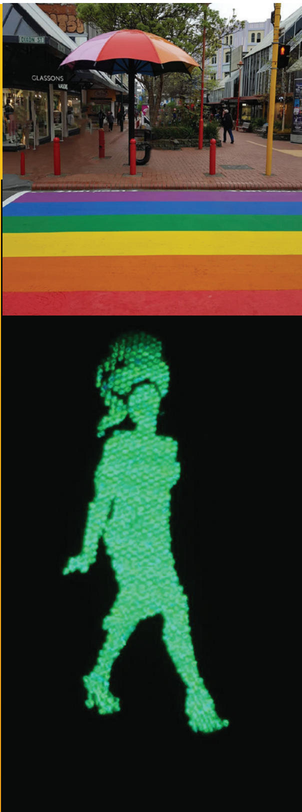
Conference Handbook

The 41st New Zealand Sexual Health Society

CONFERENCE 2019

JAMES COOK HOTEL GRAND CHANCELLOR • WELLINGTON



TIPPING POINTS in NZ Sexual Health

14 - 16
NOVEMBER 2019

Platinum Partner

ACKNOWLEDGEMENTS

The organising committee would like to extend their gratitude to all the partners and exhibitors without whom this conference would not have been possible. Please take the time to visit all the exhibition stands to say hello and see what's new.

In particular we gratefully acknowledge the following partners:

Platinum Partner

Silver Partners

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Aotearoa Statement

Tēnā koutou katoa.

In line with the 41st Conference theme of 'Tipping Points', the New Zealand Sexual Health Society is promoting equitable sexual health outcomes between Māori and other New Zealanders.

The Aotearoa Statement calls upon sector clinicians, promoters, researchers, managers and policy makers to sign up to the Statement and, using best evidence, reorient services so that Māori achieve good sexual health. Conference participants can visit the Society information booth and use the online sign-up facility, and organisations supporting the Aotearoa Statement can add their logo to the Statement.

The Aotearoa Statement is part of a broader Australasian campaign to achieve equity and improve Indigenous sexual health outcomes. Check out the Noongar Boodja - Perth Statement that was signed by organisations and people attending the Australasian HIV & AIDS and Sexual Health Conferences in September 2019 in Perth https://ashm.org.au/programs/aboriginal-and-torres-strait-islander-program/noongar-boodja-statement/

THE AOTEAROA STATEMENT ON CLOSING THE GAP ON STIs, & BBVs AMONG INDIGENOUS PEOPLES OF AUSTRALASIA

The signatories to this statement gather for the 41st New Zealand Sexual Health Society Conference in Wellington — traditional lands of the peoples of Ngāti Toa and Taranaki Whānui ki te Upoko o te Ika a Maui. In September this year, organisations and participants attending the Australasian HIV & AIDS and Sexual Health Conferences 2019 in Perth – traditional lands of the Noongar Whadjuk peoples – signed their local version of the Aotearoa Statement called the Noongar Boodja Statement.

The Australasian signatories – peoples of Australia, Aotearoa New Zealand, the South Pacific, and Oceania including Micronesia, Melanesia and Polynesia – came together to share, collaborate and discuss the successes and challenges that lie ahead for the Australasian region in addressing STIs, viral hepatitis and HIV. A strong theme of these conferences are the persistent inequities in sexual health outcomes for the Indigenous Peoples of the Australasian nations.

Much work remains to be done by all to address disproportionate rates of STIs in Aotearoa New Zealand experienced by Māori. We confirm that these inequities are in contravention of the United Nations Declaration of the Rights of Indigenous Peoples which all Australasian countries have endorsed.

Specifically, we commit to and call upon governments to appropriately fund and work with Māori communities, their community-based organisations and leaders to:

- Action the right of Māori peoples to co-design culturally responsive policies and strategies that match their sexual health priorities, knowledges and practices
- Support Māori communities to provide health promotion and harm reduction services, particularly to young Māori peoples
- Provide high quality low-cost testing and care, in primary health care programs for Māori peoples
- Sustain a culturally responsive and expert STI, HIV and blood-borne virus (BBV) health workforce in Māori communities
- Build our sector knowledge, research and statistical information in order to improve sexual health outcomes for Māori and reduce inequities.

For organisational sign up please send an endorsement email including your logo to info@nzshs.org

Te Whāriki Takapou

NZSHS
THE NEW ZEALAND SEXUAL HEALTH SOCIETY INCORPORATED
SEXUAL HEALTH FOR ALL

WELCOME

Welcome to Wellington and the 41st Annual New Zealand Sexual Health Society Conference "Tipping Points in NZ Sexual Health"

The inspiration for this theme came from Cuba Street and its iconic bucket fountain, where the Wellington Sexual Health Clinic and organising committee is based. We feel that Sexual Health is at a number of tipping points. There are persistent and unacceptable inequities in sexual health outcomes for the indigenous peoples of Australasia, including Aboriginal Australians, Māori and Pasifika. The nature of sexual networks has changed with rapid connections through social media and apps. With increasing gonorrhoea, syphilis and cases of congenital syphilis, ongoing high rates of chlamydia and the ever-present threat of antibiotic resistance, under-resourced sexual health services are struggling to meet the needs of our communities.

During this conference we will discuss how we might address these issues. The Legacy Statement calls on all of us, from frontline health workers to central government, to commit to reducing inequity. Presenters will discuss frameworks and examples for how this can be achieved. We will hear about responses to the syphilis epidemic, and their challenges, successes and future directions. Challenges lead to innovations in health promotion, prevention, testing, and contact tracing, and we will learn about such interventions in NZ, Australia and abroad.

We would like to thank all the invited speakers and those who have proffered papers and posters for sharing their research, experience and expertise with us. As always, we thank our sponsors for their support to bring this conference to life. Finally thank you to all delegates for attending, and for your commitment to improving the sexual health of everyone in Aotearoa New Zealand. Please provide feedback at the end of the conference, we want to continue improving and ensure we are meeting your needs. We hope you have a wonderful conference and enjoy your time here.

Julia Scott, NZSHS President and conference organising committee member

Conference committee: Jane Kennedy, Gill Dawidowski, Allyson Wakeham, Jenny Hayward, Twiggy Johnston

Conference Organisers:
ForumPoint2 Conference Partners
PO Box 1008, WMC
Hamilton 3240
T+64 7 838 1098
www.fp2.co.nz
Contact: Paula Armstrong | paula@fp2.co.nz

HEALTH AND SAFETY

The Conference Managers, ForumPoint2 Limited, in conjunction with the New Zealand Sexual Health Society Organising Committee and venues are morally and legally responsible to provide a safe and healthy environment for all attendees at the conference. This commitment extends to ensuring the NZSHS Conference operations do not place the local community at risk of any injury, illness or property damage.

All measures within our ability will be undertaken to ensure that attendees are as informed as possible about any potential risks or hazards they may face whilst attending conference.

All attendees will need to:

· listen to the health and safety briefing onsite and/or read the health and safety document available at the Registration Desk.
· ensure that all health and safety concerns; and all accidents or near misses are immediately reported to the Registration Desk.

All attendees are encouraged to be responsible at all times and to promote a safe and healthy working environment for the entire conference duration.

First aid kit is located at the Registration Desk.

In the event that emergency medical assistance is required, please call 111 from a mobile.

The nearest medical centres to the James Cook Hotel Grand Chancellor are:

- City Medical Centre
  2/190 Lambton Quay, Wellington, 6011
  T: (04) 471 2161
- Central Wellington Medical Centre
  Level 8, 111 Customhouse Quay City, Wellington 6011
  T: (04) 912 2642
- The Terrace Medical Centre
  1/50 The Terrace, Wellington 6011
  T: (04) 472 5723

The nearest pharmacy is:

- Unichem Wellington Central
  204 Lambton Quay, Wellington 6011
  T: (04) 472 0362

Fire and emergency:
In the event of fire:

- On the discovery of fire, immediately activate an alarm and notify the ForumPoint2 team.
- Upon hearing alarms, evacuate immediately. Further instructions may be given from the venue – please follow all directions.
- Proceed immediately to your nearest exit.
- Await further instructions or clearance for an orderly re-entry.
- Fire hoses and fire alarm switches must remain visible and accessible to the public at all times.

Earthquake Evacuation

- Remain in the building
- Move away from any equipment, windows and furniture
- Take immediate shelter under solid furniture such as tables or desks
- If an evacuation order is given, follow the fire evacuation procedures
- Keep calm and assist those who panic

Accident Reporting

- All accidents and incidents must be reported immediately to the Registration Desk or Paula Armstrong, ForumPoint2, 027 649 2081.

Toilets

- Toilets are in various locations in the venue. Please follow signage in corridors.

Smoking

- James Cook Hotel Grand Chancellor smoking area (outdoor deck) is located on the Lobby Level near Sojourn Café.

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GENERAL INFORMATION

REGISTRATION AND INFORMATION DESK

The registration desk is staffed by Paula. If you have any questions about the conference or require local information, please contact the team at the registration desk.
The desk will be open at the following times:

Thursday	4.00pm - 8.30pm
Friday	7.30am - 7.30pm
Saturday	7.00am - 1.00pm

USEFUL TELEPHONE NUMBERS

Paula Armstrong	027 649 2081
James Cook Hotel Grand Chancellor	04 499 9500
Wellington Combined Taxi	04 384 4444
Supershuttle	0800 748 885 or 04 472 9552
Wellington Combined Shuttles	04 387 8787

ACCOMMODATION

Check out of the James Cook Hotel Grand Chancellor is by 11.00am. Please ensure that your accommodation accounts are settled in full prior to departure (including all meals, telephone calls and mini bar charges). The New Zealand Sexual Health Society and ForumPoint2 are not responsible for any of these unpaid accounts.

EVALUATION

An online evaluation survey will be emailed to attendees after the conference. We welcome your feedback and would be grateful for a few minutes of your time to complete this.

CERTIFICATE OF ATTENDANCE

A certificate of attendance will be emailed to you once the conference evaluation has been completed online.

INSURANCE

Registration fees do not include personal travel or health insurance of any kind. The New Zealand Sexual Health Society and ForumPoint2 take no responsibility for delegates failing to take out adequate insurance cover.

INTERNET ACCESS

Complimentary internet access is available within the conference and exhibition area.

Username: JAMES COOK HOTEL
Password: not required on the conference floor

MOBILE PHONES

During conference sessions mobile phones must be turned off or turned to silent. Mobile phones are not to be used when sessions are in progress.

NAME BADGES

All conference attendees and industry representatives are asked to wear their name badges at all times during the conference and social functions. It is your official entrance pass to the sessions, conference catering and a requirement of health and safety.

PARKING

James Cook Hotel

Covered valet car parking is available at a rate of $30.00 per day at your own expense. Availability is limited.

Public parking

Available via Wilsons Carpark, this is a separate operation to the James Cook Hotel Grand Chancellor. Entrance off the Terrace and directly beside the James Cook Hotel.
Hours of Operation 24 Hours

- Casual Rates apply Monday to Friday. 6.00am to 5.00pm. Per half hour (or part thereof) $6.00 to a max of $48.00
- Earlybird rates apply Monday to Friday. Entry between 6.00am and 10.00am. Exit before 7.00pm.
- Night rate applies Monday to Sunday. 5.00pm - 6.00am. Per half hour (or part thereof) $4.00 to a max of $24.00
- Saturday / Sunday Weekend rates apply Saturday or Sunday. Between 6.00am to 5.00pm Per half hour (or part thereof) $4.00 to a max of $24.00

Limited on street parking is available on The Terrace. Paid parking applies:

- 8.00am - 6.00pm: Thursday, Saturday and Sunday
- 8.00am – 8.00pm: Friday

For those with e-vehicles, there is an electric charging point located nearby (opposite Noel Leeming on Grey Street)

PRESENTERS' INFORMATION

Oral Presenters

Presentations are being loaded at the back of the main plenary room in Chancellor 1. Please see the AV technician to load and check your presentation as soon as possible after your arrival at the conference.

If you plan to present using your own laptop, please still see the AV technician sooner rather than later to ensure all is in order.

Please go to the conference room in which you are presenting 10 minutes before the start of the session to check your presentation, familiarise yourself with the AV set-up and meet the session chair.

Poster Presenters

Please report to the conference registration desk for reconfirmation of your poster number and location of your poster board. Posters will be displayed in the pre function area outside the conference rooms.

All posters must be put up by 10.00am on Friday and removed from 11.00am on Saturday.
Posters must be removed by 1.00pm on Saturday.
Posters must be attended during the second half of the lunch break on Friday.

POWERPOINT PRESENTATIONS

Presentations for which presenters have granted permission will be saved and posted to the website www.nzshs.org.nz following the conference.

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† Please refer to the Data Sheet to find out when *TIVICAY* should be dosed twice daily.

Please refer to Data Sheet for prescribing information available at www.medsafe.govt.nz/Medicines/InfoSearch.asp.

References: 1. Walmsley et al. *N Engl J Med* 2013;369:1807–18 **2.** Walmsley et al. *J Acquir Immune Defic Syndr* 2015;70:515–9 **3.** Clotet et al. *Lancet* 2014;383:2222–31 **4.** Molina et al. *Lancet HIV* 2015;2:e127–e136 **5.** Orrell et al. *Lancet* 2017;4:e536–e546 **6.** Raffi et al. *Lancet* 2013;381:735–43 **7.** Raffi et al. *Lancet Infect Dis* 2013;13:927–35 **8.** Cahn et al. *Lancet* 2013;382:700–8 **9.** Aboud et al. *IAS* 2017. Slides TAUB0105LB **10.** Trottier et al. *Antivir Ther* 2017;22:295–305 **11.** Castagna et al. *J Infect Dis* 2014;210:354–62 **12.** Vavro et al. *12th European Workshop on HIV & Hepatitis* 2014. Abstract O-10 **13.** TIVICAY (dolutegravir) Data Sheet 2018

TIVICAY® (dolutegravir sodium), 50 mg film-coated tablets, is an integrase inhibitor active against Human Immunodeficiency Virus (HIV). **Indication:** Treatment of HIV infection in combination with other antiretroviral agents in adults and children over 12 years of age, weighing 40kg or more. **Dosage and administration:** One 50mg tablet once daily or one 50mg tablet, twice daily, in patients with integrase resistance or when when co-administered with etravirine (without boosted protease inhibitors), efavirenz, nevirapine, tipranavir/ritonavir, rifampicin, carbamazepine, phenytoin, phenobarbital and St. John's Wort. *TIVICAY* may increase metformin concentrations, adjust dose accordingly. *TIVICAY* may be administered with or without food. **Contraindicated:** In combination with dofetilide or pilsicainide. **Precautions:** *TIVICAY* does not prevent the risk of transmission of HIV, appropriate precautions should be taken. Caution should be given to co-administering medications (prescription and non-prescription) that may change the exposure of *TIVICAY* or medications that may have their exposure changed by *TIVICAY*. *TIVICAY* should not be co-administered with polyvalent cation-containing antacids, calcium or iron supplements. **Adverse Events:** diarrhoea, headache, insomnia, anxiety, fatigue, depression, dizziness, elevated creatine, neutropenia, rash. Before prescribing *TIVICAY*, please review the Data Sheet at www.medsafe.govt.nz. *TIVICAY* is a registered trade mark of the ViiV Healthcare group of companies, marketed on behalf of ViiV Healthcare by GlaxoSmithKline NZ Limited, Auckland. **Adverse events involving ViiV Healthcare products should be reported to GSK/ViiV Healthcare Medical Information on 0800 808 500. TIVICAY is a funded Prescription Medicine. Special Authority criteria and a prescription charge apply**.

TAPS DA1853JL/DGR/JUL18/0001/18

SESSION CHAIRS

Please go to the conference room to meet the presenters 10 minutes before the session you are chairing. Please ensure that each session starts and finishes at the advertised time, to ensure smooth running of the conference.

SPECIAL DIETS

If you have advised us of any special dietary requirement on your registration form, these have been notified to the caterers. Vegetarian selections will be available on the main buffets. There will be a "pre-ordered special dietary requirements" table in the catering area for other special diets. Please make yourself known to the catering staff at the social functions. If you have any concerns, contact the team at the conference registration desk.

DISCLAIMER OF LIABILITY

Whilst we have endeavored to ensure that information on the conference website and printed material is accurate details may be subject to change without notice. Any corrections or amendments will be notified as soon as possible. In the event of industrial disruptions or service provider failures, the New Zealand Sexual Health Society and ForumPoint2 accept no responsibility for losses incurred by delegates and their partners.

Acceptance of oral or poster free papers does not indicate endorsement by the conference committee of any product or activity that the session or poster may promote. Although care has been taken to ensure accuracy the conference committee does not accept liability for any errors in published abstracts.

SOCIAL PROGRAMME

WELCOME FUNCTION

Date:	Thursday 14 November
Time:	7.20pm – 8.30pm
Venue:	Exhibition Area, Chancellor 3 and Foyer
Dress:	Smart Casual
Tickets:	The cost of this function is included in the full registration fee. Cost includes canapés and one drink, please exchange the voucher in the back of your lanyard for a beverage. A cash bar will be operating (Cash, Visa, Mastercard, Eftpos). Tickets for guests can be purchased on an individual basis for $45.00, including GST.

This function is an occasion to catch up with friends and colleagues and meet with the conference partners and exhibitors whilst enjoying drinks and nibbles.

Important for this function:
Your function ticket is your admission ticket to this event, so remember to bring it with you!

CONFERENCE FRIDAY NETWORKING FUNCTION

Date:	Friday 15 November
Time:	5.00pm - 7.30pm
Venue:	Exhibition Area, Chancellor 3 and Foyer
Theme/Dress:	Smart Casual
Tickets:	The cost of this function is included in the full registration fee. Cost includes canapés and one drink, please exchange the voucher in the back of your lanyard for a beverage. A cash bar will be operating (Cash, Visa, Mastercard, Eftpos). Tickets for guests can be purchased on an individual basis for $40.25, including GST.

This function is an occasion to catch up with friends and colleagues and meet with the conference partners and exhibitors whilst enjoying drinks and nibbles

Important for this function:
Your function ticket is your admission ticket to this event, so remember to bring it with you!

INVITED SPEAKERS

James Ward

Associate Professor James Ward is a Pitjantjatjara/ Narungga man, and a national leader in Aboriginal and Torres Strait Islander research. He is currently the Head of Infectious Diseases Research Program, Aboriginal Health, at the South Australian Health and Medical Research Institute. James has a long history working in Aboriginal communities, beginning as a men's health educator for 29 remote communities in central Australia in the late 1990s. James has been awarded funding applications in the area of STI's/ BBV's/ AOD totalling $23M since 2013; including $7.14M as CIA on NHMRC funded grants and has authored 100 publications. In 2017, James was recognised by the NHMRC with the Rising Star Research Excellence Award for the top-ranked application by an Indigenous researcher in the Early Career Fellowship scheme and by the local Aboriginal community by being awarded the NAIDOC SA Scholar of the Year. In 2018 James was awarded the Viertel Senior Medical Research Fellowship- Australia's most prestigious fellowship to continue to develop his research. Throughout his health and research career, James has demonstrated a true commitment to improving the health and wellbeing of Aboriginal and Torres Strait Islander adolescents, and a dedication to awareness, education, dissemination advocacy and community engagement.

Joanne Baxter

Joanne Baxter (Poutini Ngāi Tahu, Ngāti Apa ki te Rā Tō) is a Public Health Medicine Physician and Associate Dean Māori for Otago's Division of Health Sciences. She is the Director of Kōhatu, Centre for Hauora Māori with research interests including Māori mental health, health inequalities, cultural competency in medical education and Māori Health Workforce Development.

Sue Bagshaw

Sue Bagshaw works as a primary care doctor specialising in adolescent/youth health at a one stop community youth health centre for 10-25 year olds, which she helped to set up, under a trust called Korowai Youth Well-being Trust.

She is working with others to set up a Youth Hub of services and transition housing. She is a senior lecturer in adolescent health in the department of Paediatrics at the Christchurch School of Medicine, and she is an educator with the Collaborative Trust (a research and training centre for youth health and development). She worked for the Family Planning Association for 20 years and worked for ten years part time on the Methadone programme in Christchurch: Which is why she has interests in common with young people – sex, drugs and rock 'n roll!

Samuel Andrews

Samuel is the Harm Reduction Projects Advisor at the NZ Drug Foundation. He supports community responses to drugs, leads a culture change programme for the Defence Force, and helped establish drug checking at festivals. He is completing his Masters of Health Science on sexualised drug use in the gay community.

PROGRAMME

THURSDAY 14 NOVEMBER 2019

1.00pm – 3.30pm	**PASHANZ Meeting** *Venue: Chancellor 2*
4.00pm	**Registration desk opens**
5.30pm – 8.30pm	**Conference Opening, Plenary 1 and Welcome Function** *Venue: Chancellor 1* *Chair: Julia Scott*
5.30pm – 6.00pm	Call into Chancellor 1 ***Callum Katene***
6.00pm – 6.10pm	Presidents Welcome ***Julia Scott***
6.10pm – 6.40pm	Hard to reach populations - Indigenising sexual health interventions for impact ***James Ward***
6.40pm – 7.20 pm	Increasing syphilis and gonorrhoea case numbers and sustained high chlamydia rates in New Zealand: How surveillance data can be used to support control efforts ***Jill Sherwood,*** *C Newbern*
7.20pm – 8.30pm	**Welcome Function** *Venue: Exhibition Area, Chancellor 3 and Foyer*

THURSDAY

FRIDAY 15 NOVEMBER 2019

7.30am	**Registration desk opens**
8.00am – 10.00am	**Plenary 2** *Venue: Chancellor 1* *Chair: Alison Green*
8.00am – 8.15am	**Welcome and Housekeeping**
8.15am – 8.25am	The Aotearoa Statement: On Closing the Gap on STI's and BBV's among Indigenous Peoples of Australasia ***Alison Green***
8.25am – 9.10am	Syphilis - A tale of two populations, syphilis and how inequity plays out in contemporary Australia ***James Ward***
9.10am – 9.40am	Māori health and equity – frameworks, challenges and opportunities ***Joanne Baxter***
9.40am – 9.55am	He Tapu Te Whare Tangata - the sacred house of humankind ***Jane MacDonald,*** *S Geller, N Sikanda, K Stevenson, A Adcock, F Cram, L Denmead, P Sykes, M Hibma, B Lawton*
9.55am – 10.00am	Q&A
10.00am – 10.30am	**Morning Tea and Exhibition** *Venue: Exhibition Area, Chancellor 3 and Foyer*
10.30am – 12.00pm	**Plenary 3** *Venue: Chancellor 1* *Chair: Jane Kennedy*
10.30am – 10.50am	National Syphilis Action Plan – an update from the Ministry of Health ***Niki Stefanogiannis, Tara Swadi***
10.50am – 11.10am	Congenital syphilis in New Zealand: A crisis of inequity ***Teena Mathew***
11.10am – 11.25am	Syphilis outbreak: The Auckland Experience ***Subha Rajanaidu***
11.25am – 11.40am	Contact tracing in Auckland ***Maggie Vulinovich***
11.40am - 12.00pm	Discussion ***Subha Rajanaidu, Maggie Vulinovich, Sunita Azariah***
12.00pm – 1.00pm	**Lunch and Exhibition** *Venue: Exhibition Area, Chancellor 3 and Foyer*
12.05pm – 12.15pm	**Oral abstracts for scholarship holders** 3 minute lunchtime presentations from Scholarship recipients *Venue: Chancellor 1* ***Lei Johnson*** ***Judith Crump*** ***Hadley Taylor***

FRIDAY

Parallel Sessions **1.00pm – 3.00pm**	**Parallel Session 1A: Allied Health / Health Promotion / Behavioural** *Venue: Chancellor 1* *Chair: Evelyn Mann, Twiggy Johnston-Welsh*	**Parallel Session 1B: Clinical / Laboratory** *Venue: Chancellor 2* *Chair: Jennifer Hayward*
1.00pm – 1.15pm	Porn, the new norm – New Zealand stakeholders responding to changing youth sexual culture ***Lief Pearson**, M Powell, N Denholm, **Jo Roberston***	*ResistancePlus* MG FleXible for the GeneXpert enables near patient testing of mycoplasma genitalium and macrolide resistance markers ***Corey Oostendorp, Emma Sweeney,** T Lonergan, R Weem, A Arvind, LY Tan, DM Whiley*
1.15pm – 1.30pm	Are we scared to talk about sex? Maybe it's the other question, we're scared to tell our children that it's pleasurable, what are we scared of? ***Tracy Clelland***	Low rates of gonorrhoea culture in the era of nucleic acid amplification testing have implications for antimicrobial surveillance ***Sunita Azariah***
1.30pm – 1.45pm	Sexuality and disability: Realising sexual and reproductive health and rights *H Coulter, **Abby Knight***	Chlamydia and gonorrhoea reinfection: Inequitable outcomes by gender and ethnicity ***Sally Rose,** SM Garrett, J Stanley, SRH Pullon*
1.45pm – 2.00pm	Relationships, sex and values: Meaning-making around relationships by queer young men in Aotearoa ***John Egan***	SH:24 The development of an online service and impact on sexual health in London ***Gillian Holdsworth,** J Moore, E Ardines, P Baraister*
2.00pm – 2.15pm	Triangulation - an agile method for evaluating effective health promotion in Aotearoa ***Abby Leota***	Initial experience with the Xpert® CT/NG system in Tauranga ***Massimo Giola,** A Edwards, R Mackay, A Ashman, H Read, S Abdool-Raheem*
2.15pm – 2.30pm	Adolescent masculinities and the drama of sexual health promotion ***Evan Hastings, Dylan Fa'atui, Lakely Montagne, Mila Fati***	Changes to maternity guidelines for pregnant women living with HIV ***Caroline Bree***

2.30pm – 2.45pm	Sexual assault prevention in tertiary institutions with applied theatre ***Evan Hastings***	Breastfeeding and mothers who have HIV ***Jane Bruning***
2.45pm – 3.00pm	Collaborative partnerships between health promoters and academia: Methodological considerations when partnering with Pacific communities ***Analosa Veukiso-Ulugia***	Comprehensive sexual health screening among gay and bisexual men in Aotearoa/New Zealand ***Andy Anglemyer,*** *P Saxton, A Ludlam*
3.00pm – 3.30pm	**Afternoon Tea and Exhibition** *Venue: Exhibition Area, Chancellor 3 and Foyer*	
3.30pm – 5.00pm	**Plenary 4: Gender Affirming Healthcare in Aotearoa New Zealand** *Venue: Chancellor 1* *Chair: Jeannie Oliphant*	
3.30pm – 3.45pm	Guidelines for gender affirming healthcare in Aotearoa, New Zealand ***Jeannie Oliphant, Jaimie Veale***	
3.45pm – 4.00pm	Sexual Health and sexual healthcare access for the trans and non-binary people in Aotearoa ***Jack Byrne, Jaimie Veale***	
4.00pm – 4.15pm	Sexual orientation and sexual activity in a cohort of transgender individuals ***Massimo Giola,*** *B Mijatovic, D Pritzgintas, R Mackay*	
4.15pm – 5.00pm	**Panel Discussion - Reflections on healthcare provision at Sexual Health for the trans community** ***Ahi Wi-Hongi, Mani Mitchell, Jove Horton***	
5.10pm – 6.10pm	**New Zealand Sexual Health Society Annual General Meeting** *Venue: Chancellor 1*	
5.00pm – 7.30pm	**Friday Networking Function** *Venue: Exhibition Area, Chancellor 3 and foyer*	

SATURDAY 16 NOVEMBER 2019

7.00am	**Registration desk opens**	
7.15am	**RACP Chapter of Sexual Health Medicine** Admittance by invitation only *Venue: Chancellor 2*	
8.00am – 10.10am	**Plenary 5: New Technologies / Strategies to Increase Access in Sexual Health** *Venue: Chancellor 1* *Chair: Gill Dawidowski*	
8.00am – 8.30am	Anonymous partner notification and effective linkage to care ***Anatole Menon-Johanssen***	
8.30am – 8.50am	Use of diverse testing modalities to facilitate access to HIV testing for New Zealand key populations ***Alex Anderson,*** *J Beaumont, A Ludlam, J Rich*	
8.50am – 9.20am	YOSS – Increasing access to sexual and reproductive health care ***Sue Bagshaw***	
9.20am – 10.10am	Sex Workers: Doing it right ***Chanel Hati, Tanya Drewery, Cherida Fraser***	
10.10am – 10.40am	**Morning Tea and Exhibition** *Venue: Exhibition Area, Chancellor 3 and Foyer*	
Parallel Sessions **10.40am – 11.55am**	**Parallel Session 2A: HIV Prevention** *Venue: Chancellor 1* *Chair: Suzanne Werder*	**Parallel Session 2B: Reproductive Health and Genital Pain** *Venue: Chancellor 2* *Chair: Beth Messenger*
10.40am – 10.55am	Recent trends in HIV diagnoses in New Zealand ***Sue McAllister***	**10.40am – 11.10am** Physiotherapy management of pelvic pain and sexual dysfunction in women and men ***Liz Childs***
10.55am – 11.10am	Early adopters "On PrEP": 12 months follow-up of adherence, behaviours and STIs ***Peter Saxton,*** *S Azariah, R Jenkins on behalf of the NZPrEP study team*	
11.10am – 11.25am	Combination HIV prevention use among an online sample of gay and bisexual men in Aotearoa New Zealand ***Adrian Ludlam,*** *J Kolodziej, J Rich, P Saxton, D Petousis-Harris*	A survey of penetrative and non-penetrative sexual pain experiences in women with pelvic pain ***Charlene Rapsey,*** *C Cunningham-Tisdall, B Battersby, N Swain*

11.25am – 11.40am	Progress toward virtually eliminating HIV transmissions in New Zealand ***Joe Rich**, JM Myers, MP Shaw, AH Ludlam, PJ Saxton*	Review and comparison of intrauterine device/Intrauterine system insertion problems by medical and nursing staff, and type of pre insertion consultation ***Shan McCann,** L Ingram, Y Lake*
11.40am – 11.55am	Finding the perfect fit: Condom use at a tipping point *T Gray, **Victoria Walsh,** A Walton, M Shaw*	Strategies for reducing contraceptive failure ***Catriona Murray***
12.00pm – 1.00pm	**Plenary 6** *Venue: Chancellor 1* *Chair: Peter Saxton*	
12.00pm – 12.30pm	Pleasure and risk: Responding to sexualised drug use and chemsex among MSM ***Samuel Andrews***	
12.30pm – 12.50pm	In search of my tribe ***Jane Morgan***	
12.50pm – 1.00pm	**Conference Closure and Awards**	

SATURDAY

POSTERS

Poster Number	Title and Presenter
1	Improving sexual health care provision in New Zealand: Insights from primary care clinicians ***Sally Rose***, *SM Garrett, SRH Pullon*
2	Where are young people tested for STIs? Implications for the delivery of quality care ***Sally Rose,*** *SM Garrett, SRH Pullon, J Stanley*
3	Adding value – the role of the trans health key worker ***Jove Horton***, *J Oliphant*
4	Collaborative partnerships between health promoters and academia: Methodological considerations when partnering with Pacific communities ***Analosa Veukiso-Ulugia***

BOOK OF ABSTRACTS

1. Plenary 1
Thursday 14 November, 6.10pm – 6.40pm

HARD TO REACH POPULATIONS – INDIGENISING SEXUAL HEALTH INTERVENTIONS FOR IMPACT

J Ward*[1]
[1] *South Australian Health and Medical Research Institute*

For too long rates of STIs particularly Chlamydia, gonorrhoea, trichomoniasis and syphilis have notified at disproportionate rates in Aboriginal and Torres Strait Islander communities. This is despite significant advances in technology over time, a rich policy and program environment and moderate investments in research. Clearly conventional approaches to address endemic conditions are not enough. This presentation will highlight new ways to approach this wicked issue including multi-sectorial approaches, that help to understand and address social determinants of health and their impact on this area. Additionally, new technology such as implementation of pathogen genomics or point of care technology is adopted early in communities where there is greatest need should be a priority. Finally, the meaningful involvement of Aboriginal and Torres Strait Islander people at all levels of decision making is required to address these issues.

2. Plenary 1

Thursday 14 November, 6.40pm – 7.20pm

INCREASING SYPHILIS AND GONORRHOEA CASE NUMBERS AND SUSTAINED HIGH CLAMYDIA RATES IN NEW ZEALAND: HOW SURVEILLANCE DATA CAN BE USED TO SUPPORT CONTROL EFFORTS

JM Sherwood*[1], C Newbern[2]

[1] *Public Health Physician, Health Intelligence Group, Institute of Environmental Science and Research Ltd*

[2] *Epidemiologist, Health Intelligence Group, Institute of Environmental Science and Research Ltd*

Background: Syphilis case counts have been increasing in New Zealand since 2012. Initially this appeared to be confined to men who have sex with men (MSM) but counts in heterosexual males and females have also risen since 2015 and congenital syphilis cases have been reported yearly since 2016. Gonorrhoea rates have increased since 2015 with a significant rise in males. Understanding the changing epidemiology will contribute to control efforts.

Methods: Data from the Institute of Environmental Science and Research Ltd (ESR) STI surveillance systems for 2013-2019 were analysed with a focus on the demography and risk factor information collected for infectious and congenital syphilis and gonorrhoea cases.

Results: The 548 syphilis cases provisionally reported in the 12 months ending 31 March, 2019 is seven times higher than the 82 cases reported for 2013. The highest number of cases were reported in males in the 25-29 year age group, and from regions with large urban centres. 65% of the cases were reported in MSM. The highest numbers of cases reported in heterosexual females in the past 12 months were in the 20–39 years age group. A similar age distribution was seen for gonorrhoea cases, although female cases had a slightly younger age range. Based on limited completion of sexual behaviour questionnaires 30% of gonorrhoea cases were reported in MSM. Conclusion: Surveillance data shows an increase in both infectious syphilis, with a corresponding increase in congenital syphilis cases, and gonorrhoea cases in recent years. Analysis of the surveillance data provides information for control efforts but also highlights areas where there are some gaps in our knowledge.

Disclosure of Interest: Dr Sherwood has no conflicts of interest relevant to this work to disclose.

3. **Plenary 2**

Friday 15 November, 8.15am – 8.25am

THE AOTEAROA STATEMENT: CLOSING THE GAPS ON STI, HIV AND BBV EXPERIENCE BY THE INDIGENOUS PEOPLE OF AUSTRALASIA

A Green*[1]

[1] *Te Whāriki Takapou*

4. **Plenary 2**

Friday 15 November, 8.25am – 9.10am

SYPHILIS - A TALE OF TWO POPULATIONS AND HOW INEQUITY PLAYS OUT IN CONTEMPORARY AUSTRALIA

J Ward*[1]

[1] *South Australian Health and Medical Research Institute*

In 2011 an outbreak of infectious syphilis commenced in far north Queensland that has amassed more than 3000 cases, all among young Aboriginal people living in remote and regional communities spanning four jurisdictions. The scale of this outbreak has the potential to embed syphilis as an endemic infection that will resonate for decades to come. The rate of infectious syphilis diagnoses is currently 7 times the non-Indigenous rate, but it has also increased more rapidly in the Aboriginal population during the last 10 years than the non-Indigenous rate. This presentation will highlight why this might be occurring and approaches currently underway and some ways forward.

5. **Plenary 2**
Friday 15 November, 9.10am – 9.40am

MĀORI HEALTH AND EQUITY – FRAMEWORKS, CHALLENGES AND OPPORTUNITIES

J Baxter*[1]
[1] *University of Otago*

Contemporary New Zealand health and wider social policy has strengthened its focus and emphasis on the importance of equity across a wide range of societal outcomes, including health. Inequalities in the health of Māori when compared with non-Māori are substantial, pervasive and persistent. Although there have been some changes in the nature and extent of these inequalities over time, substantial gaps remain. Indeed, for some health issues, outcome gaps have been widening and Māori continue to experience relatively more poor outcomes across diverse health issues that span gender, and age-groups.

This talk will discuss the concept of health equity, outlining frameworks and contemporary contexts and approaches for thinking about equity with a particular focus on Māori health. A vision for health equity will be outlined, and challenges and opportunities for achieving equitable Māori health outcomes will be explored.

6. Plenary 2

Friday 15 November, 9.40am – 9.55am

HE TAPU TE WHARE TANGATA - THE SACRED HOUSE OF HUMANKIND

EJ MacDonald*[1], S Geller, N Sikanda, K Stevenson, A Adcock, F Cram, L Denmead, P Sykes, M Hibma, B Lawton

[1] *Victoria University of Wellington*

Background: Globally cervical screening is changing to test HPV virus as the primary test and several countries have switched including Scandinavia and Australia.[(1)] In Aotearoa, the National Cervical Screening Program (NCSP) using the standard speculum examination for cytology, is failing indigenous Māori women, with 33% unscreened compared to 24% of NZ European/other women unscreened. [(2)] Māori women are more than twice as likely to die of cervical cancer - a preventable cancer- than NZE women. [(3,4)] HPV testing is more effective in detecting pre-cancer changes on the cervix and preventing cervical cancer, than conventional cytology. [(5)] Self-collected specimens (self-testing) can be used for HPV testing, providing screening with comparable sensitivity and specificity to clinician-collected specimens. [(60] This community based RCT offered HPV self-test to under-screened Māori women in partnership with Māori communities and primary care practices. The overall aim was to increase cervical screening coverage and in this presentation we will share the methodology and interim results showing uptake among the intervention group of under-screened Māori women.

Methods: Inclusion criteria were Māori women aged 25-69 years, who had not had a cervical smear screen in 4 years or more. Six primary care clinics in a rural area of Te Tai Tokerau were randomised to intervention (offer of self-swab) and control (usual offer of cervical smear). Recruitment started on 5th March 2018 and ended on 31st August 2019. HPV genotyping was carried out using the Abbott Real-time High Risk HPV assay distinguishing HPV-16 and HPV-18 from 'other' high-risk types and from negative samples.

Interim Results: Of the 500 eligible under-screened Māori women. 263 (52.6%) accepted the swab and 24 (4.8%) chose a cervical smear resulting in 57% of the intervention group having a cervical screen. Only 30 women (6%) declined the swab. Of the total 263 swabs, 233 (88.6%) were taken by the patient, and 30 (11.4%) were taken by the nurse/doctor or other. Of those that had a screen (n =283) 35 had results positive for HPV 16, 18 or 'other' and were referred to colposcopy. Three women required surgical Lletz loop for CIN II/III and there was one micro-invasive cancer requiring a cone biopsy.

Conclusion: We conclude that self-screening for HPV has the potential to halve the number of under-screened Māori women and is an acceptable and sustainable equity tool. However, because of inadequate funding, the NCSP has delayed introduction of HPV testing as a primary test for another 3-4 years. We argue that this is unsafe, inequitable and unacceptable and that self- testing should be incorporated into the new NCSP in Aotearoa as soon as possible to decrease the morbidity and mortality caused by cervical cancer and decrease inequities in health care.

References

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7. Plenary 3

Friday 15 November, 10.30am – 10.50am

NATIONAL SYPHILIS ACTION PLAN - AN UPDATE FROM THE MINISTRY OF HEALTH

N Stefanogiannis*[1], T Swadi*[1]

[1] *Ministry of Health*

Syphilis has been increasing in New Zealand every year since 2012. We are now also seeing cases of congenital syphilis in New Zealand - a condition that was very rare previously. The Ministry has developed a national syphilis action plan (the action plan) to guide a systematic and coordinated health sector response to stop the increase in syphilis. This action plan was released in June 2019.

The action plan was developed in consultation with the wider sexual health community and takes a comprehensive approach to addressing the increase in syphilis, focussing on both prevention and treatment. Four priority areas have been identified:

- prevention and health promotion
- testing and management
- antenatal care
- surveillance and monitoring.

The Ministry will provide an overview of the plan and an update on the delivery of the actions to date.

8. Plenary 3

Friday 15 November, 10.50am – 11.10am

CONGENITAL SYPHILIS IN NEW ZEALAND: A CRISIS OF INEQUITY

T Mathew*[1], J Kennedy, J Scott, J Morgan

The presentation will discuss some of the epidemiology of congenital syphilis cases in NZ to highlight inequities.

NZSHS are in the process of developing' Syphilis in pregnancy guidelines '. The presentation will focus on some of the recommendations from these draft guidelines.

9. Plenary 3

Friday 15 November, 11.10am – 11.25am

SYPHILIS OUTBREAK: THE AUCKLAND EXPERIENCE

S Rajanaidu*[1],

[1] *Auckland Regional Sexual Health Service*

Auckland has been experiencing a gradual escalation in syphilis cases since the early 2000s. This increase is consistent with other developed nations such as Australia, the UK and USA. In Auckland, the rate of infection had become apparent between 2016 and 2018, and a more comprehensive approach to managing the outbreak was established.

This presentation focusses on the key areas outlined within the syphilis outbreak plan for Auckland, the evolving epidemiology and future work priorities.

10. **Plenary 3**
Friday 15 November, 11.25am – 11.40am

SYPHILIS CONTACT TRACING IN AUCKLAND

M Vulinovich[1]
1 Auckland Sexual Health Services

Since 2012 Syphilis has swept is way through Auckland rapidly spreading through regional New Zealand affecting all populations. In response to Auckland's rise in infectious cases a contact tracing initiative was developed by Auckland Sexual Health Services. A team of two sexual health nurses launched and implemented an active process for syphilis contact tracing within Auckland. The contact tracing team' priority is to engage, encourage and empower index cases to inform sexual partners of their potential risk of syphilis.

A growing concern is the impact syphilis is having on New Zealand's most vulnerable populations, particularly those with low health literacy, vulnerable youth, drug and alcohol dependency, mental health issues, limited access to health care, those who are transient and worryingly increasing numbers of pregnant women.

Managing the spread of syphilis has proved a challenge for all health professionals. Traditionally there are elements of stigma and shame associated with having a STI and informing partners of the risk of infection can be a difficult task. In some instances, it is not possible or safe for the index case to contact sexual partners highlighting the need for further contact tracing support. Additional methods of contact used by the contact tracing team include; provider referral, home visiting, social media and liaising with other health professionals.

Syphilis, presumed to be a disease of antiquity by many in the community is poorly understood and this lack of awareness is a significant barrier to contact tracing. We present a case from Auckland to demonstrate the barriers and successes of contact tracing.

Friday 15 November, 12.30pm – 1.00pm

Oral Abstracts for Scholarship Holders:

L Johnson[1]
[1] *Hawke's Bay DHB*

J Crump[1]
[1] *Number 10 Southland*

H Taylor[1]
[1] *Auckland Sexual Health Service*

11. Parallel Session 1A: Allied Health / Health Promotion / Behavioural

Friday 15 November, 1.00pm – 1.15pm

PORN, THE NEW NORM – NEW ZEALAND STAKEHOLDERS RESPONDING TO A CHANGING YOUTH SEXUAL CULTURE

L Pearson*[1], M Powell, N Denholm, J Robertson*[1]

[1] *The Light Project, Auckland*

New Zealand is seeing the impacts of widespread porn access and usage amongst its youth with two-thirds of NZ teens aged 14-17 having viewed porn, ¼ aged 12 or younger. Porn is now a primary sex educator, informing young people's sexual attitudes, expectations and behaviours in new and diverse ways.

In response to this, the pilot project The Light Project was established by a group of sexual health experts aiming to equip young people, their whānau and communities to positively navigate the new porn landscape through developing national resources and training. To inform these resources, The Light Project undertook an international literature review and conducted a survey of 622 stakeholders called **'Porn and Young People — What do we Know?'**

Lessons learnt during this pilot include firstly, porn is new territory for sexual and youth health services with 94% of stakeholders reporting porn is an issue for young people, but 59% feeling ill-equipped. Secondly, many youth are struggling with issues related to porn usage and its impacts. Some of these include watching more porn than they want to but feeling unable to stop; feeling pressured to re-enact porn with partners; seeking increasingly violent porn; feeling uncomfortable or distressed about what they are watching and requiring porn to stay aroused.

Steps ahead include an urgent need for ongoing research; widespread, cross-sector training; services that provide therapeutic support for youth impacted by porn and creating resources for Māori and pacific groups, youth with long-term health disabilities and sexuality and gender diverse young people.

12. Parallel Session 1A: Allied Health / Health Promotion / Behavioural
Friday 15 November, 1.15pm – 1.30pm

ARE WE SCARED TO TALK ABOUT SEX? MAYBE IT'S THE OTHER QUESTION, WE'RE SCARED TO TELL OUR CHILDREN THAT IT'S PLEASURABLE, WHAT ARE WE SCARED OF?

T Clelland*[1]
[1] *University of Canterbury*

Aim: The aim of this research was to explore how New Zealand parents with young people aged 11-14 understand and experience their role in sexuality education.

In 2017 the Minister of Education at the time, Hekia Parata, discussed sexuality and consent education and stated it was "first and foremost a parental, family and whanau responsibility" (Stuff, April 3, 2017). This statement was problematic as it failed to consider the feelings and emotions deeply embedded in adult engagement, and silence, around sexuality education. Furthermore, it continues to perpetuate a public/private, home/school divide that fails to engage with the complexities of sexuality education in the digital age. Adults are often haunted by their own sexuality education experiences and continue to try and protect young people from the complexity, irrationality and joy of relationships. Rather than opening up discussion around the broader determinants of sexuality, this protection often shuts down the opportunity to engage with young people.

Method: The research drew on a feminist post structural theoretical framework and utilized qualitative focus group interviews with 56 parents.

Results: Data were analysed through a Foucauldin inspired discourse analytic lens which highlighted key themes. This presentation will explore the theme of parental feelings of inadequacy and identify strategies that address the affective element of sexuality education. 'Tipping over' adult feelings about sexuality is crucial for sexual health promotion.

Conclusions: Parental fears and anxieties about the provision of sexuality education must be addressed if we are to deliver quality sexual health promotion.

13. Parallel Session 1A: Allied Health / Health Promotion / Behavioural

Friday 15 November, 1.30pm – 1.45pm

SEXUALITY AND DISABILITY: REALISING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

H Coulter, A Knight*[1]

[1] *Family Planning New Zealand, Auckland*

Issues: People with intellectual disabilities experience significant disparities in sexual and reproductive health. This includes inequitable access to health services, higher prevalence of abuse and violence, and lack of information and education[1]. Those supporting them are often ill-equipped to have conversations which will empower them to realise their sexual and reproductive health rights.

Description: Family Planning engages with support workers, teachers and whānau, and delivers workshops and training. This focuses on building knowledge around sexual and reproductive health and rights, developing skills to have supportive conversations, and exploring attitudes and values. Through this, professionals are equipped to provide effective support to their clients.

Family Planning also works directly with people with intellectual disabilities, empowering them to realise their rights, to communicate and to have safe and enjoyable experiences and relationships.

Lessons learned: Evaluations show that following training, professionals felt more confident and equipped to provide support around sexuality and relationships. Professionals adapted their language and had more open, positive conversations. Individuals with intellectual disabilities expressed their enjoyment of having open and honest discussions. With a deeper understanding of positive sexuality, many sought out health and support services and initiated conversations with their partners and whānau.

Next steps: On-going support is required for all professionals and others supporting people with intellectual disabilities to ensure access to accurate, comprehensive information that meets their diverse needs. Additional funding and training is needed for all professionals working with vulnerable individuals to ensure information is strengths based rather than solely focused on harm reduction.

[1] Greenwood, N. W., & Wilkinson, J. (2013). Sexual and reproductive health care for women with intellectual disabilities: a primary care perspective. *International journal of family medicine, 2013.*

14. Parallel Session 1A: Allied Health / Health Promotion / Behavioural

Friday 15 November, 1.45pm – 2.00pm

RELATIONSHIPS, SEX AND VALUES: MEANING-MAKING AROUND RELATIONSHIPS BY QUEER YOUNG MEN IN AOTEAROA

J Egan*[1]

[1] *University of Auckland – Faculty of Medical and Health Sciences*

Aim: Queer young men in Aotearoa grow up in heterocentric and heteronormative contexts (Egan and Flavell, 2006), with little modelling of their sexual and romantic lives. This paper looks at these men's experiences seeking love, companionship and sex as a andragogic (Knowles, 1980) process.

Method: This ethnographic study (Bernard, 2012; Chambers; 2000) examines how 16-29 year-old queer-identified men understand their lived experience in the context of elevated HIV vulnerability. Data collection included participant observation and key informant interviews. Thirty-one participants completed up to three interviews on a broad range of topics. These data have been analyzed using Mezirow's transformative learning theory (Mezirow & Associates, 1990; Mezirow 1996; 1997; 1998) via Atlas.ti qualitative data analysis software.

Results: The predominant social justice discourses around LGBTQ+ rights focuses on the non-sexual actor in the context of individual and familial rights, where monogamous partnership with one other person is framed as the norm: what these men experience in queer community is much more diverse. Much of their meaning-making is based on heteronormative and homophobic ideas around sex, love and pleasure. All participants understood the rudiments of sexual harm reduction, but often their values were an impediment for implementing this knowledge consistently.

Conclusion: These men's experiences have implications for sexual health promotion. Rather than assuming sexual harm reduction is technical or procedural, educators need to help young queer men to examine—and challenge—their beliefs around sex, love and relationships to craft knowledges that are queer-centric and celebratory.

15. **Parallel Session 1A: Allied Health / Health Promotion / Behavioural**
Friday 15 November, 2.00pm – 2.15pm

TRIANGULATION – AN AGILE METHOD FOR EVALUATING EFFECTIVE HEALTH PROMOTION IN AOTEAROA

A Leota*[1]
[1] *Positive Women Inc. and Positive Speakers Bureau*

Issues: As Health Promoters, how can we meet our reporting obligations and ensure that we are constantly monitoring how effective our service are, and not just "ticking the box" for evaluation?

Description: The Positive Speakers Bureau, a health promotion service for HIV education and prevention managed by Positive Women Inc, will share our use of triangulation evaluation as a valuable method to collect data to report, validate and monitor our service. We will also include what has worked well, some of the challenges with evaluation in general, and the tools we use to help us with the triangulation method.

Lessons learned: Evaluation can be a ***tipping point*** for any organisation. Triangulation gives us an opportunity to reflect and respond in an agile way and plays an invaluable role in our service delivery model.

16. Parallel Session 1A: Allied Health / Health Promotion / Behavioural

Friday 15 November, 2.15pm – 2.30pm

ADOLESCENT MASCULINITIES AND THE DRAMA OF SEXUAL HEALTH PROMOTION

E Hastings*[1], D Fa'atui*[1], L Montagne*[1], M Fati*[1]

[1] *The Theatre in Health Education Trust, Ōtepoti/Dunedin, Aotearoa/New Zealand*

Issues: Sexual Health Promotion, Adolescent Masculinities, Applied Theatre, and Positive Youth Development.

Description: Sexwise is an Applied Theatre based Sexual Health Promotion program, devised by Performer/Facilitators (in their early 20's), for rangatahi/youth across Aotearoa New Zealand, with a focus on North Island low decile (1-6) schools and schools with a high percentage of Māori and Pacific Island students.

Sexwise aims to challenge and motivate rangatahi/youth to discuss, explore and reflect on behaviours that affect their health and that of others, with reference to current accurate information. Sexwise provides an engaging and safe forum for discussion of often contentious, tabu and stigmatised subject matter. Funded by the Ministry of Health.

Lessons learned: Dynamics of homophobia can be a barrier to meaningful engagement with Sexual Health Promotion for adolescent males. Facilitators must address homophobia skillfully to maintain a safe space without shutting down or shaming anyone. Male Performer/Facilitators can model healthy emotional expression and vulnerability in the process of Sexual Health Promotion with rangatahi/youth, offering young men a space to discuss Sexual Wellbeing with depth and nuance.

Next steps: Further dialogue about masculinities and male representation in our programs can ensure that we remain culturally relevant to the communities in Aotearoa/New Zealand we engage with while increasing our effectiveness with young men.

17. Parallel Session 1A: Allied Health / Health Promotion / Behavioural

Friday 15 November, 2.30pm – 2.45pm

SEXUAL ASSAULT PREVENTION IN TERTIARY INSTITUTIONS WITH APPLIED THEATRE

E Hastings*[1]

[1] *The Theatre in Health Education Trust, Ōtepoti/Dunedin, Aotearoa/New Zealand*

Issues: Sexual Assault Prevention, Health Promotion in Tertiary Education, Theatre of the Oppressed, Drama Therapy.

Description: Shadow Liberation is a participatory theatre initiative facilitating sexual assault prevention in tertiary education. Shadow Liberation integrates Drama Therapy for trauma informed practice, Theatre of the Oppressed as a participatory method for critical dialogue and Shadow Theatre for its aesthetic richness in representing the otherwise unspeakable.

Lessons learned: Shadow Liberation can be an effective approach to Sexual Assault Prevention for Tertiary Institutions as a compliment to holistic Institution-wide prevention programming. This conclusion is based on case studies and participant surveys as indicators of behavioral change. The Center for Disease Control and Prevention in the United States recognizes bystander intervention as a promising approach to sexual assault prevention (2014). Research on dating violence intervention programs at colleges in the United States shows that while initial survey findings after programs can look promising, their effect diminishes over-time, casting doubt on the effectiveness of one-off interventions (Kaukinen, 2014). There is also research that demonstrates that some Sexual Assault Prevention programs backfire at Colleges and Universities (Malamutha, Huppinb, and Linzc, 2018), where interventions serve to reinforce previously held prejudice in some men.

Next steps: Sexual Assault Prevention programming needs to be ongoing and integrated with other initiatives focused on well-being within Institutions. The Shadow Liberation approach has the potential to be adapted to be culturally relevant for communities in Aotearoa/New Zealand.

18. Parallel Session 1A: Allied Health / Health Promotion / Behavioural
Friday 15 November, 2.45pm – 3.00pm

COLLABORATIVE PARTNERSHIPS BETWEEN HEALTH PROMOTERS AND ACADEMIA: METHODOLOGICAL CONSIDERATIONS WHEN PARTNERING WITH PACIFIC COMMUNITIES

A Veukiso-Ulugia*[1]

[1] *School of Counselling, Human Services and Social Work, Faculty of Education and Social Work, The University of Auckland, Auckland*

Tipping point - a time during a process when an important decision must be made or when a situation changes completely. Pacific communities in Aotearoa-New Zealand are living in a time of rapid cultural and technological shifts, however cross-generational taboos and sensitivity around sexual health issues remain. These socio-cultural pressures as well as resourcing constraints in the sexual health sector necessitate strong inter-sectoral and intra-sectoral partnerships to ensure quality sexual health promotion and provision for all communities, including Pacific.

This paper highlights important methodological questions for academia partnering with Pacific communities and vice versa. It explores cultural responses to three research issues arising from a partnership project between the Centre for Community Research and Evaluation (CCRE) at the University of Auckland and Village Collective, a Pacific-centric organisation supporting Pacific youth, families and communities with sexual health and wellbeing.

This partnership resulted in the development of an evaluation framework and extended the knowledge base of both parties. Robust community-engaged healthcare research requires a commitment to the spirit of partnership and responsibility, as well as genuine engagement and negotiation. Findings from this project raise important questions for further enquiry:

- How should limited resources and staff expertise be invested to enable the best possible assessment of programme quality and delivery?
- What institutional commitments are in place to promote successful academic-community partnerships?
- How can I as an (Pacific) academic pursue the advocacy and policy issues that emanate from the research?

19. Parallel Session 1B: Clinical / Laboratory
Friday 15 November, 1.00pm – 1.15pm

RESISTANCEPLUS MG FLEXIBLE FOR THE GENEXPERT ENABLES NEAR PATIENT TESTING OF MYCOPLASMA GENITALIUM AND MACROLIDE RESISTANCE MARKERS

C Oostendorp*[1], E Sweeney*[2], T Lonergan[1], R Wee[1], A Arvind[1], LY Tan[1], DM Whiley[2,3]
[1] SpeeDx, Sydney, Australia
[2] University of Queensland Centre for Clinical Research, The University of Queensland, Brisbane, Australia
[3] Pathology Queensland Central Laboratory, Brisbane, Australia

Aim: Molecular assays that detect Mycoplasma genitalium (Mgen) and presence of macrolide resistance markers such as ResistancePlus® MG, have enabled clinicians to implement resistance-guided therapy for Mgen infections. This is a crucial strategy in the management of STIs, with the challenge of increasing antimicrobial resistance and limited treatment options, where syndromic management may no longer be adequate. The ResistancePlus MG test is intended for testing in centralised laboratories, however there is also a demand for clinics with onsite STI testing and to improve workflow for small to medium laboratories. Therefore, the ResistancePlus MG FleXible was developed to run on the GeneXpert. Here, we evaluated the clinical performance of ResistancePlus MG FleXible.

Method: Clinical performance of ResistancePlus MG FleXible was evaluated on 68 Mgen positive and 116 Mgen negative samples (performed at the University of Queensland). Mgen detection was compared to a MgPa real time PCR assay and detection of the 23S rRNA mutations was compared to ResistancePlus MG (performed on the ABI 7500 Fast Dx).

Results: Compared to the reference methods, ResistancePlus MG FleXible was shown to have 97.1% sensitivity and 99.1% specificity for detection of Mgen, and 100% sensitivity and 100% specificity for the detection of 23S rRNA mutants.

Conclusion: With the availability of ResistancePlus MG FleXible for use on the GeneXpert instrument, clinicians can have faster access to patient results for both Mgen infection and macrolide resistance, allowing wider implementation of resistance-guided therapy.

Conflicts of interest: Non-SpeeDx employees received funding from SpeeDx supporting this work. Corey Oostendorp, Tina Lonergan, Rachel Wee, Akanksha Arvind and Litty Tan are employees of SpeeDx and have shares in the company.

20. **Parallel Session 1B: Clinical / Laboratory**
Friday 15 November, 1.15pm – 1.30pm

LOW RATES OF GONORRHOEA CULTURE IN THE ERA OF NUCLEIC ACID AMPLIFICATION TESTING HAVE IMPLICATIONS FOR ANTIMICROBIAL SURVEILLANCE

S Azariah*[1]
[1] *Auckland Regional Sexual Health Service*

Aims: Firstly, to determine whether a switch in testing methodology from direct plating to using transport swabs had affected sensitivity of gonorrhoea culture at Auckland Regional Sexual Health Service and secondly to determine whether staff were adhering to clinic guidelines for performing gonorrhoea culture.

Method: Two successive audits of gonorrhoea testing data from Auckland Regional Sexual Health Service clinics were undertaken using quarterly laboratory data reports from the hospital laboratory. Three quarterly time periods between 2017 and 2019 were audited.

Results: The total volume of nucleic acid amplification tests (NAATs) being taken increased over time and also the number of positive gonorrhoea NAATs increased, however the number of positive gonorrhoea cultures decreased by 35%. Staff were not following clinic guidelines for performing gonorrhoea culture. Although the sensitivity of culture dropped slightly after the change in methodology this should not have reduced the overall number of positive cultures had staff been adhering to clinic guidelines.

Conclusion: Although the introduction of NAAT testing for gonorrhoea has improved sensitivity and acceptability of testing for patients, positive gonorrhoea culture rates have fallen. This has the potential to negatively impact on the reliability of anti-microbial resistance (AMR) surveillance. New measures will need to be introduced to improve staff adherence to clinic guidelines.

21. **Parallel Session 1B: Clinical / Laboratory**
Friday 15 November, 1.30pm – 1.45pm

CHLAMYDIA AND GONORRHOEA REINFECTION: INEQUITABLE OUTCOMES BY GENDER AND ETHNICITY

SB Rose*[1], SM Garrett[1], J Stanley[2], SRH Pullon[1]
[1] *Department of Primary Health Care and General Practice, University of Otago, Wellington, New Zealand*
[2] *Biostatistical Group, University of Otago, Wellington, New Zealand*

Aim: To describe chlamydia and gonorrhoea retesting and reinfection rates, and to identify factors associated with retesting and repeat positivity.

Methods: Retrospective cohort study analysing chlamydia and gonorrhoea testing data from the two laboratories providing community testing services for the Tairāwhiti, Hawkes Bay, Whanganui and Midcentral District Health Board (DHB) regions. Three years of data were obtained (2015-2017), with testing rates analysed over 2.5 years with a minimum of 6-months follow-up for all individuals. Rates of retesting and reinfection between 6-weeks and 6-months of a positive result were calculated and time to retesting plotted using Kaplan-Meier curves. Logistic regression modelling was used to determine the odds of retesting (outcome 1) and reinfection (outcome 2) between 6-weeks and 6-months of follow-up.

Results: Overall, 34% of the cohort were retested during follow-up (3151/9241), of whom 21% retested positive. Significant differences were observed in the odds of retesting by gender, age-band, ethnic group, index test location and DHB region ($p<0.002$ for all factors). The odds of a subsequent positive on retesting within 6-months differed significantly by gender, age-band, and ethnic group ($p<0.01$).

Discussion: This study highlights inadequate retesting rates, high reinfection rates and clear evidence of inequitable outcomes by gender and ethnicity. These findings are reflective of an ongoing failure to prioritise the delivery of quality sexual health care in New Zealand. System and provider level changes that are tailored to meet the needs of priority populations are urgently needed to improve partner notification and access to testing and retesting.

22. Parallel Session 1B: Clinical / Laboratory

Friday 15 November, 1.45pm – 2.00pm

SH:24 THE DEVELOPMENT OF AN ONLINE SERVICE AND IMPACT ON SEXUAL HEALTH IN LONDON.

GMC Holdsworth*[1], J Moore[1], E Ardines[1], P Baraitser[1]

[1] *SH:24*

Issues: Lambeth and Southwark are two London boroughs with the highest rates of STIs and HIV in England and insufficient capacity in clinics.

Description: We describe the development of an online sexual health service offering home sampling for sexually transmitted infections. SH:24 users order a testing kit to their home which they use to self-sample for chlamydia, gonorrhoea, HIV and syphilis. The samples are returned to the laboratory and SH:24 issues the service user with results and options for treatment.

The service is a result of work of a multiple professional team including public health, sexual health, designers and academics working alongside users to shape the service.

Lessons learned: STI testing in Lambeth and Southwark doubled following the introduction of SH:24 with an 8% reduction in STI rates.

Those testing online are appropriately high risk with overall Chlamydia positivity 6.8%, Gonorrhea 0.9%, Syphilis 0.6% and HIV reactive rate of 0.8%. 36.4% of users report never using a clinic before. These 'new-testers' have high infection rates. In BME and U25s the overall positivity rate is 7% higher in never tested compared with previous clinic attenders. Among MSM overall positivity in those who never tested is lower (14%) than those who have tested before (18%).

Next steps: Home sampling for STIs is an effective and acceptable approach to increase access to testing in the UK with implications for New Zealand and high return rates can be achieved amongst previously untested populations. Health professionals should embrace innovative ways to increase access to STI testing for their patient cohort.

NB: We encourage work that introduces new ideas and conceptualizations, research and understandings to the field, as well as analysis of both success and failure.

23. **Parallel Session 1B: Clinical / Laboratory**
Friday 15 November, 2.00pm – 2.15pm

INITIAL EXPERIENCE WITH THE XPERT® CT/NG SYSTEM IN TAURANGA

M Giola*[1], A Edwards[1], R Mackay[1], A Ashman[1], H Read[1], S Abdool-Raheem[1]
[1] Bay of Plenty DHB Sexual Health Service, Clinic 2, Tauranga

Issue: Antimicrobial stewardship's (AMS) principles, in an era of increased antibiotic resistance, mandate that antibiotic therapy of STIs and STI contacts must be directed by sensitive and specific tests, rather than being empirically administered following presumptive diagnosis and syndromic algorithms.

Description: In order to provide rapid, point-of-care diagnosis of Chlamydia (CT) and gonorrhoea (NG) infections, we introduced the use of the Xpert® CT/NG system in our clinic in Tauranga. The system allows for the rapid (90' turnaround time), onsite DNA amplification diagnosis of CT and NG from a variety of clinical samples. The size of the machine is comparable to a desktop computer with printer, and only requires a power point as the single-use cartridges are completely self-contained. As a preliminary step (stage one), we have assessed the staff satisfaction using the test, by administering a 5-item questionnaire using a 5-point, semi-quantitative visual Likert scale (very unsatisfied, unsatisfied, neutral, satisfied, very satisfied).

Lessons learned: Staff satisfaction was high, as the score was, for all items and all questionnaires, either 4 or 5 (satisfied or very satisfied).

Next steps: We are currently proceeding to stage two of our experience with the test, by evaluating the concordance of the results with the traditional lab-run PCR and assessing the AMS outcomes in terms of avoidance of inappropriate and excessive use of antibiotics.

24. **Parallel Session 1B: Clinical / Laboratory**
Friday 15 November, 2.15pm – 2.30pm

CHANGES TO MATERNITY GUIDELINES FOR PREGNANT WOMEN LIVING WITH HIV

C Bree*[1]
[1] *Positive Women Inc. and Auckland DHB*

Issues: Delay in updating the Ministry of Health National Maternity Referral Guidelines 2012 to reflect advances in HIV treatment led to the lack of a coordinated approach to the care of women living with HIV. Women have often felt powerless and were denied choice about their birth experience

Description: The ***tipping point*** has been the recognition that according to international guidelines HIV alone no longer met the criteria for Medical Clinic care led to revision of the 'Pathway for Pregnancy Care of Women with HIV Infection'. Women who remain on medication with an undetectable viral load are now able to choose a Lead Maternity Care midwife who can provide continuity of antenatal, intrapartum and postnatal care

Lessons learned: The importance of listening to healthcare consumers and adapting provider policies to reflect current research and best practice. The role of non governmental peer advocacy groups in leading dialogue and positive change

Next steps: Implementation of the new policy in Auckland DHB, including HIV Update workshops for midwives. It is hoped that sharing this presentation will lead to updated MOH National Guidelines and an integrated approach throughout the country

25. Parallel Session 1B: Clinical / Laboratory

Friday 15 November, 2.30pm – 2.45pm

BREASTFEEDING AND MOTHERS WHO HAVE HIV

J Bruning*[1]

[1] *Positive Women Incorporated*

Issues: It is generally understood that women who have HIV should not breastfeed their babies due to a possible risk of transmitting HIV to their babies

Description: A review was undertaken in 2016 of the government's recommendations on breastfeeding and women who have HIV. As a result, a significant amendment was made which provides the option of informed choice. The information is however buried deep within the official recommendations and not widely known.

Lessons learned: While there has been some research, there continues to be confusing messaging around this issue. WHO suggests each country should make recommendations which best suits their national situation.

Next Steps: It is important for health professionals to understand the implications of the amendment to the New Zealand recommendations to ensure optimal care, support and to respect the wishes of the women they work with in this regard.

26. Parallel Session 1A: Clinical / Laboratory

Friday 15 November, 2.45pm – 3.00pm

COMPREHENSIVE SEXUAL HEALTH SCREENING AMONG GAY AND BISEXUAL MEN IN AOTEAROA/NEW ZEALAND

A Anglemyer*[1], P Saxton[2], A Ludlam[3]

[1]*Preventive and Social Medicine, University of Otago, Dunedin*

[2]*School of Population Health, University of Auckland, Auckland*

[3]*New Zealand AIDS Foundation, Auckland*

Background: Sexually transmitted infection (STI) incidence among gay and bisexual men (GBM) is rising and is higher among HIV-infected GBM. Aotearoa/New Zealand guidelines recommend comprehensive STI screening (CSS) annually for all GBM regardless of sexual practices, though no studies have investigated CSS.

Methods: We examined a national cross-sectional community and internet study of GBM in 2014. Participation was anonymous, voluntary, and self-completed. We estimated recent (<12 months) prevalence of CSS [anal (exam or swab), throat, penile (swab or urine), syphilis test], and identified socio-demographic, clinical, and behavioural factors associated with recent CSS using multivariable logistic regression.

Results: 3097 GBM participated. CSS was more common at a sexual health clinic than at a general practitioner (GP). Overall, 32% of HIV+ and 12% of HIV-/unknown participants had an STI diagnosed <12 months. HIV prevalence was 5% (n=155). Recent CSS prevalence among HIV+ participants was two-fold greater than among HIV-/unknown participants (45% and 21%, respectively). HIV-infection (aOR=2.1; $p < 0.001$), anal intercourse (aOR=1.83; $p = 0.009$), more than 20 male partners (aOR=1.85; $p < 0.001$) increased the odds of CSS, while being 45 or older (aOR=0.53; $p < 0.001$), having a GP who did not know their patient's sexual orientation (aOR=0.36; $p < 0.001$), and reporting Pacific Island ethnicity (aOR=0.52; $p = 0.038$) decreased the odds.

Conclusions: CSS prevalence fell short of guidelines for all GBM, though was twice as common among HIV+ participants. GBM experience a high burden of STIs; barriers to screening should be removed to expedite treatment and interrupt transmission.

27. **Plenary 4: Gender Affirming Healthcare in Aotearoa New Zealand**
Friday 15 November, 3.30pm – 3.45pm

GUIDELINES FOR GENDER AFFIRMING HEALTHCARE IN AOTEAROA, NEW ZEALAND

J Oliphant[1], J Veale[2]
[1] Auckland Regional Sexual Health Service, Auckland
[2]University of Waikato, Hamilton

Issues: The 2008, New Zealand Human Rights Commission (HRC) report, To Be Who I Am, identified major gaps in "the availability, accessibility, acceptability, and quality" in the provision of gender affirming healthcare1. Since 2008, work to improve healthcare services has been undertaken by small groups of dedicated health professionals around New Zealand, but there is evidence that much of what was highlighted by the HRC may still remain true.

Description: This guideline was developed to help address some of the concerns raised in the HRC report. In addition, it was recognised that New Zealand's previous good practice guide, Gender Reassignment Health Services for Trans People within New Zealand,2 which was based heavily on the World Professional Association of Transgender Health, Standards of Care, version 6 (WPATH SOC v6),3 required updating to be in step with current practice and international guidelines.

Lessons learned: Sir Mason Durie's models of healthcare, Te Pae Māhutonga and Te Whare Tapa Whā provided a valuable framework to build the guideline and incorporate feedback from community and clinicians around Aotearoa. The collaborative approach of developing the guideline helped to ensure that it was relevant for health services and reflected the needs of the community.

Next steps: It is the intention that the guidelines for gender affirming healthcare4 will be used to support the development of health services providing gender affirming healthcare around the country and provide guidance to District Health Boards (DHBs).

References:

1. To Be who I am. Kia noho au ki tōku anō ao. Report of the inquiry into discrimination experienced by transgender people. Human Rights Commission. 2008.
2. The Gender Reassignment Health Services for Trans People within New Zealand, Good Practice Guide for Health Professionals. Counties Manukau District Health Board, 2011. Wellington: Ministry of health.
3. The Harry Benjamin International Gender Dysphoria Association. The Harry Benjamin International Gender Dysphoria Association's Standards of Care for World Professional Association for Gender Identity Disorders 6th Version 2001
4. Oliphant J, Veale J, Macdonald J, Carroll R, Johnson R, Harte M, Stephenson C, Bullock J. *Guidelines for gender affirming healthcare for gender diverse and transgender children, young people and adults in Aotearoa, NewZealand.* Transgender Health Research Lab, University of Waikato, 2018.

28. **Plenary 4: Gender Affirming Healthcare in Aotearoa New Zealand**
Friday 15 November, 3.45pm - 4.00pm

SEXUAL HEALTH AND SEXUAL HEALTHCARE ACCESS FOR THE TRANS AND NON-BINARY PEOPLE IN AOTEAROA

JL Byrne*[1],[2], JF Veale*[1]
[1] *University of Waikato*
[2] *TransAction*

Aim: This presentation will report the experiences of trans and non-binary people in Aotearoa New Zealand with sexual partners, use of protective barriers during sex, prevalence of sexually transmitted infections, access to sexual health education, and experiences with pregnancy and parenting.

Method: We developed a survey questionnaire in consultation with a Community Advisory Group and health professionals. It includes questions from the New Zealand Health Survey to allow comparisons with the general population. A convenience sample of 1,178 participants aged 14 and older was recruited through community organisations, social media, and health professionals. Most responses were completed online.

Results: Almost one-in-five participants (19%) had ever had an STI, with chlamydia the most common (7%). Only 42% of participants had received trans-specific sexual health information. The most common source of this information was from participants looking it up themselves (25%), and few participants had received this information from healthcare providers (9%) or from school (4%).
A sexual health physician was the main provider of gender-affirming care for 15% of participants. Only 34% of participants who had accessed hormones or genital surgery had received information about fertility preservation options, and 17% had received fertility services to preserve their eggs or sperm. One-in-six participants (16%) were parents, and 4% of participants who were assigned female at birth had been pregnant since identifying as trans or non-binary.

Conclusion: Sexual health is an important consideration for trans and non-binary people. We found both a demand for and shortcomings in access to relevant sexual health and fertility preservation information.

29. Plenary 4: Gender Affirming Healthcare in Aotearoa New Zealand

Friday 15 November, 4.00pm – 4.15pm

SEXUAL ORIENTATION AND SEXUAL ACTIVITY IN A COHORT OF TRANSGENDER INDIVIDUALS

M Giola*[1], B Mijatovic[2], D Pritzgintas[3], R Mackay[1]

[1] *Bay of Plenty DHB Sexual health service (Clinic 2)*

[2] *Bay of Plenty DHB Adult Consult Liaison Psychiatric Service*

[3] *Clinical Psychologist*

Aim: To describe the relation between gender identity, sexual orientation, and sexual activity in a cohort of transgender individuals.

Method: Retrospective study of the electronic medical records. The following variables were extracted: gender identity, sexual orientation, sexual activity, and gender identity of the sexual partners.

Results: 74 transgender individuals on active follow up were included: 38 assigned male at birth (AMAB) transwomen, 33 assigned female at birth (AFAB) transmen, and 2 AFAB non-binary gender queer (NBGQ) individuals. Of the 38 transwomen, 22 were not sexually active (12 describing their sexual orientation as heterosexual, 5 as asexual, 2 as bisexual, 1 as homosexual, and 1 as pansexual); 17 transwomen were sexually active (13 describing their sexual orientation as heterosexual and reporting their partners to be cismen, 3 as bisexual with the partners being cismen and ciswomen, and 1 as homosexual with her partners being ciswomen). Of the 33 transmen, 14 were not sexually active (5 heterosexuals, 4 homosexuals, 2 bisexuals, 2 asexuals, 1 declined to answer); 20 transmen were sexually active (16 heterosexuals with ciswomen partners, 3 homosexuals with cismen partners, 1 bisexual with cismen partners). 1 AFAB NBGQ person was sexually active, homosexual, in partnership with a cisman; the other AFAB NBGQ person was not sexually active, asexual.

Conclusion: The sexual orientation and experiences of transgender individuals are highly diverse. It is important not to make assumptions and to actively ask about them, to improve the sexual health care (STI screenings, vaccinations, indication for PrEP) of transgender individuals.

30. **Plenary 5: New Technologies / Strategies to Increase Access in Sexual Health**
Saturday 16 November, 8.00am - 8.30am

ANONYMOUS PARTNER NOTIFICATION AND EFFECTIVE LINKAGE TO CARE

A Menon-Johanssen*[1]
[1] *SXT Health CIC*

Issues
Sexually Transmitted Infection (STI) epidemics cannot be addressed by infection testing alone but also require effective partner notification (PN). PN services are time consuming to deliver and measuring impact is difficult. We therefore built an anonymous PN tool using SMS within a cloud-based system to determine if we could improve the ability to test partners.

Description
Data from digital partner notification tool (SXT, www.sxt.org.uk) was analysed from 2018 and compared against the latest PN outcomes reported by Public Health England (PHE). Key Performance Indicator (KPI) is the number of partners tested per index patient.

Lessons learned:

Sexually transmitted Infection	Chlamydia	Gonorrhoea	Syphilis	HIV
Number of index patients using SXT for PN	8042	2879	570	98
Partners tested at time of treatment (KPI)	2088 (0.26)	946 (0.32)	150 (0.26)	48 (0.49)
Partners tested after treatment of index patient [SXT verified] (KPI)	1152 (0.14)	721 (0.25)	231 (0.41)	23 (0.23)
Partners tested after treatment of index patient verified by staff (KPI)	1496 (0.19)	549 (0.19)	170 (0.30)	18 (0.18)
Total KPI for providers using SXT	0.59	0.77	0.97	0.91
% Prospective PN delivered by SXT	44%	57%	58%	56%
Estimated saving in staff time (£17/index)	£19,584	£12,257	£3,927	£391
PHE 2018 reported KPI	0.49	0.41	0.63	0.57

More effective PN is delivered with less staff time using SXT.

Next Steps:
Further work is required to increase the number of clinics using the SXT PN tool, to support index patients to inform partner and to link partners expeditiously to testing.

31. Plenary 5: New Technologies / Strategies to Increase Access in Sexual Health

Saturday 16 November, 8.30am - 8.50am

USE OF DIVERSE TESTING MODALITIES TO FACILITATE ACCESS TO HIV TESTING FOR NEW ZEALAND KEY POPULATIONS

A Anderson*[1], J Beaumont, A Ludlam, J Rich

[1] *New Zealand AIDS Foundation*

Background/Purpose: Reducing rates of undiagnosed HIV in New Zealand is a core strategic goal for the New Zealand AIDS Foundation (NZAF). Ensuring NZAF provides testing services to gay, bisexual and other men who have sex with men (GBM) that are equitable, accessible and acceptable is essential.

The NZAF delivers a range of rapid testing service types both within and beyond clinic settings, to meet the diverse needs of priority populations. These testing opportunities include point-of-care rapid testing at community health centres (booked appointments or walk-in), outreach at sex-on-site (SOS) venues, and HIV self-testing.

The aim of this project was to assess whether providing additional testing modalities effectively targets more diverse client sub-populations.

Approach: We analysed NZAF HIV testing client data from the period between May 2018 and April 2019. It includes ethnicity, reported condom use, and previous testing. We compared client characteristics associated with different testing modalities.

Outcomes/Impact:

	NZAF centres – booked. (n=2206)	NZAF centres - walk-in (n=611)	Self-test (n=1261)	Sex-on-site venue outreach (n=124)
% GBM clients non-European/Pakeha	42%	52%	40%	52%
% GBM clients Maori	4%	4%	9%	6%
% GBM clients reporting non-recent testing (never or not in last 12 months)	29%	33%	64%	29%
% GBM clients reporting infrequent condom-use	33%	31%	47%	16%
Positivity rate (per 1000 tests)	5.4	3.3	5.0	8.1

Innovation and Significance: Understanding demographic profile and risk factors of clients using different testing service types is useful in evaluating their effectiveness. These insights can support how NZAF apportion future testing resources and more importantly the ways that we can target testing communication in relation to each testing opportunity.

Disclosure of Interest Statement: New Zealand AIDS Foundation is a registered Charitable Trust funded through New Zealand government and private donations and granting bodies. No pharmaceutical grants were received in the development of this project

32. Plenary 5: New Technologies / Strategies to Increase Access in Sexual Health

Saturday 16 November, 8.50am - 9.20am

YOSS – INCREASING ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH CARE

S Bagshaw*[1]

Young people between 18 and 24 are the worst served group in our population. They are expected to pay adult fees but have little or no income being on student or unemployment benefits or having part time low paid jobs.

YOSS (Youth One Stop Shops) and sexual health are helpful in providing free care, but cost is not the only barrier. Not knowing where to go for what, fear of embarrassment and judgement are other barriers. This presentation will show how YOSS overcome those barriers and give details of a new YOSS on steroids being developed in Christchurch.

33. **Plenary 5: New Technologies / Strategies to Increase Access in Sexual Health**
Saturday 16 November, 9.20am - 10.10am

SEX WORKERS: DOING IT RIGHT

C Hati*, T Drewery*, C Fraser*

This session will lubricate thinking about the ins and outs of working effectively with sex workers in the age of syphilis, on-line sex work, prep, consent, and some...

34. Parallel Session 2A: HIV Prevention
Saturday 16 November, 10.40am - 10.55am

RECENT TRENDS IN HIV DIAGNOSES IN NEW ZEALAND

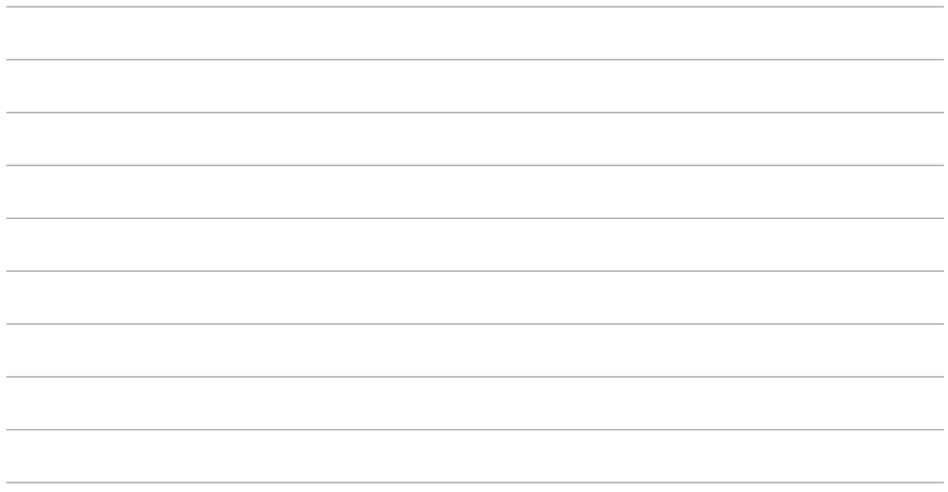
S McAllister*[1]
[1] *AIDS Epidemiology Group, Department of Preventative and Social Medicine, University of Otago*

The AIDS Epidemiology Group has, since 1989, undertaken the surveillance of HIV in New Zealand.

Men who have sex with men (MSM) continue to be the most affected by HIV in New Zealand (NZ), accounting for 79% of all locally-acquired diagnoses in 2018. Following three years of increasing numbers of diagnoses among MSM, the numbers diagnosed in 2017 and 2018 have declined to numbers similar to those reported between 2003 and 2010. This decline was seen particularly in MSM reported to have been infected in NZ. Changes within the last few years including treating all HIV positive individuals, availability of pre-exposure prophylaxis, and ongoing campaigns emphasizing the use of condoms and regular HIV testing are likely to have impacted on this decline.

Amongst heterosexual men and women, the number diagnosed with HIV peaked in the mid-2000s, declined around 2009 and has remained relatively stable at low numbers since then. In the years 2015-2018, around half (55%) of heterosexual men and women had a CD4 count <350 at the time of diagnosis – an indication of prolonged undiagnosed infection. Early HIV testing, therefore, needs to be emphasised and clinicians need to consider HIV as a possibility in people with compatible clinical features.

There has been an ongoing small number of HIV diagnoses among people who inject drugs. In 2018, however, there were six MSM who also reported injecting drug use as a possible means of infection – the highest number ever in one year. HIV prevention needs to continue to be maintained in this high-risk population.



35. Parallel Session 2A: HIV Prevention
Saturday 16 November, 10.55am - 11.10am

EARLY ADOPTERS "ON PREP": 12 MONTHS FOLLOW-UP OF ADHERENCE, BEHAVIOURS AND STIS

P Saxton*[1], S Azariah[2], R Jenkins[2] on behalf of the NZPrEP study team
[1]*School of Population Health, University of Auckland, Auckland*
[2]*Auckland Sexual Health Service, ADHB, Auckland*

Aim: HIV pre-exposure prophylaxis (PrEP) is funded in New Zealand for individuals most at risk. However, there are no local data on continuation, adherence, behaviour change or sexually transmitted infection (STI) incidence. We report the first New Zealand findings from early PrEP adopters.

Methods: We analysed 12 months follow-up from participants in the NZPrEP demonstration project, an open label, single arm treatment evaluation study conducted in Auckland sexual health clinics (n=150). We ensured a 50:50 European/non-European quota. Every 3 months participants attended a clinic for STI screening, received a daily PrEP prescription and completed an anonymous online survey using a unique study identifier. We examine clinical and behavioural indicators overall and by ethnicity.

Results: Study retention was 83% at 12 months. Most (98%) were "on PrEP" (≤3 missed doses <7 days). However 26.6% and 57.6% missed 1+ dose <7 days and <30 days respectively; adherence being lower in non-Europeans. A third (34.3%) reported side-effects at 3 months, reducing to 11.3% at 12 months. PrEP breaks increased from 3.8% to 14.2% and were significantly higher for non-Europeans at 12 months (23.1% vs 5.6%) (p=0.01). The number of sexual partners <3 months declined and the number of condomless receptive anal intercourse partners was stable from baseline to 12 months (median=3, 3; 10%, 13.9% reported 10+). STI incidence at 3,6,9 & 12 month intervals was: 24%, 32%, 32%, 21% (any STI); 17%, 16% 23%, 14% (rectal STI); 9%, 13%, 13%, 10% (gonorrhoea).

Conclusion: PrEP policy and delivery challenges include long-term adherence, high STI incidence and ethnic inequalities.

36. PARALLEL SESSION 2A: HIV PREVENTION

Saturday 16 November, 11.10am - 11.25am

COMBINATION HIV PREVENTION USE AMONG AN ONLINE SAMPLE OF GAY AND BISEXUAL MEN IN AOTEAROA NEW ZEALAND

A Ludlam*[1], J Kolodziej[1], J Rich[1], P Saxton[2], D Petousis-Harris[1]

[1] *New Zealand AIDS Foundation (NZAF), Auckland*

[2] *School of Population Health, University of Auckland, Auckland*

Aim: Combination HIV prevention is publicly funded in New Zealand and incorporates condoms, pre-exposure prophylaxis (PrEP) and undetectable viral load (UVL). We explore self-reported combination HIV prevention use among gay, bisexual and other men who have sex (GBM) to assess progress.

Method: We conducted a voluntary, anonymous cross-sectional survey in 2018 using social media and mobile dating applications targeted at GBM. This analysis focuses on participants reporting anal sex with a “casual” male partner in the previous six months. Participants were categorised into the following groups based on self-reported behaviour: “UVL”; “PrEP” (HIV-negative and on PrEP regardless of condom use); “Condom users” (HIV-negative and used condoms always or almost always); “None” (HIV-negative and used condoms less often). Fisher’s exact test was used to determine significant differences between groups.

Results: Of the 1086 participants, 667 (61%) were eligible. The majority (59%) were “Condom users”, 19% used “PrEP”, 7% used “UVL” and 14% used “None”. Overall 86% reported at least one form of combination HIV prevention. Participants who used “None” combination prevention approaches were less likely to recall the Ending HIV social marketing campaign, reported fewer sexual partners and were more likely to live outside Auckland. Of HIV-negative participants reporting condomless casual sex, 28% were on PrEP and 48% were not but wanted to be.

Conclusion: Engagement with combination HIV prevention is high among GBM in our sample. Lower than indicated PrEP uptake, differences by regions, and non-use of barrier methods with casual partners during an STI epidemic are areas of concern.

37. Parallel Session 2A: HIV Prevention
Saturday 16 November, 11.25am - 11.40am

PROGRESS TOWARD VIRTUALLY ELIMINATING HIV TRANSMISSIONS IN NEW ZEALAND

JG Rich*[1], JM Myers[1], MP Shaw[1], AH Ludlam[1], PJ Saxton[2]
[1] *New Zealand AIDS Foundation*
[2] *School of Population Health, University of Auckland*

Issues: Gay and bisexual men (GBM) continue to be over-represented in HIV diagnoses in New Zealand and until 2016 infections were continuing to rise. Successful international demonstrations prompted New Zealand AIDS Foundation (NZAF) to develop a comprehensive behaviour-change strategy incorporating condoms, pre-exposure prophylaxis (PrEP), scaled-up testing and prompt treatment to achieve an 80% reduction in transmissions among GBM by 2025.

Description: Interventions included:

- Advocacy resulting in public funding of PrEP and the removal of the CD4 threshold for accessing treatment
- Supporting a capable workforce by developing a national consensus statement on HIV prevention and delivering PrEP training through partnerships
- Improving access by developing PrEP service map, rapid testing drop-in clinics, outreach testing and HIV-self-testing.
- Launching a multi-channel behaviour change campaign, Ending HIV, to empower GBM with updated information and mobilise them to join a social movement to end new transmissions.

Lessons learned: An interconnected approach to change has contributed to supportive policies and services, increased community knowledge and a reduction in HIV diagnoses. From 2016-2018:

- HIV diagnoses among GBM (infected in NZ) decreased by 39%
- GBM reporting HIV testing <12mths increased from 47% to 61%
- NZAF-provided HIV tests increased by 50%. 2000 HIV self-tests were distributed
- 1750 GBM accessed funded PrEP
- GBM reporting consistent condom-use declined. However, when excluding those using biomedical prevention, this was not statistically significant.
- 71% of GBM reported recall of the Ending HIV brand.

Next steps: Ongoing challenges include resurgent STIs, inconsistent PrEP readiness in primary care and no recent behavioural surveillance.

38. Parallel Session 2A: HIV Prevention
Saturday 16 November, 11.40am - 11.55am

FINDING THE PERFECT FIT: CONDOM USE AT A TIPPING POINT

T Gray[1], V Walsh*[1], A Walton[1], M Shaw[1]
[1] *New Zealand AIDS Foundation, Auckland*

Issues: For one in four men, standard-sized condoms are either too tight or too loose. Correct condom fit decreases chance of breakage and discomfort and increases pleasure and long-term condom adherence.

Description: We designed and produced the Ending HIV Condom Toolbox (Toolbox) containing 12 condoms in different sizes and materials, with various lubricants, printed resources and a masturbation sleeve. The Toolbox is free to GBM (gay and bisexual men) and trans people aged 16-20.

To accompany this, we developed the Ending HIV Condom Masturbation Trainer (CMT). The CMT is an interactive, pick-a-path experience, using a model who masturbates with the viewer. Starting with a standard 56mm condom viewers click buttons like "It feels too tight" or "I want to try something thinner" the next video is triggered, until the best fit condom is identified. Viewers can then have this condom mailed to them for free.

Lessons learned: Over six months, 500 units were distributed. The Toolbox improved condom knowledge, access and confidence among GBM and trans people. Of users that completed the feedback survey, 42% learnt different sizes of condoms were available and 59% learnt condoms were available at low cost (prescription). For 44%, a condom size outside of the standard range was the right fit. Almost all users (98%) felt more confident using condoms after the Toolbox experience.

Next steps: We are rolling out 5,000-10,000 improved Toolboxes on 1 October 2019 for GBM and trans men under 25. This innovation may be translatable to young heterosexual men.

39. **Parallel Session 2B: Reproductive Health and Genital Pain**
Saturday 16 November, 10.40am - 11.10am

PHYSIOTHERAPY MANAGEMENT OF PELVIC PAIN AND SEXUAL DYSFUNCTION IN WOMEN AND MEN

L Childs[1]
[1] *Tiaki Pilates, Yoga and Physio*

Traditionally pelvic health physiotherapy was concerned with treatment of conditions such as incontinence and prolapse, resulting from weak, lengthened pelvic floor muscles. Over the past decade there has been increasing interest and research into the presence of overactive / hypertonic / shortened pelvic floor muscles, and the association of this with many urogynaecological and pelvic pain conditions.

The aim of this presentation is to provide an overview of:

- pelvic floor muscle anatomy and function in women and men
- pelvic floor muscle assessment
- signs and symptoms of an overactive pelvic floor
- conditions associated with pelvic floor muscle overactivity
- causes of overactivity in the pelvic floor
- physiotherapy management for women and men with pelvic and genital pain

40. **Parallel Session 2B: Reproductive Health and Genital Pain**
Saturday 16 November, 11.10am – 11.25am

A SURVEY OF PENETRATIVE AND NON-PENETRATIVE SEXUAL PAIN EXPERIENCES IN WOMEN WITH PELVIC PAIN

CM Rapsey*[1], C Cunningham-Tisdall[1], B Battersby[1], N Swain[1]
[1] Department of Psychological Medicine, Otago Medical School, University of Otago

Aim: In the medical literature, women's sexual pain is almost universally defined as a problem that interferes with penetrative sex. Little attention is given to sexual and pelvic pain that interferes with arousal/orgasm. We aimed to assess penetrative and non-penetrative sexual pain experience and to investigate women's perspectives of the assessment and treatment of their sexual pain.

Method: We used a voluntary response sampling method, with advertisements placed on pelvic pain support group websites and Facebook pages. We recruited 295 participants with experiences of pelvic pain and sexual pain (≥ 6-months duration). Attempts were made to recruit women with diverse sexualities and relationship status.

Results: Frequent pain with penetrative sex was almost universally reported. Approximately one-third of participants reported never experiencing pan with non-penetrative sex, arousal, and orgasm. Qualitative results indicated that sexual pain was seen as important by a participant's clinician when it interfered with fertility.

Conclusion: Framing of female sexual pain as relevant to the degree that it interferes with reproductive capacity has two potential implications: 1) Women's sexual pain experiences outside of penetrative sex are overlooked; and 2) Opportunities to promote sexual pleasure outside of penetrative sex activities are ignored.

41. **Parallel Session 2B: Reproductive Health and Genital Pain**
Saturday 16 November, 11.25am – 11.40am

REVIEW AND COMPARISON OF INTRAUTERINE DEVICE/INTRAUTERINE SYSTEM INSERTION PROBLEMS BY MEDICAL AND NURSING STAFF, AND TYPE OF PRE INSERTION CONSULTATION

HSP McCann*[1], L Ingram, Y Lake
[1] *Family Planning NZ*

Family Planning New Zealand (FPNZ) increased the number of trained nurse Intrauterine device /Intrauterine system (IUD/IUS) inserters recently, and now offers a phone consultation before insertion as an option to attending a clinic for a pre IUD/IUS discussion.

This review compares whether there is any difference in the incidence of problems and complications with insertions by doctor or nurses, and whether phone consultations are adequate preparation for the insertion visit.

Method: Chart review of 1 Clinic (Manukau) IUD/IUS insertions in the first 6 months 2019. 484 cases were identified and charts reviewed by the authors. There were 367 (76%) inserted by doctors and 117 (24%) by nurses.

Findings: No significant difference was found in the proportion of nulliparous women, type of device, difficulty with insertion, or complications between nurse or doctor inserters. There was also no difference whether the consultation prior to insertion was by phone or in the clinic.

18% of Nulliparous women required cervical dilation compared to 11% of multiparous women. Age was not a significant risk factor for problems occurring in 16% of <20yrs and 14% >20yrs

Conclusion: Our study confirmed appropriately trained nursing staff have an important role in providing IUD/IUS services for all women both nulliparous and multiparous and that phone consultations prior are a suitable option.

42. **Parallel Session 2B: Reproductive Health and Genital Pain**
Saturday 16 November, 11.40am - 11.55am

STRATEGIES FOR REDUCING CONTRACEPTIVE FAILURE

C Murray*[1]
[1] *Family Planning, Porirua*

Issues: For those people who choose to use reversible contraception, many (over 40% for short-acting methods) stop using it in the first year[a]. Many factors, including barriers to access and adverse side effects bring people to the 'tipping point' of discontinuation.

Description: Highlighting latest research and developments, this paper discusses how the effectiveness of reversible contraception can be improved and side effects reduced.

Lessons learned: Long-acting reversible contraceptives (LARCs) have a lower failure rate than short-acting methods. Management of side effects, particularly bleeding issues with LARCs, will be discussed. For those taking the combined oral contraceptive pill, consider shortening or eliminating the contraceptive-free interval.

Next steps: Ensure providers have the required training and patients are aware of the options available. Engage with policy makers to provide the necessary resources for education, training and service delivery.

a. Birgisson et al. Preventing Unintended Pregnancy: The Contraceptive CHOICE Project in Review. J Womens Health 2015;24(5):349–353.

43. Plenary 6

Saturday 16 November, 12.00pm - 12.30pm

PLEASURE AND RISK: RESPONDING TO SEXUALISED DRUG USE AND CHEMSEX AMONG MSM

S Andrews[1]

[1] *NZ Drug Foundation*

Gay communities have higher rates of substance use and sexualised drug use is common. The FLUX study of gay and bisexual men in New Zealand found more than half of those who recently used a drug were motivated by having 'better sex'. Chemsex is an intense form of sexualised drug use that is characterised by the concurrent use of methamphetamine and GHB/GBL in group sex settings. Also called 'party and play' it is often organised through hook-up apps and hosted in private homes where sessions can last up to three days. Sex is often condomless and long lasting with the 'chems' increasing sex drive and endurance. Those engaging in chemsex are often motivated by pleasure, pushing boundaries, being disinhibited and having collective experiences. Despite not intending to be harmed it is a high risk practice with risk of HIV, sexually transmitted infections, overdose, non-consensual sex, violence, and addiction. Acute trauma can compound with difficulties related to sexual identity, isolation from the gay community, potential criminal charges and stigma related to drug use.

In New Zealand chemsex is rare but men engaging were more likely to be mid 30s, single, HIV positive, using PrEP if HIV negative, have had a recent STI, have anxiety or depression, and have gay friends (FLUX NZ). This group also had very high rates of engagement in sexual health services and are likely to identify chemsex as 'sex issue' rather than a 'drug problem'. This presents an opportunity for early intervention within sexual health services as they often request disclosure of drug use, also culturally competent, have a high level of trust, and provide harm reduction advice around sexual health. Including drug use into a non-judgemental conversation about sexual health, providing drug harm reduction advice, and referring onto community or peer based services are all shown to be effective in reducing the risk of harm from chemsex and sexualised drug use.

44. **Plenary 6**
Saturday 16 November, 12.30pm - 12.50pm

IN SEARCH OF MY TRIBE

J Morgan*[1]
[1] *Waikato DHB*

It's human nature to search for belonging. To say we are looking for "our tribe" means that we are looking for people who share commonalities or traits we aspire to adapt. Whether it's family, community, whoever we reach out to, our tribe is important in satisfying our need to connect. But are we now at a tipping point in our tribalism, of being more connected and yet at the same time, more disconnected than ever before?

POSTER 1

IMPROVING SEXUAL HEALTH CARE PROVISION IN NEW ZEALAND: INSIGHTS FROM PRIMARY CARE CLINICIANS

SB Rose*[1], SM Garrett[1], SRH Pullon[1]

[1] *Department of Primary Health Care and General Practice, University of Otago, Wellington, New Zealand*

Aims: To understand some of the key issues impacting on sexual health and sexual health care in four adjacent North Island DHB regions; and to seek insights from primary care clinicians about ways to facilitate the delivery of quality sexual health care.

Methods: We interviewed 22 clinicians from General Practice, Youth Health, Family Planning, Sexual health and Iwi-run Primary Care clinics. Interviews took place over 4-months (Aug-Nov 2018) by phone or in person following a semi-structured interview schedule. Key themes were collated and summarised using framework analysis.

Results: Many factors were identified as barriers to access and provision of quality sexual health care. Challenges included complete lack of, or in some cases steadily eroding funding, ever-changing models of funding, consultation time constraints and gaps in provider knowledge. When asked what was urgently needed to facilitate the provision of high-quality sexual health care, increased funding was at the top of the wish list for many. Better access to clinician education and ongoing sexual health updates, more collaboration between services, removing access barriers for patients and reaching people outside of clinical settings were also suggested as ways forward. Several participants described initiatives set up in their own clinics in recognition of the need to facilitate better access for patients.

Discussion: While many important factors impacting on sexual health and wellbeing are beyond the control of primary care providers, there is considerable scope for widespread clinic and provider-level approaches that could positively impact on sexual health service provision and patient outcomes.

POSTER 2

WHERE ARE YOUNG PEOPLE TESTED FOR STIS? IMPLICATIONS FOR THE DELIVERY OF QUALITY CARE

SB Rose*[1], SM Garrett[1], SRH Pullon[1], J Stanley[2]

[1] *Department of Primary Health Care and General Practice, University of Otago, Wellington, New Zealand*

[2] *Biostatistical Group, University of Otago, Wellington, New Zealand*

Aim: To describe the range of health services in which testing and diagnosis of common bacterial STIs (chlamydia and gonorrhoea) occurs for young people in New Zealand.

Methods: Laboratory data for chlamydia and gonorrhoea testing undertaken in four adjoining North Island DHB regions were obtained for the period 2015-2017. Requesting clinics were assigned to one of six categories of healthcare provider: Sexual Health, Student Health, Family Planning, Youth health, all other Primary Care, and Secondary Care. Proportions of individuals tested and diagnosed in each of these settings were described by region, infection type and demographic characteristics (gender, age, ethnicity and NZDeprivation).

Results: Of the 46,573 tests performed for 15-24 year olds during the 3-year period, 5.2% were requested from Sexual Health clinics, 6.6% from Family Planning, 22% from Youth and Student Health clinics, and 57% were from all other primary care settings (including general practice, iwi providers, midwives, defence force and prison services). Nine percent of tests were requested via secondary care. Clear differences were observed in the spread of testing across provider types between regions, and in the demographics of those tested in different services.

Discussion: While the majority of young people are diagnosed with STIs in primary care settings, there are a wide range of services within which this occurs and huge variation in testing volumes between clinics. These findings raise important questions about access to testing, the quality and completeness of care provided in different settings and the extent to which it aligns with best practice guidelines.

POSTER 3

ADDING VALUE – THE ROLE OF THE TRANS HEALTH KEY WORKER

J Horton*[1], J Oliphant[2]
[1] *Auckland Sexual Health Service, Auckland*
[2]*Auckland Sexual Health Service, Auckland*

Issues: The 2008, New Zealand Human Rights Commission report, identified major gaps in "the availability, accessibility, acceptability, and quality" of gender affirming healthcare in Aotearoa. A two-year DHB funded project was commenced in 2017 to improve trans health services across the Auckland region, building on an earlier developed model of care. The 2018 NZ trans health guideline recommended DHBs provide flexible and responsive pathways on the basis of informed consent and self-determination. ***Hauora Tāhine, pathways to transgender healthcare services*** was created to link gender affirming healthcare services across Auckland. Publically available information on healthpoint describes referral options.

Description: The project advisory group of consumer and clinical representatives highlighted the need for a key worker to help consumers navigate health services. Following a successful business case proposal a key worker was recruited in 2019 to join the team at Auckland Sexual Health Service (ASHS).

Lessons learned: Issues identified at ASHS included: increasing wait times for first visits, high FTA rates, no clear point of contact for queries regarding healthcare and how to access. Minimal trans positive imagery and representation within the service. While the role of the key worker is still evolving, early feedback indicates that having someone to translate and facilitate navigation of both medical and community pathways has enabled people feel to feel more welcomed, understood, and supported.

Next steps: Ongoing evaluation of FTA rates, trans competency training for all ASHS staff, inclusion of pronouns on business cards etc. to become standard. Non gendered signage/facilities to become the norm.

References:

1. *To Be who I am*. Kia noho au ki tōku anō ao. Report of the inquiry into discrimination experienced by transgender people. Human Rights Commission. 2008.
2. Oliphant J, Veale J, Macdonald J, Carroll R, Johnson R, Harte M, Stephenson C, Bullock J. ***Guidelines for gender affirming healthcare for gender diverse and transgender children, young people and adults in Aotearoa, New Zealand***. Transgender Health Research Lab, University of Waikato, 2018.

POSTER 4

COLLABORATIVE PARTNERSHIPS BETWEEN HEALTH PROMOTERS AND ACADEMIA: METHODOLOGICAL CONSIDERATIONS WHEN PARTNERING WITH PACIFIC COMMUNITIES

A Veukiso-Ulugia*[1]

[1] *School of Counselling, Human Services and Social Work, Faculty of Education and Social Work, The University of Auckland, Auckland*

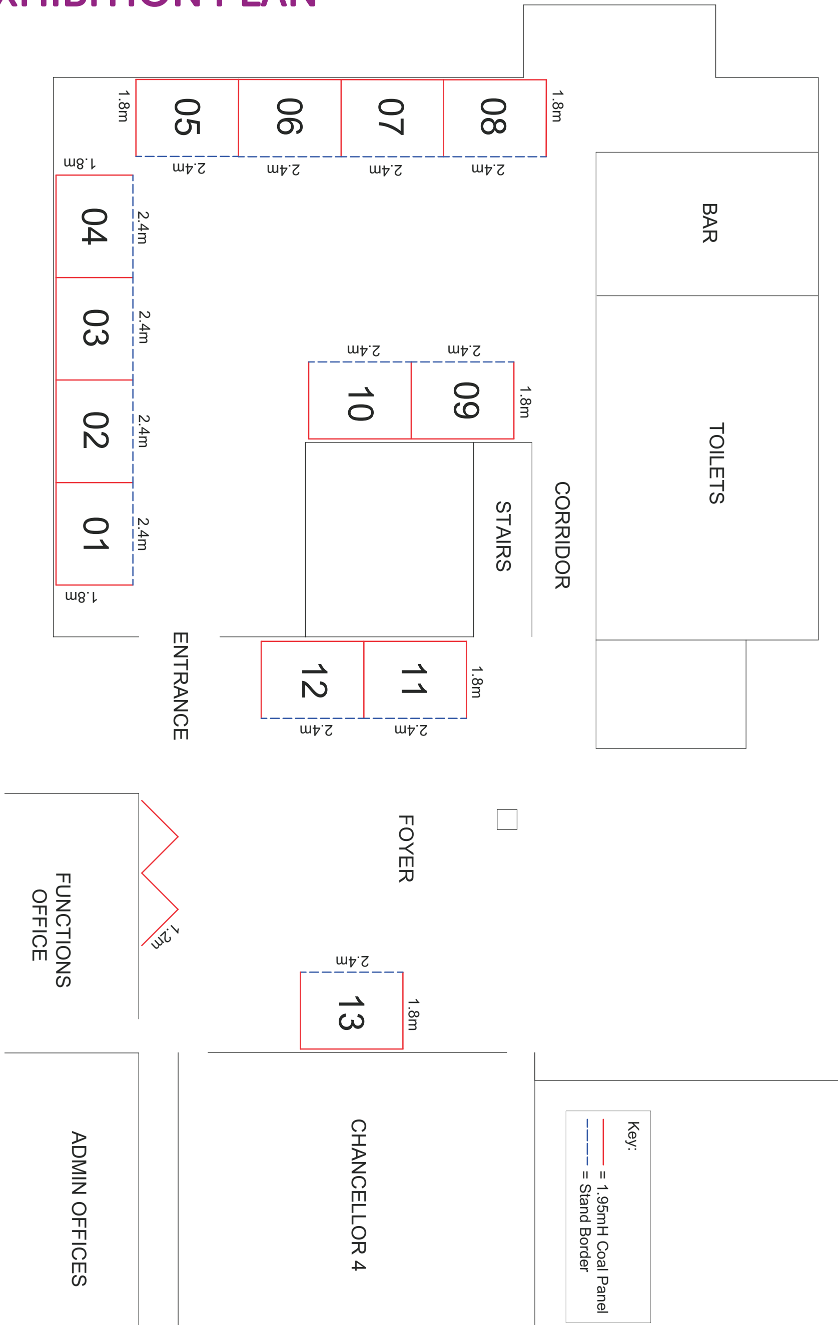
Tipping point - a time during a process when an important decision must be made or when a situation changes completely. Pacific communities in Aotearoa-New Zealand are living in a time of rapid cultural and technological shifts, however cross-generational taboos and sensitivity around sexual health issues remain. These socio-cultural pressures as well as resourcing constraints in the sexual health sector necessitate strong inter-sectoral and intra-sectoral partnerships to ensure quality sexual health promotion and provision for all communities, including Pacific.

This paper highlights important methodological questions for academia partnering with Pacific communities and vice versa. It explores cultural responses to three research issues arising from a partnership project between the Centre for Community Research and Evaluation (CCRE) at the University of Auckland and Village Collective, a Pacific-centric organisation supporting Pacific youth, families and communities with sexual health and wellbeing.

This partnership resulted in the development of an evaluation framework and extended the knowledge base of both parties. Robust community-engaged healthcare research requires a commitment to the spirit of partnership and responsibility, as well as genuine engagement and negotiation. Findings from this project raise important questions for further enquiry:

- How should limited resources and staff expertise be invested to enable the best possible assessment of programme quality and delivery?
- What institutional commitments are in place to promote successful academic-community partnerships?
- How can I as an (Pacific) academic pursue the advocacy and policy issues that emanate from the research?

EXHIBITION PLAN



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12 Morwbray Terrace
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Queensland 4169
Australia
www.abbott.com
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GSK

Stand 12

Hepatitis Foundation of New Zealand

Stand 6

61 Alexander Street
Whakatane 3120
New Zealand
T: 07 307 1259
www.hepatitisfoundation.org.nz

The Hepatitis Foundation of New Zealand is a not-for-profit organisation that supports people living with hepatitis B. Our services are free. We also provide advocacy and support for people with hepatitis C, and deliver community-based fibroscan services in the Midlands and Central regions.

We have completed many major screening, vaccination and research programmes in New Zealand, the Pacific Islands and Vietnam during our 30-year history.

Our national long-term monitoring programme was established in the early 2000s and now has about 25,000 people enrolled.

Hepatitis B help, care and support *(Hepatitis B āwhina, tiaki me te tautoko)*

The New Zealand AIDS Foundation

Stand 9

www.nzaf.org.nz

T: 09 300 6962

The New Zealand AIDS Foundation (NZAF) has been at the forefront of the community response to HIV in Aotearoa for more than 30 years. With the same passion and commitment as those that came before us, NZAF continues to prevent HIV transmission, reduce stigma and maximise the wellbeing of those most affected. Through our community engagement, behavior change marketing campaigns, and testing and therapeutic support services, we reach people across Aotearoa. The NZAF continues to advocate for healthy public policy and supportive environments while utilising the best available science and evidence to inform and drive our diverse work programs and services.

Jackson Allison

Stand 5

www.jacksonallison.co.nz

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New Zealand Sexual Health Society

Stand 11

www.nzshs.org

The New Zealand Sexual Health Society (NZSHS) Incorporated is a group of professionals working or interested in the field of Sexual Health. Membership is multidisciplinary and includes doctors, nurses, counsellors, educators, health promoters and others in Public Health working in the field of sexually transmissible infections, including HIV/AIDS, and sexual and reproductive health.

Positive Women

Stand 1

www.positivewomen.co.nz

T: 09 303 0094

Positive Women Inc was born in 1990 to support and empower women and families living with or affected by HIV or AIDS. An often overlooked yet significant part of the HIV community living in New Zealand. We raise awareness of HIV and AIDS in the community through educational programmes with a focus on prevention and de-stigmatisation.

Seqirus

Stand 3

P O Box 62 590
Greenlane
Auckland 1546
T: +64 9 377 1520
www.seqirus.co.nz

Seqirus (formerly bioCSL) markets vaccines and pharmaceutical products in New Zealand with a focus on products for the prevention and treatment of serious medical conditions. Our key New Zealand products are Gardasil® 9, influenza vaccines and travel vaccines. We also in-license a number of products from partner companies to ensure a comprehensive range of products are available to New Zealanders.

SH:24

Stand 7

35a Westminster Bridge Road
London SE17JB
United Kingdom
England
T: +44 747 919 8873
www.sh24.org.uk

SH:24 (www.sh24.org.uk) is a free, not-for-profit digital sexual health service, delivered in partnership with the UK National Health Service. SH:24 makes it easier for people to get tested for sexually transmitted infections (STIs). We provide free test kits, information, advice and clinic referral where required - 24 hours a day – our service is quick, discreet and completely confidential.

The service was designed around people's needs and was established by a team of public health professionals, sexual health clinicians, designers and academics. SH:24's vision is to deliver system transformation in sexual and reproductive health care with users at the heart.

SpeeDx

Stand 8

www.plexpcr.com
T: +61 2 9209 4170

Founded in 2009, SpeeDx is an Australian-based private company with offices in London and the US, and distributors across Europe. SpeeDx specializes in molecular diagnostic solutions that go beyond simple detection to offer comprehensive information for improved patient management. Innovative real-time polymerase chain reaction (qPCR) technology has driven market-leading multiplex detection and priming strategies. Product portfolios focus on multiplex diagnostics for sexually transmitted infection (STI), antibiotic resistance markers, and respiratory disease.

The Theatre in Health Education Trust (THETA)

Stand 2

8 Stafford St, Dunedin 9016
T: 021 0844 9043
E: manager@theta.org.nz
www.theta.org.nz
Contact: Grant Millman

The Theatre in Health Education Trust (THETA) provides innovative and challenging health education programmes to the rangatahi/youth of Aotearoa-New Zealand through the experiential medium of theatre. Our interactive theatre-based programmes use a combination of traditional theatre, educational drama, structured role play and decision-making activities to engage students in the exploration of issues relevant to their lives. THETA currently has an agreement with the Ministry of Health to deliver Sexwise.

Wholesale Solutions

Stand 4

25 Hanning Street
Wellington 6011
T:04 555 0746
www.wholesalesolutions.co.nz

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