

infection in 'humanized' mouse models provides an unprecedented ability to study this exquisitely host-adapted pathogen *in vivo*, facilitating efforts to define the contribution of virulence factors to infection and immunopathogenesis, and providing a tractable model in which to test vaccine candidates. Finally, the re-establishment of human male volunteer urethral challenge models provides a clear path for the definitive validation of high priority vaccine formulations. The material nature of these advances has energized the community to coordinate efforts in the common goal of developing a vaccine to defeat this relentless pathogen.

S07 - Hooking up with new technology: influences on young people's sexual health

S07.1 NEW TECHNOLOGIES AND SEXUAL HEALTH PROMOTION

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New technologies have changed the way we communicate; we have 108 mobile subscriptions for every 100 Australians, 89% of adults own a smartphone, and more than 13 million Australians use Facebook. The popularity, low-cost, and scalability of these new media are ideally suited to sexual health promotion. There are numerous examples of innovations in sexual health promotion using mobile phones, social networking sites, apps and games. Programs have ranged from mass broadcasting of social marketing messages to highly individualised interventions. This presentation will provide an overview of some of these and will present the evidence for their success.

This presentation will also discuss evaluation practices used in sexual health promotion via new technologies. There is little guidance about methodology in this emerging field; measuring the true impact of a program, beyond counting 'likes,' is difficult. Opportunities to utilise the technologies themselves in evaluation are sometimes missed.

Finally, challenges in scale-up and translation of programs from research settings to the real world will be discussed. Successful and unsuccessful examples, and the lessons we can learn from these, will be examined. Common pitfalls in the field, such as confusing medium and message, assuming that newer is better, and mistaking reach for impact will be discussed.

S07.2 DR GOOGLE, PORN OR FRIEND OF A FRIEND? WHERE DO YOUNG MEN GET THEIR SEXUAL HEALTH INFORMATION?

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Background Young people are vulnerable in relation to sexual health. Young men are especially so as they attend the general practitioner less often than females and are less likely to be offered testing for sexually transmitted diseases. Access to good quality health information and education is a cornerstone of primary prevention yet we know very little about how, where and why young people obtain information about sexual health.

Methods One-on-one semi-structured interviews were conducted with 35 male students aged 16–19 years from at one regional and one metropolitan Victorian educational institution for trade skills until data saturation was reached. Interviews were audio-recorded, transcribed and thematically analysed.

Results The young men were generally poorly informed about sexual health. Their existing knowledge mainly came from school based sexual health education, which while valued, was generally poorly recalled and provided only a narrow scope of physiological information. Young men seek sexual health information from various sources including family, the Internet, friends, and pornography, with information from the latter three sources perceived as unreliable. GPs were seen as a source of trustworthy information but were not accessed for this purpose due to embarrassment. Young men preferred the GP to initiate such conversations. A desire for privacy and avoidance of embarrassment heavily influenced young men's preferences and behaviours in relation to sexual health information seeking.

Conclusions The current available sources of sexual health information for young men are failing to meet their needs. Results identify potential improvements to school based sexual education and online resources and describe a need for innovative technology based sources of sexual health education.

S07.3 FACILITATING SEXUAL HEALTH: WHY DO 12–16 YEAR OLDS ATTEND A RURAL SEXUAL HEALTH CLINIC?

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Introduction Chlamydia is the most commonly diagnosed bacterial STI in Australia and is asymptomatic in approximately 80% of people. If untreated, potential consequences include pelvic inflammatory disease, ectopic pregnancy and infertility. Those experiencing recurrent infections are more likely to experience these unwanted complications, and as such consideration must be given to those who are very young when first infected.

Methods In 2014 we undertook a retrospective audit at a rural sexual health service to determine what proportion of patients attending the clinic were aged 12–16 years, tested for and infected with chlamydia and their reasons for attending the clinic.

Results There were 595 consultations for patients aged 12–16 years during the study period, with a total of 111 individual patients attending the clinic, 104 (95%) were female. 194 chlamydia tests were conducted with the proportion of individual patients having at least one test per year being 100% in 2011, 81% in 2012, 72% in 2013 and 78% in 2014. There was no difference in the proportion tested by age over the study period ($p = 0.59$). 46 tests were positive for chlamydia (23.7%; 95% CI: 17.8%, 30.9%) with the proportion decreasing with increasing age from 46.7% (95% CI: 16.4%, 79.5%) in those aged 12 or 13 years to 15.5% (95% CI: 9.4%, 24.2%) in those age 16 years ($p = 0.02$). The reasons for attending the clinic when a chlamydia test was ordered included i) pregnancy testing, request for emergency contraception and/or termination of pregnancy (18.3%, 34/185), ii) symptoms of anything (16.7%, 31/185), iii) a request for STI screening or treatment (32.4%, 60/185) and presenting for contraception (32.4%, 60/185). Only 29.7% (33/111) of these patients would have tested for chlamydia if