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

Megan Lim*. *Burnet Institute, Melbourne, Australia*

10.1136/sextrans-2015-052270.44

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?

Amy Litras*, Sarah Latreille, Meredith Temple-Smith. *University of Melbourne, Melbourne, Australia*

10.1136/sextrans-2015-052270.45

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?

Jane Tomnay*, L Coelli, J Hocking. *The University of Melbourne, Department of Rural Health, Centre for Excellence in Rural Sexual Health, Regional Health Service, THe University of Melbourne School of Population and Global Health*

10.1136/sextrans-2015-052270.46

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

symptoms or requesting a screen were the only reasons a test was ordered.
Conclusion Consideration should be given to amending the current chlamydia screening recommendation to annual screening of any sexually active person under 29 years.
Conflict of interest None declared.

S07.4 BETTER, SOONER, MORE CONVENIENT: INCREASING YOUTH FRIENDLINESS OF FAMILY PLANNING SERVICES IN NEW ZEALAND

Rose Stewart*. *Family Planning, Wellington, New Zealand*

10.1136/sextrans-2015-052270.47

Family Planning New Zealand has been working towards making services more accessible using technology since 2010. Young people want to access services via the web. There is a limitation to what you can do via phone and internet but some simple services can make a big difference to remoter clients. It started with merging the national clinical databases from 35 to two. We asked young people how they would like services to be. Setting up a national call centre streamlined client contact with us. At the same time a nurse results line was implemented and run via the call centre. I will share Family Planning New Zealand's progress so far and provide some information about the types of services we are now offering and planning to offer

S07.5 SOCIOCULTURAL CONTEXT AND SEXUAL HEALTH INFORMATION AMONG ADOLESCENTS AND YOUNG ADULTS

[1]JS Leichliter*, [1]R Cramer, [2]A Bodas LaPollo, [2]S Hexem, [1]HW Chesson, [1]MM McFarlane. *[1]Centers for Disease Control and Prevention, Atlanta*; *[2]Public Health Management Corporation, Philadelphia, USA*

10.1136/sextrans-2015-052270.48

Introduction Youth STD/HIV information seeking and policy changes (e.g. same-sex marriage) may vary by sociocultural context. We used state-level same-sex marriage laws in the United States (US) as proxy measure for sociocultural context to examine sources of STD/HIV information among youth within different contexts.
Methods We used Westlaw to collect 2013 US state-level laws related to same-sex marriage as a proxy for state sociocultural context related to STD/HIV. Same-sex marriage laws were coded as 1) prohibited — explicitly bans same-sex marriage (n = 34), 2) not addressed – does not mention sex (n = 11), 3) recognised – explicitly permitted (n = 6). Laws were merged with data from a 2013 US survey of 15–25 year olds (n = 4017) to assess sources of STD/HIV information among youth living in different sociocultural contexts.
Results Information sources for whether to have sex differed by sociocultural context. Youth living where same-sex marriage was recognised were more likely to report the following sources: doctor (54.9%, $p < 0.0001$), social media (15.5%, $p < 0.01$), and television/radio (25.0%, $p < 0.01$); those living where same-sex marriage is prohibited (26.4%) or not addressed (26.3%) had the highest reports of religious institutions as a source. Traditional information sources (parent, doctor, school, religious institutions) about sexual relationships also differed by context; however, technological sources did not differ (internet, online expert, social media or television/radio). Those living where same-sex marriage was prohibited had the highest reports of parents ($p < 0.01$), religious institutions ($p < 0.05$) and magazines ($p < 0.05$) as STD/HIV information sources. Youth living where same-sex marriage was recognised had the highest reports of using social media for STD information ($p < 0.05$). Finally, for information on preventing STD/HIV during sex, respondents where same-sex marriage is not addressed were least likely to report social media as a source ($p < 0.05$).
Conclusion Readily available policies may be a useful proxy measure of sociocultural context in the field of STD/HIV prevention.

S08 - Changing the trajectory of three related epidemics – HIV, viral hepatitis and sexually transmitted infections – through new global health sector strategies

S08.1 WHO GLOBAL HIGHLIGHTS AND CHALLENGES IN RELATION TO HIV, HEPATITIS AND STIS

Nathalie Broutet*. *World Health Organization, Geneva, Switzerland*

10.1136/sextrans-2015-052270.49

This presentation will introduce: the rationale for strategic action; opportunities provided by the emerging Sustainable Development Goal framework; proposed goals and targets – overview of modelling and target-setting meetings and other processes informing the proposed goals, targets and milestones for the three strategies; and the structure of the strategies.

S08.3 ENSURING EQUITY, REALISING RIGHTS, AND PROMOTING EVIDENCE: HOW CAN THE NEW WHO STRATEGIES RESPECT PRINCIPLES OF EQUITY AND JUSTICE AND STILL BE EFFECTIVE?

Sarah Hawkes*. *University College London, London, UK*

10.1136/sextrans-2015-052270.50

WHO and the UN system have agreed upon a goal of Universal Health Coverage (UHC) – which will be included in the September 2015 Sustainable Development Goals. However, while the principles of human rights (including the right to health), equity and justice underlie commitments to the SDGs, the reality of priority-setting within health care systems is likely to influence decisions around resource allocation even within UHC. This talk will examine how decisions around priority-setting for STI prevention and care can be taken – what will prevail: rights or cost-effectiveness? Are the two principles compatible and how will national programmes and international agencies allocate resources? These issues will be explored in depth in relation both to WHO's new STI control strategy and its wider commitment to UHC and human rights.