Vale Carol Martin

The ASHHNA executive would like to pay tribute to our friend, colleague and ASHHNA Vice-President, Carol Martin who very sadly passed away in February 2011.

What good is sitting alone in your room
Come hear the music play
Life is a Cabaret, old chum
Come to the Cabaret
Come taste the wine
Come hear the band
Come blow your horn
Start celebrating …

Many of us know the song ‘Cabaret’ and would like to live our life by its theme - but Carol did it with gusto. When people heard the news of Carol's accident, one phrase was often repeated “Carol had a great passion for life”.

Carol as many of you know came from Scotland and lived in Australia for many years. Her fabulous accent and great sense of humour always bought about a good laugh when she was around.

Carol had great pride in her choice of and role in the nursing profession. She was a clinical expert in sexual health and HIV with a high reputation both locally and internationally.

Carol was a strong patient advocate who passionately believed the main way she could make a difference was through education. She was a member of many steering committees and working groups targeting various educational programs. She developed a one week nurses course at Royal North Shore Hospital and was the chair of the Sydney HIV Nursing Education Steering Committee. Carol cared about her peers, often discussing the concept of mentoring nurses in the Asia Pacific region – she really wanted to help nurses develop their experience and skills with the focus on improved patient outcomes. She worked with the Australasian Society of HIV Medicine and the International Unit at Albion Street Centre travelling to PNG on several projects. She loved PNG and the many friendships she made there. On many trips to PNG she would often try to tie in a scuba dive if she could. If you knew Carol you knew she loved diving. She travelled across the globe to pursue her great passion - exploring the sea. She also loved exploring terra firma but Neptune’s Kingdom was her Shangri la. What a courageous adventurer she was!

The nursing profession has lost a clinical expert who was proud to be a nurse. She will be greatly missed on a professional level and more greatly her loss will be felt on a personal level across many parts of the world. RIP Carol.
Carol Martin Professional Development Scholarship

The annual ASHHNA scholarship has been renamed the Carol Martin Professional Development Scholarship in honour of Carol Martin and her contribution to sexual health and HIV nursing. The scholarship, which is sponsored by CSL Biotherapies, is now open. Click on the link below to apply. To read reports from successful applicants from 2010 pages 9 – 12 of this newsletter.


ASHHNA Presidents Report 2011

The executive has worked with great commitment and enthusiasm all year to provide professional support and promote peer engagement for sexual and reproductive health and HIV nurses. A lot of work goes on behind the scenes to making our goals a reality.

Firstly welcome to the new look newsletter, I’m sure you will agree it looks fantastic and is packed with lots of interesting information. We skipped an edition in 2010 getting the new look right, but you can look forward to 2 editions per year in 2011 and beyond. I extend a warm welcome to the new Newsletter Editor Jude Armishaw and thank Jo Perks for all her hard work in compiling the newsletter over the past years, as the previous editor. The newsletter is a great way to find out about new projects, nursing roles and enables all ASHHNA members to contribute sharing information about sexual health and HIV nursing with your colleagues.

ASHHNA had a successful stall at the Sexual Health and HIV conferences. Executive members (and others) were at the stall at morning tea and lunch times and so it was a great opportunity to have a central place to meet nurses working in sexual health and HIV. Congratulations to Edwina Jachimowicz, from the Sexual Health Clinic Fremantle WA, who was presented with the ASHHNA / Kendra Sundquist Nurses Prize for her poster titled Download to Diagnosis: Testing for Chlamydia Online.

Responding to feedback to the ASHHNA survey we moved the AGM to coincide with the conferences and this will be continued to be promoted in the conference program each year. The new ASHHNA Executive was voted in at the AGM. Welcome to all the new members of the Executive and welcome back to members who are continuing on the Executive. The Executive will hold a Planning Day in February to determine priorities for ASHHNA over the coming 12 months.

To guide and focus the activities of the association, the ASHHNA strategic plan outlines 5 key directions. You will find a summary of our achievements in these key directions on the following page.

Donna Tilley
ASHHNA President

Picture – ASHHNA Executive at Planning Day at Sydney Hospital Feb 2011

Back Row: Karen Biggs, Glenn Curran, Sue Porter, Nicky Sharp, Edwina Jachimowicz, Jennifer Walsh
Middle Row: Shannon Woodward, David Lee,
Front Row: Brad Whitton, Jo Perks, Donna Tilley, Jude Armishaw
ASHHNA Strategic Plan – 5 Key Directions

Governance
Accountable governance is key to the smooth running of the association. We have streamlined our banking and financial reporting processes to make them clear and accessible, which has been a large step forward in improving the workflow of the Treasurer. As an association we meet monthly and follow the model rules and access support from our Public Officer to ensure compliance. This year the AGM has been moved to coincide with the Australasian Sexual Health and HIV conferences to help raise the profile of ASHHNA and encourage participation from nurses across Australasia.

Membership
This year we have welcomed many new members to ASHHNA, increasing our membership by approximately 40%. All members receive an email welcome pack including access to the ASHHNA Knowledge Network and ASHM affiliation.
An ongoing challenge is to promote membership, particularly among HIV nurses, and we have focused our energy on increasing the visibility of ASHHNA at the Australasian Sexual Health and HIV conferences.

Professional Development
The ASHHNA sexual and reproductive health and HIV nursing competencies are in the process of being reviewed. An enthusiastic working group with representatives from across Australasia has been meeting this year with the aim of developing up to date and clinical relevant competencies for the specialties. These are due for completion in early 2011.
With the generous support of CSL Biotherapies we were once again able to offer a professional development scholarship to members. This has assisted the successful nurses to attend conferences and professional development courses.
The Kendra Sundquist nurses prize is now a yearly fixture at the Australian Sexual Health Conference, with the aim of supporting and promoting nurses’ involvement in research.
The sub branches across Australasia have had a very active year, with sub branches in Victoria, WA, SA and the ACT. The sub branch reports and contact details can be found on the ASHHNA website.
With the advent of national registration we have placed links on the ASHHNA website about professional portfolio development and members have been sharing information within the Knowledge Network.

Advocacy and Collaboration
The ASHHNA/ASHM Affiliation is now underway. This affiliation provides access for all ASHHNA members to ASHM benefits free of charge. Many of the members have taken up this opportunity, which improves individual access to information and professional development.
There has been some confusion with the process of ASHM Affiliation and the executive will be working in the coming year on improving the process and communication to members. To be an affiliate nurses need to be members of ASHHNA, unfortunately the agreement does not work in reverse for members of ASHM. Once you are a member of ASHHNA you personally log on to the ASHM affiliate link on the website and register all your details with ASHM. Nurses who have been members of both organisations will need to cancel their ASHM membership.
We continue to have a strong affiliation with the Coalition of National Nursing Organisations (CoNNO), which support and guide specialty nursing organisations.

Information and Networking
Our website and email are the key tools we use to communicate with members about issues important to them. The website is the key access point for the dissemination and sharing of information, including the bi-annual newsletter. It is updated regularly to reflect current news and information for members.
The email list is a unique member benefit and is a key way to network with colleagues about clinical issues, position vacancies and evidenced based information. Both these tools form the communication structure for the ASHHNA Knowledge Network.
I would like to extend a thank you to all the ASHHNA members. The commitment of members in contributing to Knowledge Network discussions, content for the newsletter and website, and our working group on the ASHHNA Advanced Competency Standards for Registered Nurses has ensured another strong and productive year. We look forward to the year ahead and I look forward to meeting many of you over the coming year.
**Qlaira – New COCP**

**Qlaira** is a 26/2 pill – (26 hormone tablets and 2 placebo tablets)

Instead of ethinyl oestradiol which is the oestrogen component of all other currently marketed pills it contains oestradiol valerate – this is an esterified form of natural 17 beta – oestradiol which may have beneficial effects on clotting factors and Sex Hormone Binding Globulin compared to ethinyl oestradiol. This beneficial effect has not however been proven yet so we would consider that it has the same risks in terms of VTE as all other marketed pills.

It contains the progestogen dienogest which has been used for many years as a component of HRT and is also present in a pill called Valette. Dienogest has 2 useful properties in relation to non contraceptive benefits and side effects: it has anti – androgenic action so may have beneficial effects on skin; it has an endometrial focus meaning that it effectively thins out the lining of the uterus resulting in significantly lighter and shorter bleeding. Women need to be advised/warned that it may also be associated with absent withdrawal bleeding in some cycles.

The regimen is quadruphasic (a so called dynamic dosing regimen)

- **Day 1 – 2**: 3mg oestradiol valerate
- **Day 3 – 7**: 2mg oestradiol valerate/2mg dienogest
- **Day 8 – 24**: 2mg oestradiol valerate/3mg dienogest
- **Day 24 – 26**: 1mg oestradiol valerate
- **Day 27 – 28**: placebo tablets

This dosing regimen has been developed to maximise cycle control and withdrawal bleed. The missed pill protocol is a bit complicated and uses a 9 day rule – it is set out on each pack. This rule has been set because of the 2 oestrogen only pills at the start of the pack which are considered to be non contraceptive.

**Who would you consider Qlaira for?**

- Women with heavy menstrual bleeding
- Women who have withdrawal symptoms such as headache or pelvic pain in the pill free week
- It might be a useful alternative for women with acne
- Women who want to try something new

Dr Deborah Bateson
Medical Director FPNSW

**Genital Wart Competency Package**

Until recently genital warts were a common presentation at sexual health centres and GP practices in Australia. This was prior to the introduction of the Gardasil vaccine, which has helped reduce the amount of genital warts seen in women and subsequently reduced the prevalence of genital warts in men. Despite the community reduction in genital warts, clients will continue to present for treatment and management of this condition. A new competency package has been developed to assist nurses in the diagnosis, treatment and management of genital warts.

Although diagnosing warts is common practice for many nurses, this competency package bench marks the educational and supervised clinical practice required for new and experienced nurses to maintain and develop this expansion to clinical practice.

The new competency package has detail information about home topical therapies. Nurses are able to confidently recommend a range of topical therapies best suited to the clients’ presentation and situation. There is growing evidence that the combined use of cryotherapy (liquid nitrogen) and home topical therapy enhances wart clearance and reduce the amount of clinic visits required to clear visible warts.

The nursing collaboration with medical staff ensures that the best treatment decisions are made and the centre is already seeing less return wart treatments. The development of medication checklists and client information sheets has seen no adverse outcomes with the increase of topical treatments being used.

The competency package is available from the MSHC website [www.mshc.org.au](http://www.mshc.org.au) in the Health Professional section under Sexual Health Nursing.

Matiu Bush
Times are a changing – past reactions to TOP nurses

In 1991, some walked out of the tea room when I entered. Others sat and hotly debated the issue with anyone who would listen. Is it morally right, or morally wrong? Ethically were do you sit? I had commenced employment in a termination of pregnancy (TOP) clinic in a new hospital. In those early years there were many debates and discussions and my advocacy for women attending the clinic grew stronger. I started presenting the facts, doing audits, finding research to support my views. I sat on committees, then ran the committees. Now I am nearly finished my PhD into women aged over 30 years of their fertility management/control experiences and sexual health knowledge prior to TOP. Fortunately staff opinions have changed over the years and people don’t leave the tea room when I enter. Public opinions have also changed with recent research showing 87% of Australians supporting TOP in the first trimester, up from 81% in 2003 (Betts 2004; de Crespigny et al. 2010). I have experienced those changes in opinions with emotions ranging from anger at injustices and myths, to excitement and joy when another barrier to care is removed (such as law changes in Victoria, and removal of the ‘Harradine Amendment’). Evidence-based practice cannot be underestimated in improving outcomes for women undergoing TOP or for those working in the area. I am proud to be a sexual health nurse, and proud of the small changes I can make by providing up-to-date research in this sensitive area of health care.


Wendy Abigail
Flinders University, School of Nursing & Midwifery

My Story

I recently had a meaningful consult. An 18 year old man walked into the clinic wanting to speak with a nurse because he was very unwell. We went into the clinic room and I asked, “How can I help today?” He proceeded to tell me that

“there is something wrong with me and I need blood tests because I masturbate once a day and afterwards, I feel incredibly weak and unwell”.

He was also distressed because he always wanted sex and was concerned that there was something wrong with him. He had multiple female sexual partners till two weeks ago, when he decided not to have sex anymore. Since then his masturbation and sexual drive had increased.

I thought to myself “Wow! This young man was in distress, but was able to access our service, acknowledge his feelings and verbalise his concerns!” We discussed adolescence, the male sex drive and I tried to normalised his sexual feelings. It seemed that he had physical weakness post masturbation as he had been bought up with strict views, beliefs and values and thought that masturbation and pre marital sex were wrong. We also talked about safe sex.

The consult was an hour long and the young man left wanting to make an appointment with a counsellor to explore how his beliefs and values were affecting his sexual journey through adolescence into adulthood.

Tammy Nowicki
Clinical Nurse: Adelaide

Newsletter Survey

ASHHNA is currently surveying members for IHNA newsletter. As you read through this current edition please think about what the newsletter gives you. What do you like, what could be improved? Do we need a newsletter at all? Should we be focusing more on keeping the website up to date with latest information and ASHHNA related news? To take the short 5 minute survey, please copy the address below into your address bar.

http://www.surveymonkey.com/s/YTVVMSY
Congratulations to Edwina Jachimowicz who won the ASHNA Kendra Sundquist prize for the best poster (below) by a nurse at the 2010 Sexual Health Conference.

Background

Chlamydia is the most common sexually transmitted infection (STI) throughout Australia, with infection rates that continue to rise. In an effort to improve access to clinical services for young people aged between 16-29 years of age, the WA Department of Health, Sexual Health and Blood-borne Virus Program has developed an online chlamydia testing program (OLC). Launched in February 2010 it is coordinated by Fremantle Hospital’s B2 Sexual Health Clinic. Participants incur no financial costs and can access the program via two WA Health websites (www.getthefacts.health.wa.gov.au, www.couldidhaveit.com.au).

This poster illustrates the preliminary data and participant feedback for the programs first 6 months of operation.

Eligibility

Participants must:
- be 16 years of age or older
- provide a mobile telephone number
- have access to a computer with printer
- attend PathWest specimen collection site.

Participant recruitment

The OLC website went live February 9th 2010. Participant enlistment relied principally on word of mouth, opportunistic promotion at events, and internet searches until a media campaign was launched July 26th.

How to get tested online

2. Select Online Test
3. Complete the Self Risk Assessment
4. Fill in the request form, download and print it
5. Attend PathWest, provide form & sample.
6. A nurse will ring you if your test is positive.

Preliminary Results

General data
3169 unique website hits, with almost one third of these occurring in the sixth month (coinciding with the media launch). From 0/10/10-08/10 website hits increased 183% and tests performed increased 103%.

Positive Results
- Seven participants (13%) tested positive for Chlamydia, one was also positive for gonorrhoea.
- All participants testing positive were aged 16-29 years.
- All were successfully contacted and treated with contact tracing, education and follow-up testing addressed.
- The OLC coordinator was notified via fax of a positive result each day after specimen collection (range 1-8 days).
- In all cases an attempt to contact the client to inform them of results was made within 24 hours of OLC staff notification.
- Clients were informed of their positive test result on average 0.7 days after OLC staff were notified (range 0-3 days). Contact attempts averaged 1.3 (range 1-2).
- Time from specimen collection to treatment averaged 6.8 days (range 1-16 days). In all cases treatment was confirmed with the participant.

Participant feedback

Participants receiving results were offered a link to an anonymous online evaluation survey and also invited to give verbal feedback on their experience of the OLC. To date feedback received has been predominantly encouraging and complimentary. Of 26 participants receiving results 24 agreed to receive the link and 50% of these completed the survey.

Highlights

- Interagency support & collaboration across WA with Region specific strategies implemented

Challenges

- Promotion of the project due to a delay in the media launch.
- Complexity of process & communication across multiple specimen collection sites.

Conclusion

The 13% positivity rate among participants of the online chlamydia program indicates that the project offers an acceptable method of testing for an at risk group. The project’s target age group is well represented, however greater rural and remote participation would be preferred. It is anticipated that the recent launch of the promotional media campaign will attract wider interest and participation in the project. Intermittent radio advertising will continue for the remainder of the project, which is funded until February 2011. It is hoped that if successful the project will be ongoing.
Drug Detecting Gloss

The 2LoveMyLips gloss, which will be available in Australia soon, comes complete with a pink taper which can detect date rape drugs in drinks. Developed in the UK in response to the increasing rate of date rape in the country, the detector works not only in alcoholic drinks but tea, coffee and soft drinks. Tracy Whittaker, the British business woman who came up with the idea, advises women to be cautious if a drink tastes funny or if you are suspicious, and that the gloss is an accurate way of testing for drugs.

According to a 2004 Australian Government report, drink spiking is under-reported to the police. The glosses are expected to become available in vending machines in bars and clubs.


First Pre-Exposure Prophylaxis Trial Results

Australian Federation of AIDS Organisations (AFAO) welcomes prophylaxis drug trial results but warns it will only complement - not replace - condoms

AFAO today welcomed the results of the iPrEx study which show that the antiretroviral drug, Truvada, is safe and reduced HIV acquisition by 44% among men who have sex with men (MSM), said Executive Director Don Baxter.

"This is the first human study to show that pre-exposure prophylaxis (PrEP) is effective in reducing sexual transmission of HIV and thereby proving the concept can have some degree of effectiveness", Baxter said.
"But the relatively low efficacy rate overall indicates that Truvada will only complement consistent use of condoms - not replace them", Baxter said.

The study was called iPrEx, which stands for Pre-Exposure Prophylaxis Initiative. The full results of this clinical trial, which included 2,500 men in six countries, was released in the US overnight in the New England Journal of Medicine.

Truvada is a fixed-dose combination of two antiretroviral drugs, called tenofovir and emtricitabine. Truvada is already licensed for the treatment of HIV infection.
The 44% reduction was achieved in combination with a full range of other prevention options-education, condoms and lubricant; peer support, diagnosis and treatment of sexually transmissible infections, counselling, and post-exposure prophylaxis (in some countries).

"While the results are not as good as many of us had hoped Truvada prophylaxis may still be a useful intervention for some individuals and groups at very high risk of HIV infection, for example, the HIV-negative person with regular partner who is HIV-positive - as it will provide an added level of protection", Baxter said.

Baxter said the drug's manufacturer now has the opportunity to make an application to regulatory authorities in the United States, Australia and elsewhere for a licence to use this drug for HIV prevention. However, as this is also an expensive drug it is not likely to be widely used in the near future.

How has nursing at SHAIDS changed in the 20 years you have been there?
Well there have been great changes in the care and management of people living with HIV. In the first few years we were responding to very sick people with HIV/AIDS, mostly young - middle aged men, some of whom had come home to die. Antiretrovirals were only available as monotherapy, so nursing wise I was busy with performing induced sputums for PCP (as it was then) detection, administering aerosolised Pentamidine and arranging care in the home. I would do home visits supporting Community Nurses in caring for people requiring treatment such as IVI Gancyclovir in the home. We have a terrific Palliative Care Unit in Lismore and they had already had experience in caring for people who were dying from advanced HIV, I would spend time at Pall Care to support clients, families (of origin and choice) and friends. As treatment regimes changed in 1996 we began to see less people dying and today our clients living with HIV are more likely to be dying from a non HIV cause.

What does your role now entail?
My clinical role these days is mostly sexual health screening, educating (one to one), treating STIs and doing contact tracing. Occasional induced sputum and assisting with routine monitoring, administering injections for some of our PLWH clients. Quality activities such as our monthly Medical Record Review and EQuIP are for ever present. My role also supports any sexual health and BBV related queries from the 8 hospital sites, in particular ones that are about Blood & Body substance exposures. I also provide education to Health Care Workers and sex education sessions for groups of young people, such as young GLBTI groups or young people with intellectual challenges.

Which part of your job do you enjoy the most?
Contact with people. Empowering people to take control of their health by spending time explaining how & why things happen to their bodies. I really enjoy seeing the 'light come on'.

Do you think SHAIDS has enough nursing hours?
No! I understand that SHAIDS & Cairns are the two busiest Rural Sexual Health Services in Australia. There is a limit to the amount of services we can offer with current staffing levels. SHAIDS has worked at over full capacity for several years now.

What do you do with yourself when you are not at work?
My partner & I have a farm in a beautiful part of NSW in a small village called Jiggi. There is always plenty to do at the weekends, sometimes chasing cattle or sheep out of the vegetable garden! For relaxation other than reading I enjoy doing cross stitching, knitting, sewing and entertaining friends on our beautiful verandas.
Scholarship Recipient Reports

Trudi McIntosh - Sydney Sexual Health Centre.
FPNSW Certificate

In September I was awarded a scholarship by ASHHNA towards my completion of the Family Planning NSW Certificate in Sexual and Reproductive health (Nursing). There was a pre-course worksheet which compiled of background reading and learning. Module 1 consists of 15 learning packages and then a 3 day practical course, where the theory learned can be put into practice. In February, at the end of the 3 day practical session, there is an exam to consolidate learning over the past few months.

I completed the Pre-course worksheet which I found was very beneficial. It included reading and questions regarding the menstrual cycle, male and female hormones and the male and female sexual response. Anatomy and physiology were also reviewed. I found it helpful to discuss the menstrual cycle within the pre-course worksheet as it addressed the importance of using language which is easy for clients to understand. Previously when female clients have questions regarding their cycle and modes of contraception, I have found it difficult to explain without using too much medical terminology, however now I feel more competent.

The anatomy and physiology diagrams were also very valuable as it reminded me of correct terminology, which is helpful when communicating to clients other health professionals and also for concise documentation.

I am currently completing the learning packages. I have just finished the Cervical Screening Learning Package, which I found valuable. Through the readings provided and the tasks completed I have a better understanding of epidemiology, testing procedures and interpretation and action of Pap smear results. This will be useful within my current position as a RN in Sydney Sexual Health Centre as I am frequently required to educate clients regarding their pap smears, perform the test and understand results. From the knowledge and up to date skills I have learned I will also be able to educate and inform students and new and current staff on this complex area of reproductive health.

Margot Kingston – Family Planning Queensland
FPNZ Conference

In October 2010, Family Planning New Zealand (FPNZ) held its first national conference in more than 5 years. This was an important opportunity to attend a conference where reproductive health was central to each of the themes it addressed. The four key themes were: Promoting healthy sexuality; Contraception; Young people and Abortion

The conference was notable for a number of reasons. Firstly, the opening session provided inspiration from two NZ women who now undertake important international roles. The first speaker was Dame Jenny Shipley, former Prime Minister of NZ and currently a member of the Council of Women World leaders. She acknowledged the importance of family planning services as not only a vital element of public health programs but importantly as a cornerstone supporting human rights. This viewpoint was emphasised by Dr Gill Greer, Director-General of IPPF (International Planned Parenthood Federation). Prior to this appointment she was Executive Director of the New Zealand Family Planning Association. She talked about the work of IPPF in developing countries aimed at improving maternal and child health through effective family planning programs.

The keynote speakers were outstanding. Two were from the USA. Irving Sivin a scientist from the Population Council spoke on long acting reversible contraceptive methods. Unlike Australia, which has had a decade’s experience with Implanon, contraceptive implants in New Zealand are a relatively recent addition to the government subsidised contraceptive methods. New Zealand has made the decision to subsidise the use of Jadelle and it is interesting hear experience with the use of a different contraceptive implant albeit very similar to Implanon. Awareness of a greater use of Jadelle has implications in Australia given the migration trends.

The second US invited speaker was Dr. Douglas Kirby, a researcher working in the field of adolescent sexuality. His reviews of the research on school and community programs to reduce adolescent sexual risk-taking behaviours are internationally known. He outlined which programs had demonstrated evidence that they were effective programs in reducing adolescent pregnancy and/or rates of STIs. Further information about these studies can be found at the National Campaign to Prevent Teen and Unplanned Pregnancy official website.
It was exciting to be at a conference that placed discussion of abortion services in the mainstream of reproductive health services and a number of sessions related to medical and surgical abortion provision in NZ. The timing of the conference coincided with prosecution, in Cairns, of a young woman and her partner for ‘procuring’ an abortion. While they were found not guilty the conference brought home the challenges that Queensland women face in accessing appropriate abortion services. The final keynote speaker was Ann Furedi, Chief Executive of the sexual and reproductive healthcare charity BPAS (British Pregnancy Advisory Service). Her address was a stirring and impassioned call for the need to accept the reality of abortion in women’s lives and the importance of health services to meet the needs of women. In accepting this, she argued that both health professionals and society itself should no longer see abortion as a problem or as a failure of individuals or contraception but in fact see the safe and legal abortion services as a positive thing for society. It is notable that in NZ the availability of services offering both medical and surgical abortion is relatively well developed and FPNZ itself is now considering the introduction of medication abortion services through a number of its clinics in an effort to increase greater geographical accessibility.

There were several concurrent sessions that allowed opportunities for a wide range of practitioners to present on topics related to the conference themes. I presented the findings of a retrospective chart audit conducted on <16 year olds attending FPQ clinics during the Young People session. The audit was conducted to review changes in practice amongst FPQ clinicians following additional training in working with young people. FPQ has endeavoured to strike a balance between the legislative and policy obligations and the goal of FPQ to deliver confidential sexual health services valued by young people. The training aimed to increase skills in psychosocial assessment and deepen the understanding of adolescent behaviour. In particular, the training provided strategies for identifying protective and risk factors in the lives of young people. The audit identified that staff were making decisions about the well being (or vulnerability) of a young person based on a wide range of factors and not solely on issues related to sexual activity. These findings have contributed to staff gaining greater clarity about when to report to child protection services and or to other support services.

The conference provided an interesting mix of presentations from the grass roots through to high level international work. The conference is clearly an important one for staff from FPNZ. I found all the sessions attended were relevant to my work and feel honoured to have had the support of ASHHNA to attend. There were a number of attendees from Australia, including several from family planning organisations, Marie Stopes International and other reproductive health services. The energy generated at this conference left the Australian contingent calling for a similar conference encompassing similar themes to be held in Australia. Maybe in the future ASHHNA will join forces with others and be organising a conference where contraception, abortion services and young people’s sexual health will be the focus.

Chris Remington Cairns Sexual Health Service
7th Viral Hepatitis Australasian Conference

The highlight of this conference for myself was the recognition now being given to Hepatitis B (HBV) and its management. This report will therefore focus on HBV due to the implications the first National HBV Strategy has for Sexual Health services.

The message is that HBV must be recognised as a major health condition and managed appropriately. It is not sufficient to tell a person they have HBV, provide a little education and no on-going follow-up. The term “carrier” should be avoided as it implies ‘no problems’ – a healthy carrier does not exist. A person with HBV has a chronic infection and needs ongoing lifelong monitoring and management.

One third of the world’s population has been infected at sometime with HBV – 400 million remain with chronic infection, which is the 10th leading cause of death worldwide. 90% of the world’s population is born in high HBV prevalence countries, where even vaccination can increase the risk of acquisition if unsterile equipment is used. More than 80% of chronic infections are acquired at birth or more commonly in early childhood. In Australia, the rate of new infections is highest in people aged 20-29 years, with approximately half of all new infections occurring in people who inject drugs (PWID). Most acute infections in adults clear within 6 months.

Between 130 000 – 200 000 Australians have chronic HBV. 25% of these will die from hepatocellular cancer (HCC) or decompensated cirrhosis. In the Asia-Pacific region, HBV is the reason for more than 80% of liver transplants. However it is estimated that one third of Australians infected have not been diagnosed and are thus unaware – increased screening is required.
100 times more infectious than HIV, HBV is a silent disease with vague or no symptoms, requiring long-term monitoring. It needs to be understood that symptoms appear too late with HBV and management is needed before symptoms appear. Without treatment, mortality is approximately 25% - it is estimated 1 million people a year die worldwide from HBV related causes. In NSW the incidence of HCC is increasing faster than any other internal malignancy. Nationally it is the second fastest increasing cancer.

There are 10 known HBV genotypes with differing country prevalence, aggressiveness and treatment prognosis. Similar to HIV, treatment suppresses the virus, but is not a cure. And like diabetes, some people need medication and others do not.

Clients with chronic HBV should be monitored 6-12 monthly for transition to active disease phases, HCC surveillance and once on treatment, efficacy and development of drug resistance. The aim of treatment is to suppress viral replication, achieve an undetectable viral load, decrease progression to cirrhosis and HCC, and thereby prevent liver transplants and death.

In co-infection, HBV has not been proven to accelerate or worsen HIV, but HIV increases the morbidity and mortality of hepatitis. Tenofovir and Lamivudine treat both HIV and HBV, but development of resistance to Lamivudine is high. Tenofovir resistance is rare and provides excellent virological control, though an undetectable HBV viral load may take 2-3 years to obtain.

**CALD**

Of people living with chronic HBV in Australia, 17% are indigenous and 70% are from CALD backgrounds (i.e. are born overseas). In high prevalence countries transmission is mainly vertical or horizontal: household, reuse of medical equipment, traditional tattoos.

Addressing the needs of CALD communities in Australia to access knowledge and services in relation to HBV has a number of obvious barriers, but often overlooked is the basic difference between western individual focused care compared to the family focused care which many CALD people are used to. i.e. health is seen as a family issue, needing family involvement. The person may be confused and shamed by private, confidential, individual care. Plus HBV is family business – it is most often transmitted within a family so screening and vaccination involves everyone.

2/3 of refugees are from HBV high prevalence countries but HBV is not a routine screen provided to refugees entering Australia. Many refugees have limited education, low literacy/computer skills, and little if any knowledge of HBV. Even an accredited interpreter may not know what a liver or hepatitis is, so clinicians need to ascertain interpreter’s level of understanding.

Similarly to Indigenous Australians also, face-to-face information is preferred instead of reading translated material.

**Vaccination**

Vaccination remains a high priority. HBV vaccination was the first cancer preventing vaccine. It is estimated that the recent introduction of mass vaccination in China will prevent 500 000 future cases of liver cancer - 1 life saved for every 30-40 people immunised.

With migration, control of HBV in Australia requires restraining HBV worldwide. In relation to HBV, it would be cost-effective for developed countries to pay for vaccination programs in developing countries. In Australia, irrespective of the national neonatal vaccination program, young Indigenous Australians are acquiring HBV. Theories include vaccination courses not being completed, adequacy of sero-conversion response not being checked and possible loss of memory after neonatal vaccination. A recent study demonstrated 20% memory loss by 18 years of age. There may be the need for booster vaccination.

All adolescents and young adults should be screened irrespective of childhood vaccination history. The adolescent HBV vaccination program ends next year as the first newborn recipients reach 12 years of age. Vaccination coverage is low among PWID and should be encouraged. Vaccination of household contacts and sexual partners of a person with chronic HBV should not be overlooked.
Chris Remington - 7th Viral Hepatitis Australasian Conference cont …

The First National HBV Strategy
A National Strategy for HBV had been delayed initially due to the false belief that vaccination was the total solution, and then the identification of, and focus given to, Hepatitis C (HCV). It is now recognised that a strategy is required due to HBV’s high morbidity and mortality. A separate strategy from HCV is necessary as HBV is a different virus, affecting different communities, causing different problems, thus requiring different responses and its own separate funding. The priority populations are CALD, Indigenous Australians, children born to HBV positive women and unvaccinated adults at higher risk of infection such as MSM, sex workers, healthcare/emergency workers and travellers to high incidence countries.


Other helpful websites:
www.gesa.org.au
www.chronicliverdisease.org
www.hepbhelp.org interpreting serology results, guidelines for management, client information in multiple languages
Online information and support group: www.hblist.org

I would like to thank ASHHNA for the opportunity to attend this conference and the ongoing benefits to my clinical practise.

ASHHNA SUB-BRANCHES

There are sub branches of ASHHNA in WA, SA, ACT and Victoria which meet regularly to network, share information and provide education sessions. Below are reports from each of the sub branches on their activities in 2010. If you live in one of these states/territories and would like to become involved with your local sub branch please contact the sub branch co-ordinator.

ACT ASHHNA Sub Branch
In 2010 there were 4 sub-branch meetings held in the ACT which were well attended by members from Canberra Sexual Health Centre, Sexual Health and Family Planning ACT, Women’s Health, General Practice, Alcohol and Drug Services, and School Health. At each meeting service activity updates are provided and these meetings are the perfect opportunity for ASHHNA members to network and share ideas and information.

Guest speakers included the newly employed School Nurses, a General Practice HIV Nurse, Women’s Health Nurse, and the CNC of the Forensic and Sexual Assault Service at Canberra Hospital.

The School Nurses commenced in their roles in 2010 and are employed by the ACT Department of Education. These nurses are based in several Canberra high schools and are accessible for students to discuss issues including mental health, drug and alcohol, contraception, sexual health, and most commonly relationship issues including violence and family breakdown.

The HIV Nurse spoke on the challenges of developing a research project to improve hepatitis vaccination rates in MSM including ethics approval, conflicts of interest, and funding. The HIV Nurses role in general practice was also outlined.

The CNC of the Forensic and Sexual Assault Service discussed service activity, service operation, referrals, incidence, forensic evidence collection, and follow up of sexual assault cases in the ACT.

Women’s Health Nurses discussed service change and redesign in the ACT which has included redirecting and structuring services for women in priority population groups.

A Sexual and Reproductive Health Update for Nurses was held in Canberra in November 2010. This update was well attended by nurses from a variety of settings and the organisers received positive feedback. Two members of the ACT sub-branch are on the working party to review the ASHHNA Competency Standards.

Shannon Woodward
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Victoria ASHHNA Sub Branch
Each year the Victorian ASHHNA sub-branch in partnership with Melbourne Sexual Health Centre (MSHC) holds a very popular educational day “Sex Talk”. Sex talk is a forum for Vic Nurses to meet and ASHHNA provides sub branch meeting funding. In 2010 we had around 50 participants.

Presentations included Update on STI's in Victoria and MSHC Projects and Research; Medico Legal / Ethical issues in Sexual Health; Motivational Interviewing; Multicultural issues in Sexual Health; Pap testing Update for Vic; HIV in teenagers and STI's in Pregnancy. The day finished with a Hypothetical discussion of questions from participants from the day. The day was evaluated and further Sex Talk day and sub branch meeting to be planned for 2011.

Brad Whitton
Ph: 03 9341 6271 E: bwhitton@mshc.org.au
ASHHNA SUB-BRANCHES cont …

WA ASHHNA Sub Branch

The WA group meets four times a year. The aims of this group is to provide an opportunity for nurses to network, share information, support one another, keep abreast of state initiatives, and to provide educational opportunities. Members are diverse, reflecting the diversity of sexual health nursing: STIs, HIV, BBVs, Women’s Health, family planning and sexual dysfunction.

Meeting attendance has been opened up to non ASHHNA members. Meetings are teleconferenced to allow non-metropolitan members to attend. Videoconferencing will be trialled in 2011. Meeting formats have followed an agenda with an emphasis on networking, state-wide items of interest, and an educational component. Non-metropolitan interest has been low.

Goals for 2011 include providing peer support for nurses interested in sexual health and to offer better educational opportunities e.g. an evening meeting with varied speakers. Peer support is also provided to nurses who are interested in entering the specialty. If you are interested in attending our meetings or wanting to know more about sexual health nursing, please contact the co-ordinators:-

Cath Hakanson
9021 8266
cath.hakanson@health.wa.gov.au

Donna Keeley
9431 2874
donna.keeley@health.wa.gov.au

SA ASHHNA Sub Branch

2010 was been another difficult one for ASHHNA SA however it has been improved by combining with the SA Sexual Health Nurses and Midwives Network (SHNMN) facilitated by Shine SA.

We started this year’s meetings by combining with SHNMN for a Sexual Health Awareness Week function on Feb 22nd looking at Emergency Contraception and then a joint meeting on May 3rd with a session on “Taking an Adolescent Sexual Health History” presented by myself and Lyn Matthews (from The Second Story Youth Health Service).

The first ASHHNA SA meeting that was not with SHNMN was June 22nd where Wendy Abigail presented her research findings on “Fertility management/control in women over 30 years of age prior to a Termination of Pregnancy (TOP)”.

On August 4th we had another combined meeting with SHNMN with an Update on Sexually Transmitted Infections presented by staff from the STD clinic in Adelaide.

September 28th was the next planned meeting time, where a Guest Speaker Ralph Brew presented a session on Sexuality and Disability. This was a most important aspect of sexual health that was well presented in an informal manner by Ralph.

November 4th was the final meeting for 2010 with a combined meeting with SHNMN at Shine SA. This was a session on a Contraceptive Update presented by Katrina Allen a senior medical officer with Shine SA. Following this presentation there was a brief ASHHNA meeting to bring people up to date following the Sexual Health conference and AGM. We also looked at some planning for 2011.

The attendance at some of the ASHHNA SA sub branch meetings has been very low. If you are a member of ASHHNA and live in SA please contact Heather Woods for details of meetings for 2011. As you can see from the 2010 activities, the meetings provide an excellent educational component which can be counted towards your continuing professional development portfolio.

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ASHHNA Executive Members

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ASHHNA Membership Application Form

Personal Information
Title____________________Surname____________________
First Name(s)______________________________
Address_________________________________________________________________
_________________________________________________________________
Suburb_____________________________State_________Postcode_______
Tel-W__________________M_____________________
email__________________________

Please provide your email address, as it's the principle way ASHHNA communicates with members.

Please tick which speciality you work in:\n\n☐HIV  ☐Sexual Health  ☐Sexual & Reproductive Health
☐Women's Health  ☐Men's Health  ☐Sexual Dysfunction

Candidate Declaration
I declare I am a-\n☐Registered Nurse  ☐Enrolled Nurse

Place of employment-__________________________________________
_________________________________________________________________
Position-______________________________________________________

I apply to become a member of the Australasian Sexual Health & HIV Nurses Association (Inc.).
In the event of my admission as a member, I agree to be bound by the rules of the association.

Signature of Applicant
________________________________________
Date___________________________

☐New Member  ☐Renewal

Please tick your payment method
☐Direct Deposit  ☐Money Order  ☐Cheque

ASHM Affiliation (Australasian Society for HIV Medicine)
All ASHHNA members can elect to become an ASHM Affiliate entitled them to complementary access to all
ASHM Member benefits (excluding board/committee representation and voting).
ASHM Affiliates receive email alerts on topics of interest,
have access to the Members only section of the website
and are entitled to discounted registration rates to
training and events run by ASHM.
☐ Yes, I want to be an ASHM Affiliate.
To activate your affiliation membership, visit-
www.ashm.org.au/ashhna

Things you need to know

Membership
Full membership is open to Registered Nurses working in Sexual Health and HIV Nursing.
Associate membership is open to Registered Nurses with an interest in, but not working in
Sexual Health and HIV Nursing and to Enrolled Nurses. Associate members will enjoy all the
privileges of membership except voting rights.

Admission of Members/Applications
The annual subscription fee is $AUD 60.
Membership applications must be made on this
form. Please return your application form with
the subscription fee to the secretariat.
Annual subscriptions are due on joining
anniversary date.

Payment Details
Cheque/money order- Please make payable to-
ASHHNA Inc.
Direct Deposit banking details-
Be sure to add your name in the Narrative box
BSB: 062 000  Account Number: 10090894
Account Name: ASHHNA Inc.
Bank: Commonwealth Bank of Australia

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