcision in reducing HIV acquisition among heterosexual African men has prompted debate on whether circumcision could be effective in reducing HIV acquisition amongst MSM in developed countries. We developed a mathematical model to estimate the impact of a male circumcision intervention on HIV incidence and prevalence in a MSM community in a developed country. The model provides a simple relationship between the level of circumcision and long-term HIV prevalence. The results indicate that the decrease in HIV prevalence is much lower than that experienced amongst heterosexual men, such that if a MSM community initially had no circumcision and 10% HIV prevalence, complete circumcision would reduce this to 6%. However, it would require decades before a substantial drop in HIV prevalence was achieved. HIV incidence follows a similar pattern with a drop during intervention and then gradual decline over decades. Strategic positioning, another risk reduction strategy, can provide a slight increase to the effectiveness of circumcision reducing prevalence from 6% to 1%. These results suggest that circumcision is not a viable option to substantially reduce HIV prevalence amongst MSM in developed countries.

COST-EFFECTIVENESS OF CIRCUMCISION FOR THE PREVENTION OF HIV IN GAY MEN IN AUSTRALIA

Anderson J

This study aimed to examine the incremental cost-effectiveness of a program of male circumcision in Australian MSM.

We used a dynamic model with a hypothetical population of 180,000 MSM around Australia with baseline HIV prevalence according to age but homogenous sexual mixing. Circumcision was assumed to have an efficacy of 60% (range 30-82%) in preventing acquisition by an insertive MSM. Baseline circumcision rates ranged from 50.3% (for <25 y.o.) to 82.6% (for >45 y.o.). The impact of antiretroviral therapy, sero-positioning and condom use was included. Cost per circumcision was $3,650 including pre-operative counseling, assessment and testing, operative care and post-operative follow-up. Relevant costs and outcomes including quality-adjusted life-years were discounted at 3%.

Three strategies for implementation of a circumcision intervention were compared with the status quo: circumcising all MSM at sexual debut, all insertive MSM immediately, and all MSM now. For each strategy the number of HIV infections prevented per year is shown in the table.

<table>
<thead>
<tr>
<th>HIV infections prevented per year</th>
<th>10 years</th>
<th>25 years</th>
<th>50 years</th>
</tr>
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<tbody>
<tr>
<td>sexual debut</td>
<td>11</td>
<td>37</td>
<td>72</td>
</tr>
<tr>
<td>Insertive</td>
<td>20</td>
<td>34</td>
<td>56</td>
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<tr>
<td>all MSM</td>
<td>37</td>
<td>57</td>
<td>80</td>
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</table>

All approaches were not cost-effective early post-intervention but they became cost-effective after 7-14 years for circumcising just insertive MSM; after 12-27 years for all MSM; and after 19-31 years for circumcising all at sexual debut. Intervention costs ranged from $14m a year for the sexual debut approach, to $196m in the first two years for the all MSM approach. Sensitivity analyses will be presented that explore changes in risk behaviour, uptake and parameter uncertainty.

Targeting the intervention to insertive men would be most efficient, but even in the best-case, the benefits of an intervention based on male circumcision would not be seen for at least a decade and would have significant upfront costs.
THE ACCURACY OF HIV INCIDENCE ASSAYS IN ESTIMATING THE POPULATION RATE OF NEW INFECTIONS: A SYSTEMATIC REVIEW

Guy R1,2, Gold J2,3, García Calleja JM4, Kaldor J2 on behalf of the WHO Working Group on HIV Incidence Assays

1Centre for Epidemiology and Population Health Research, Burnet Institute, Melbourne, VIC, Australia; 2National Centre in HIV Epidemiology and Clinical Research, Sydney, NSW, Australia; 3Department for Epidemiology and Preventive Medicine, Monash University, Melbourne, VIC, Australia; 4World Health Organization, Geneva, Switzerland.

Specialised HIV serological assays have been used in many countries to distinguish recent from established HIV infections in populations as a basis for estimating incidence. However there is recent evidence that the BED-CEIA assay overestimates HIV-1 incidence, due to misclassification of cases with longstanding HIV infection as recent infections, leading to a recommendation by UNAIDS that the BED assay not be used for routine surveillance, incidence estimates or monitoring incidence trends at a population level.

A review was conducted to summarise validation findings for all assays. Validation was defined to mean the process of comparing estimates of HIV incidence derived from use of an assay in a population, to concurrent estimates of incidence in the same population obtained by an alternative means that is believed to provide a reliable measure of incidence (‘gold standard’). PubMed was searched to the end of December 2007.

There were 22 papers identified, reporting 25 overall incidence estimates. The most frequently used ‘gold standard’ incidence method was a cohort study (13), followed by a database of repeat HIV testers (four) and mathematical modelling (3). The percentage difference between the median assay-derived incidence and ‘gold standard’ incidence was 10%. Twelve of the 25 overall analyses were based on the comparison of assay-derived incidence and ‘gold standard’ incidence on identical samples; the median difference for these assessments was 7.3%, compared to 26% for the 13 validations conducted using non-identical populations. The median difference was -13.4% for five validations conducted among IDUs, 13.9% for eight validations in MSM increasing to 166.3% for eight validations among heterosexuals from sub-Saharan Africa. The median difference was 10.3% for three validations conducted using the 3A11-LS assay, 7.5% for 15 validations using the BED assay and 13.9% for the six validations using the Vironostika assay.

The review showed incidence assays perform well in providing estimates of HIV incidence and assays can be reliably used to estimate HIV incidence, as long as due consideration is given to the presence of longstanding infections and people receiving HIV treatment, with their potential to produce “false-recent” findings in the population. A variety of validation methods were used, highlighting the need for a standard and comprehensive framework for the development of incidence assays.
SENSITIVITY AND SPECIFICITY OF HIV INCIDENCE ASSAYS: A SYSTEMATIC REVIEW

Gold J1,2, Guy R1,3, García Calleja JM4, Kaldor J3 on behalf of the WHO Working Group on HIV Incidence Assays

1Centre for Epidemiology and Population Health Research, Burnet Institute, Melbourne, VIC, Australia; 2Department for Epidemiology and Preventive Medicine, Monash University, Melbourne, VIC, Australia; 3National Centre in HIV Epidemiology and Clinical Research, Sydney, NSW, Australia; 4World Health Organization, Geneva, Switzerland

Reduction in new HIV infections is one of the world’s major public health objectives. Specialised serological assays have been developed to measure HIV incidence at a population level. Assays are developed to have an associated ‘estimated window period’ indicating the time in which an infection is considered recent. To maximise utility, assays must have a high probability of correctly detecting recent infections (sensitivity) and a low probability of misclassifying established infections as recent (specificity).

Publications reporting on sensitivity and specificity of assays measured against specimens of known time of infection until the end of 2007 were reviewed. Infections were classed as recent or established, as indicated by seroconversion before or after the assay window period. We also assessed specimens relating to individuals (i) known to be HIV infected for one year or more (longstanding infections), (ii) diagnosed with AIDS and (iii) receiving antiretroviral treatment.

Thirty two reports related to 16 different assays were identified. The 90 sample sets included in the reports were most commonly derived from cohorts (47) and sourced from the United States (27). Thirty six (40%) sample sets specified the subtype of the specimens; 22 were subtype B. The number of specimens assessed ranged widely (median 123, range 7-2749).

The median sensitivity for recent infections was 88.8% (n=30, range 42.3-100). The median specificity for established infections was 93.3% (n=33, range 49.5-100) compared to 98.0% for longstanding infections (n=8, range 70.0-100) and 91.6% for AIDS cases (n=23, range 72.2-100). Median specificity for individuals receiving antiretroviral treatment for one year was 95.5% (n=4, range 91.0-100) and 76.3% for individuals treated for two years (n=4, range 72.7-81.8).

The majority of sensitivity and specificity estimates were above 85% for recent and established infections. Specificity was lower for AIDS cases compared to longstanding infections and specificity appeared to decrease with increasing time on antiretroviral treatment. However the limited descriptions of sample characteristics, and limited number of specimens from individuals with longstanding infections and individuals receiving antiretroviral treatment, indicates the need for established, well-described specimens banks for sensitivity and specificity testing during assay development, before their application in the field.
EVALUATION OF THE NEW VERSION 3 CAVIDI EXAVIR™ LOAD QUANTITATIVE HIV RT LOAD MONITORING ASSAY FOR USE IN BOTH RESOURCE-CONSTRAINED AND DEVELOPED COUNTRIES

Greengrass V, Plate M, Steele P, Denholm J, Morris L and Crowe SM

There is an increasing need for inexpensive and simple tests to monitor HIV disease progression in developed and resource-constrained countries to facilitate appropriate use of antiretroviral therapy. We have extensively evaluated the new version 3 (v3) low cost manual reverse transcriptase assay, ExaVir™ Load assay from Cavidi AB (HIV RT) and compared it to the version 2 (v2) assay and the commercially available Roche COBAS Amplicor HIV-1 Monitor assay version 1.5, which measures HIV RNA (ultrasensitive preparation; HIV RNA).

Frozen plasma samples from HIV-infected individuals with previously quantified HIV RNA were also tested for HIV RT activity using the v2 (n=411) and the v3 (n=265) assays. The HIV RT v3 assay sensitivity has improved significantly from v2 with 95% of all samples detectable with HIV RNA ≥400 copies/ml compared to 85% with v2. A strong positive association was observed between detectable samples tested using the HIV RNA assay compared to HIV RT v2 and v3 assays (r=0.88; n=176 and r=0.88; n=223 respectively). Bland-Altman model was used for measuring agreement between the HIV RNA assay and the HIV RT v2 and v3 assays (mean difference: -0.19 log10 and -0.11 log10 respectively) and between the HIV RT v2 and v3 assays (mean difference: 0.01 log10).

The HIV RT v3 assay is more sensitive than the v2 assay. Other improvements include faster turnaround time and fewer consumables required. The HIV RT v3 assay is suitable for use in monitoring HIV disease progression in both resource-constrained and developed countries.

PERSISTENCE OF HIGH LEVELS OF HIV ANTIGEN-SPECIFIC CD4+ T CELLS IN UNTREATED CHRONIC INFECTION, DETECTED BY A NOVEL FLOW CYTOMETRIC ASSAY

Zaunders J1, Bailey M2, Munier ML2, Seddiki N1, Kim M1, Pett S2, Emery S2, Cunningham AL1, Cooper DA1,2 and Kelleher AD1,2

1Centre for Immunology, St Vincent’s Hospital, Darlinghurst, NSW; 2National Centre in HIV Epidemiology and Clinical Research, Darlinghurst, NSW; 3Westmead Millenium Institute, Westmead, NSW

HIV-antigen-specific CD4+ T cells are preferentially targeted and deleted by cytopathic infection. In most cases, HIV-1 antigen-specific CD4+ T cells are barely detectable by proliferation assays, and at low levels by interferon-γ production. We developed a novel assay of antigen-specific CD4+ T cells, based on up-regulation of CD25 and CD134 (OX40), and not reliant on either proliferation or cytokine production, to re-assess the level of HIV-specific CD4+ T cells in untreated chronic infection.

Samples of whole blood from 15 healthy adult controls and 13 consecutive asymptomatic untreated subjects with established HIV-1 infection (median: 158 CD4+ T cells/µl; 4.7 log10 RNA copies/ml) were incubated in vitro for 40-44 hr with either culture medium alone or with various recall antigens including lysates of CMV and M. avium; UV-inactivated HSV-1; or a pool of overlapping 15-mer peptides covering HIV-1 Gag. Cell surface CD25 and CD134 were measured on CD4+ T cells by flow cytometry. Results for subject groups were expressed as medians.

The background level of CD25+CD134+ CD4+ T cells was very low, <0.03% of CD4+ T cells (mean + 3xSD). In healthy adult controls, recall responses to CMV, M. avium and HSV-1 were a median of 3.9%, 3.6% and 1.1% of CD4+ T cells, respectively and correlated with standard assays of lymphoproliferation in 7-day cultures. In the cohort of HIV-infected subjects, responses to CMV, M. avium and HSV-1 were 4.7%, 5.2% and 2.3% of CD4+ T cells, respectively. Responses to HIV-1 Gag peptides were a median of 0.1% in healthy adult controls, but in the HIV-infected subjects responding cells were a median 0.8% of CD4+ T cells (*p<0.001 compared with controls), with 6/13 subjects having much higher responses, ranging from 1.7 to 4.8% of CD4+ T cells.

This novel assay has revealed relatively large populations of antigen-specific CD4+ T cells that respond to recall antigens, in both healthy adults and asymptomatic, untreated chronically infected HIV-infected subjects. In particular, we have discovered that there are 5-10 times more HIV Gag-specific CD4+ T cells present in peripheral blood than previously estimated by proliferation or IFN-γ production.
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Patients on the 300 mg dose of Reyataz can take one capsule once a day. It's just one more way Reyataz helps reduce the load.  

PBS Information: Private Hospital Authority Required: Treatment, in combination with 2 or more other antiretroviral drugs, of HIV infection in patients with: (a) CD4 cell count <500 cells/mm³; or (b) viral load > 10,000 copies/mL.

PLEASE REVIEW ACCOMPANYING FULL PRODUCT INFORMATION BEFORE PRESCRIBING, AVAILABLE FROM THE REYATAZ TRADE DISPLAY

Indications: Reyataz is indicated for the treatment of HIV 1 infection in combination with other antiretroviral agents. Dosage and method of use. Adults – two 200mg capsules (400mg) once daily with food. Limited data support an alternative dosing regimen of 300mg Reyataz with ritonavir 100mg daily with food. See full PI for dosing recommendation in combination with specific antiretrovirals. Contraindications: Hypersensitivity to atazanavir or any excipients; severe hepatic insufficiency; concomitant use of any medicine with a narrow therapeutic window that is a substrate of CYP3A4 enzyme; concomitant use with rifampicin*; proton pump inhibitors*; products containing St John’s wort*; benzodiazepines, ergot derivatives, cisapride, pimozide, quinidine, bepridil; see full PI for complete list of medications contraindicated for use with Reyataz with or without ritonavir. Precautions: Impaired hepatic function; patients with hepatitis B or C; cardiac effects*; pre-existing cardiac conduction system disease (first – third degree AV block); hyperbilirubinaemia and jaundice; rash, haemophilia; fat redistribution*; diabetes mellitus/ hyperglycaemia; immune reconstitution syndrome*; lactic acidosis; rare lactose/ galactose metabolic conditions*; pregnancy – Category B2; use in lactation*; use in children. Interactions with other drugs: Atazanavir is an inhibitor of CYP3A4 and UGT1A1 (and is also an inhibitor of CYP1A2 and CYP2C9); calcium channel blockers*; phosphodiesterase (PDE 5) inhibitors*; H2-receptor antagonists*; methadone*; antiarrhythmics*; fluticasone*; antifungals*; trazodone*; NNRTIs*; other protease inhibitors*; see full PI for complete list of interactions. The PI for ritonavir should be consulted when used with Reyataz. Adverse reactions: Headache; nausea; abdominal pain; rash; hyperbilirubinaemia and jaundice; altered LFT’s; insomnia; peripheral neurologic symptoms; scleral icterus; change in CD4 cell count; change in total lymphocyte count; upper respiratory tract infection; oesophagitis; pancreatitis; lactic acidosis; increased liver enzymes; decreased haemoglobin; hypokalaemia; increased creatinine; infertility; second degree AV-block*; elevated lipase, inflammatory reaction*. Others – see full PI. Presentation: 150mg capsules x 60 ($521.91), 200mg capsules x 60 ($695.88), 300mg capsules x 30 ($521.91). Reyataz Product Information is available by calling Bristol Myers Squibb on 1800 067 567. Bristol-Myers Squibb Pharmaceuticals, a Division of Bristol-Myers Squibb Australia Pty Ltd, ABN 33 004 333 322, 556 Princes Highway, Noble Park, VIC 3174. ® Registered Trademark. * Please note changes in Product information. Reference: 1. Reyataz Product Information. 10 August 2007. REY/0019/08/08 ETAL2537BM
Australasian Chapter of Sexual Health Medicine

**Sexual Health Update 2009**

**Saturday 2 May**

9am to 4pm

**Jasper Hotel**

489 Elizabeth Street
(near Victoria Market) Melbourne

**Topics will include:**

- Syphilis is back
- HIV post-exposure prophylaxis
- What’s new in urethritis and forgotten in vaginitis
- And talks on aspects of herpes, warts, PID, sex workers and gay men.

RACGP points pending

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