injecting drug use were age group 20–24 years OR = 3.4 95% CI 1.5–8.3, smoking status OR = 2.1 95% CI 1.2–4.5, daily alcohol intake OR = 3.1 95% CI 2.0–7.7 and rural area OR = 0.6 95% CI 0.5–0.8.

Conclusion Harm reduction approaches need to be instituted among out of school youths. Programming among them to reduce injecting drug use is important. Their HIV prevalence of 5.2% is above the national youth average of 3.0%. Multi-pronged strategies including motivational programs to reduce drug use and HIV risk are urgently needed. This will involve age-specific targeted interventions to effectively improve their health.

Disclosure of interest statement This is a self-funded research and no pharmaceutical grant was received to conduct this study.

Young Investigators Oral Presentations

Y1 - Surviving and thriving in STI research: research tools for young investigators

Y1.1 WHAT IS THE NEW EDITOR OF SEXUALLY TRANSMITTED DISEASES GOING TO DO WITH THE JOURNAL?

William C Miller*. *The University of North Carolina at Chapel Hill, Chapel Hill, NC, USA*

10.1136/sextrans-2015-052270.202

In January, 2015, I became the new Editor-in-Chief for the journal Sexually Transmitted Diseases. Taking over for Julie Schachter, who had been the Editor for 25 years, was a daunting task. He rescued the journal, nurtured it, and established it as a leading journal in our field. My job, simply put, is to maintain and strengthen it. Simultaneously, I will work to ensure that the high quality science in our field gets the attention it deserves.

What do you need to do to get your research published in Sexually Transmitted Diseases? First and foremost, do good research. That is the key for publication in any journal. Second, communicate that research clearly and succinctly. Many of us do not write as clearly as we think we do. Third, be responsive to the reviewers. Our reviewers do their best to provide meaningful comments that will strengthen the communication of your work. Respect them. Respond to them. And only rarely should your response be a rebuttal. The best way to ensure that your paper is not accepted, even when it was close, is to dismiss the reviewers' comments.

Going forward, you can expect to see a few minor changes in the journal. We will publish more program-oriented papers, including some from workers in the field who are not necessarily "scientists". We will also expand our coverage of HIV infection, focusing on HIV transmission, diagnosis, prevention, and monitoring, and excluding purely treatment studies. Generally, we will work to identify papers that will be difference-makers in the field of sexually transmitted diseases.

We also will be increasing our focus on young investigators. We hope to facilitate the growth of the type of people attending this meeting – encouraging bright, talented scientists to choose sexually transmitted diseases research as their career.

Y1.2 INSIDE THE WORLD OF JOURNAL PUBLISHING

Ginny Barbour*. *Australasian Open Access Support Group/Committee on Publication Ethics*

10.1136/sextrans-2015-052270.203

Journal publishing is often felt to be a black box that hides a complex system that authors have little control over. I'd argue that authors should think of publishing as a partnership between them and the journal, not a battle. In this session I'll briefly outline the basic processes that are common to all journals, suggest some ways of optimising your manuscript's chances and highlight some common pitfalls.

Y1.3 WHAT DO FUNDERS WANT TO SEE IN A RESEARCH PROPOSAL?

Carolyn Deal*. *Division of Microbiology and Infectious Diseases, National Institute or Allergy and Infectious Diseases, Bethesda, MD, USA*

10.1136/sextrans-2015-052270.204

The National Institutes of Health (NIH) is a medical research agency of the United States government. Its mission is to support improve health. The National Institute of Allergy and Infectious Diseases (NIAID) conducts and supports research to better understand, treat, and prevent infectious, immunologic, and allergenic diseases. Investigators seeking support for their research interact with a variety of NIH staff from program officers to grant managers and contract officers. This session will discuss the structure of the NIH, the various people and their roles, and some of the key funding mechanisms. An important focus will be the role of mentors, both at NIH and within the broader academic community, in facilitating the funding process for Young investigators.

Y1.4 WHAT IS THE SECRET OF THE MENTOR-MENTEE RELATIONSHIPS?

K Holmes*. *Professor, Allergy and Infectious Dis. Professor, Global Health, Adjunct Professor, Epidemiology, Adjunct Professor, Microbiology, School of Public Health, University of Washington, USA*

10.1136/sextrans-2015-052270.205

I've had the opportunity to mentor over 150 pre- and post-doctoral fellows and faculty colleagues, several of whom have mentored or advised many more. From the Mentor's perspective, many keys to success with Mentees are well known. For example, define goals explicitly. Back up your mentoring commitments with long-term investments of time, required resources, regular meetings, and a research project of mutual interest. Provide emotional and psychological support; directly assist with career development. Train mentees in the anatomy and brevity of a manuscript. Optimal mentoring is often inter-disciplinary, with the primary mentor clearly designated. Mentor on publications, posters and presentations.

Regarding "Secrets" (symposium organizers assigned the title of this talk), my first Secret is to assess the passion, enthusiasm and initiative for the work as shown in the eyes, language and demeanor of the potential Mentee. Second, get to know what is

in the applicant's heart, as well as what is in the brain. Third, mentoring often doesn't stop when the mentee leaves (e.g. mentors recommend their mentees for every possible award). The first phase of the mentoring job isn't really over until publications first-authored by the Mentee are accepted, and the first job and research grant are secured. Fourth, supervised peer group mentoring can be very effective.

In addition, I'll review ten "Lessons Learned" in mentoring research, publishing, applying for funds and finding work.

Late Breaker Oral Presentations

LB1.1 RANDOMISED CONTROLLED TRIAL OF A COMPLEX INTERVENTION TO IMPROVE SCHOOL-BASED HPV VACCINATION FOR ADOLESCENTS: THE HPV. EDU STUDY

[1]SR Skinner, [1]C Davies*, [2]S Cooper, [3]T Stoney, [4]H Marshall, [3]J Jones, [4]J Collins, [3]H Hutton, [4]A Parrella, [5]G Zimet, [6]DG Regan, [7]P Whyte, [8]JML Brotherton, [3]P Richmond, [1]K McCaffery, [9]SM Garland, [4]A Braunack-Mayer, [6]J Kaldor, [1]K McGeechan. [1]*The University of Sydney*; [2]*City University of New York*; [3]*Telethon Kids Institute*; [4]*Women's and Children's Hospital, University of Adelaide*; [5]*Indiana University*; [6]*Kirby Institute, UNSW Australia*; [7]*Deakin University*; [8]*National HPV Vaccine Program Register*; [9]*University of Melbourne*

10.1136/sextrans-2015-052270.206

Introduction In the context of universal (male and female) school based HPV vaccination program, we evaluated a complex intervention to promote: 1) student knowledge about HPV vaccination; 2) psycho-social outcomes and 3) vaccination uptake.

Methods We recruited a stratified random sample of schools across two Australian states, and randomly allocated to intervention or control. The intervention included adolescent education; distraction/relaxation on vaccination day; a brochure and decisional support tool for adolescents and parents; and program logistical strategies, in addition to routine state based vaccination guidelines. Both intervention and control followed routine state based guidelines. We compared intervention and control with regard to: student questionnaire data pre-dose 1, 2, 3 on HPV knowledge, vaccination decisional involvement, vaccination self-efficacy, fear and anxiety, and vaccine uptake. Immunisation data collection was ongoing in 2015.

Results We recruited 21 intervention schools (3806 students) and 19 control (3159). Pre-dose 1 questionnaire student knowledge: 65% vs. 33% correct responses, (difference 32%; 95% CI: 27%, 36%); decisional involvement score: 3.7 vs. 3.6 (difference 0.11; 95% CI: 0.06, 0.16); self-efficacy score: 74 vs. 71 (difference 4; 95% CI 1, 7); fear/anxiety score: 2.6 vs. 2.7 (difference -0.11; 95% CI: -0.19, -0.02). At least one vaccine dose was given to 3277 (86.1%) students in intervention schools versus 2697 (85.4%) in control schools, difference 0.4% (95% CI: -2.6, 3.3).

Conclusion Our intervention significantly improved adolescent knowledge and psycho-social outcomes, but not HPV vaccination coverage, which was high in both groups, resulting in a possible ceiling effect.

Disclosure of interest statement This study was funded through a National Health and Medical Research Council Project Grant (1026765) and an investigator driven bioCSL research grant. SR. Skinner's institution has received honoraria for Advisory Board meetings and educational symposia from GSKbiologicals and Pfizer.

LB1.2 PILOT STUDY OF IMMEDIATE ANTIRETROVIRALS AND BEHAVIOURAL INTERVENTION FOR PERSONS WITH ACUTE HIV INFECTION: OPPORTUNITY FOR INTERRUPTING TRANSMISSION

[1,2]SE Rutstein, [3]A Pettifor, [4]S Phiri, [3]D Pasquale, [2]A Dennis, [5]M Hosseinipour, [5]G Kamanga, [4]D Nsona, [2]I Hoffman, [2,3]WC Miller*. [1]*Department of Health Policy and Management, University of North Carolina at Chapel Hill*; [2]*Division of Infectious Diseases, University of North Carolina at Chapel Hill*; [3]*Department of Epidemiology, University of North Carolina at Chapel Hill*; [4]*Lighthouse Trust Clinic, Lilongwe, Malawi*; [5]*UNC Project, Lilongwe, Malawi*

10.1136/sextrans-2015-052270.207

Introduction Persons with acute HIV infection (AHI) contribute disproportionately to transmission. In a pilot study, we evaluated a short-term, behavioural and biomedical intervention among persons with AHI in Malawi.

Methods We enrolled persons with AHI. AHI was defined as negative or discordant antibody test (s) with detectable virus. Persons were randomised 1:2:2 to standard counselling (SC), a four-session behavioural intervention (BI), or behavioural intervention plus 12 weeks of antiretrovirals (BIA), and followed 26–52 weeks. ARV resistance was assessed at baseline and after therapy. Participants were asked to refer partners for testing. Follow-up was completed in August 2014; phylogenetic analyses were completed in May 2015.

Results We identified 59 persons with AHI and enrolled 46 (9 [SC], 18 [BI], 19 [BIA]). Average age was 25; 61% were male. Median viral load (VL) was 5.9 log copies/ml (6.7 [SC]; 5.1 [BI]; 6.1 [BIA]). At week four, 64% (11/17) of BIA participants were suppressed (<1000 copies/ml), versus 12% (2/17 [BI]) and 25% (2/8 [SC]) ($p < 0.001$). VL rebounded after ARV discontinuation. No ARV resistance accumulated after exposure. Risk behaviours decreased across all arms: participants reported fewer sexual encounters at week four versus baseline (4.4 vs 8.7, $p = 0.003$) and fewer encounters without condoms (21% vs 63%, $p < 0.001$). 41% (19/46) referred partners; 15 were HIV-infected and 2 seroconverted during follow-up. 13 of 15 HIV-infected partners had nucleotide sequences available; 92% (12/13) were phylogenetically linked with AHI index.

Conclusion ARV quickly reduced viremia below transmissible levels and did not induce resistance; however, patients experienced rapid virological rebound after discontinuation. Sexual risk decreased rapidly in all arms. Most referred partners with available sequences were linked transmissions with the AHI index. Early diagnosis with standard AHI counselling and early ARV referral may be sufficient to reduce transmission risk.

Disclosure of interest statement This study was supported by the National Institutes of Health, USA; ARVs donated by Merck and Gilead.