

Challenges

durex[®] network - Raising awareness of sexual health across the globe

Summer 2008

HIV prevention: work in progress

When it comes to monitoring progress in the worldwide response to HIV/AIDS, money matters can be at the root of diverging opinions



Condoms distributed at a health clinic in Ethiopia as part of a UNFPA programme

US RESEARCHERS from the Harvard University School of Public Health have called for a radical rethink on how worldwide funding for HIV prevention is being spent.

Their research, published in the magazine *Science*, argues that substantial investment in condom promotion, HIV testing and vaccine research has had limited success in Africa.

Instead, they believe that male circumcision and reducing multiple sexual partners should become the “cornerstone” of prevention.

“Despite relatively large investments in AIDS prevention efforts for some years now, it’s clear that we need to do a better job of reducing the rate of new HIV infections,” said study leader Dr Daniel Halperin, a lecturer in international health. “We need a fairly dramatic shift in priorities, not just a minor tweaking.”

Dr Halperin said many studies have shown that male circumcision significantly reduces the risk of heterosexual HIV infection. Furthermore, programmes to promote fewer sexual partners appear to have had a primary role in reducing HIV rates in a number of countries including Uganda, Kenya and Ethiopia.

The criticism over funding comes at a time when the United Nations is calling for significant increases in resources for HIV prevention, while a number of countries such as Australia are reducing their HIV/AIDS budgets.

Dr Peter Piot, UNAIDS executive director, told the UN General Assembly at a high-level meeting on AIDS, “Sometimes I hear that there is ‘too much money for AIDS’. Nothing could be further from the truth. The sobering reality is that the AIDS response remains under funded: last year there was an \$8 billion shortfall.”

He said success depended on taking multiple approaches while continuing to intensify research into an HIV vaccine and microbicides. This means working harder to make HIV prevention accessible to everyone through an array of complementary initiatives.

Although the rate of new HIV infections has been falling globally, it has increased in countries including China, Indonesia and Russia and there has been no detected fall in some of the most heavily affected countries such as Lesotho, Swaziland and South Africa.

A growing frustration with HIV incidence figures has been acknowledged by Aidsmap spokesman Michael Carter, who said this inevitably leads to the search for methods of prevention that appear more effective.

“Circumcision and partner reduction do have a role to play and will have greater

Continued on page 2

Inside News

Page 2-3 Sex education brings confidence

Page 6-7 PEPFAR and abstinence policies

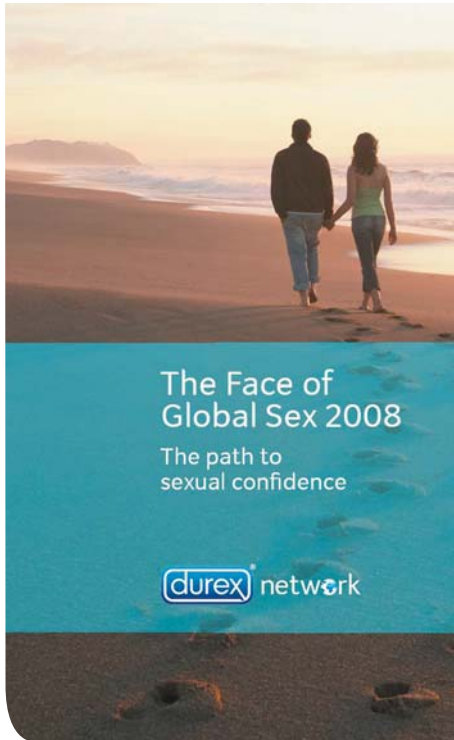
Page 4 Fluctuating age of consent

Page 8 The media – is it giving the right message?

Page 5 Parents: back at the centre of sex ed?

Sex education brings confidence

The findings of a Durex Network study are stimulating debate on developing more effective and sustainable solutions to sexual health problems across the globe



A NEW study has provided a unique perspective on the role that sex education plays in helping people go on to make informed choices about their sexual health.

The 2008 Face of Global Sex Report – The Path to Sexual Confidence – published by the Durex Network examined data from 26,000 adults worldwide and its findings show that comprehensive and inclusive sex education is vital for people to develop sexual confidence in later life.

The study indicates that the earlier a person receives formal sex education, the more sexually confident they are likely to be throughout their lives. This was found to be particularly true for respondents who received their formal sex education before the age of 17.

Based on the results, the study concludes that the 11 to 16 age range should be considered a “window of opportunity” for the most effective provision of sex education.

The study set out to highlight the circumstances that provide the best opportunities to gain sexual knowledge by identifying which socio-demographic variables most influence sexual confidence.

Sources of sex education were evaluated – together with geographical region and

area of residence, age, gender, income level, virginity status, and level of education – against scales of confidence on sex related issues.

The analysis of these variables made it possible to generate an innovative analysis tool, the Durex Sexual Confidence Scale (DSCS), to use as a basis of reliable assessments of sexual confidence.

The DSCS was based on four levels of sexual confidence in knowing how to: avoid unwanted pregnancy; prevent STIs/HIV/AIDS; reach sexual fulfilment; find guidance on various sexual health issues.

Durex Network Vice President Peter Roach said: “The findings show a way ahead for the targeting of sex education programmes.

“In particular, the importance of multiple sources working together to enhance sexual knowledge and skills from different points of view has been shown as a clear success factor in achieving higher levels of overall sexual confidence.

Continued on page 3

Continued from page 1
success in some settings than others,” he added.

The limited results that have been obtained through condom promotion activities can be linked back to a number of problems. UNFPA, the UN Population Fund, has recently recognised a lack of progress in male and female condom programming and has invited a small number of partner organisations to form an UNAIDS Interagency Task Team on Comprehensive Condom Programming (CCP) to explore factors impeding the scale-up of CCP.

Despite the knowledge that condom use is one of the most effective means of preventing sexual transmission of HIV, scaling up of condom programming has

not happened at a fast enough rate. UNFPA estimates that some 13.5 billion condoms were needed in 2006 to help halt the spread of HIV and other STIs, but the reality falls far short of this. In 2006, the donors provided 2.3 billion condoms and 3.3 billion in 2007.

Because too few condoms are being provided by the UN agencies, bilateral donors and social marketing organisations, many developing countries face having to meet the shortfall by paying for imported condoms with funds needed for food, medicine and other necessities.

But as the Interagency Task Team is pointing out, answers will be found by looking beyond condom supply at behaviour change and sexual and reproductive

education initiatives that need to accompany the distribution of condoms.

CCP programme co-ordinator Bidia Deperthes said, “Condom programming has not been to the scale that matches the gravity of the epidemic for a number of reasons, among them insufficient political leadership and inadequate resources. The CCP Task Team is working to find a way to break the current impasse by reviewing the whole context of condom promotion from analysing the keys to successful initiatives to identifying prohibiting factors and discussing ways of overcoming them.” ■

The Task Team has already begun work and will host a satellite session at the International AIDS conference in Mexico on 7 August 2008.

Continued from page 2

“For example, the source of sex education can have a significant effect on sexual confidence, and males and females tend to prefer different sources. This finding stresses the need for a careful review of which sources should be used as a priority in creating the most effective sex education programmes.”

The study found that parents and guardians are the single most impactful source of sexual education for achieving higher levels of sexual confidence overall.

However, despite this effectiveness, they were only listed as the eighth most likely source to be approached – falling well behind friends, the most cited source overall, as well as the Internet and TV.

There were distinct gender differences revealed in where people go for information about sexual issues. Males are more likely to use the media – magazines, the Internet, TV and radio – or institutional sources such as NGOs or government.

Females, on the other hand, tend to prefer more interpersonal sources such as health clinic doctors, partners, parents or other family members.

Interestingly, however, female respondents are more likely than males to cite school as being their main source of sex education.

When looking at geographical variants, the study shows that people in most Asian countries fall well below those in Western states when it comes to confidence in protecting themselves against STIs and HIV/AIDS.

Those most unsure about protection against STIs are in Thailand and Hong Kong with an average confidence level of only 65 per cent compared to 87 per cent in South Africa. Other countries such as Spain, Mexico, Switzerland, Brazil and Canada come close behind with an 85 per cent average confidence.

Similar findings for Asian countries appeared when respondents were asked about their confidence in how to avoid pregnancy. In this case, Singapore came lowest with a 68 per cent score while South Africa again proved the most confident with 85 per cent.

Asian countries were also found to have lower levels of confidence in knowing where to look for guidance on sexual matters, while those on the American continent scored highest. The most confident of all are in Brazil (80 per cent) who scored almost double that of adults in Japan (42 per cent).



Study reviewer Prof. Carl Latkin of the Department of Health, Behavior and Society at Johns Hopkins University, USA

However, the results were very different in answer to questions about the respondents' confidence in having a happy and fulfilling sex life. Here, Asian countries such as Malaysia achieved higher levels (70 per cent) than some European countries such as France (63 per cent).

Age was found to have a significant impact on sexual confidence at several levels. The study found a linear increase in confidence which reached a plateau around the age of 50 and dropped marginally after 55.

Income also plays a part and, in particular, has a significant impact on people's confidence in protecting themselves and others against STIs, avoiding pregnancy and where to go for guidance. However, it was found to have little effect on confidence in having a fulfilling sex life.

The educational level of respondents does impact on their choice of main sources of sex education, particularly in the use of the Internet. Those with the highest level of education were nearly twice as likely to cite the Web as their

preferred choice than those with the lowest level.

However, area of residence – whether rural or urban – appears to have little effect on confidence levels overall, although some minor differences were found in the four sub scales. For example, urban residents were more confident in knowing where to go for guidance, while rural residents showed higher confidence in their knowledge of avoiding pregnancy.

Utilising the data, the study profiled the characteristics of a typical sexually confident person. It showed they could be male or female, over 40 years old, have a higher income level and a higher standard of education.

They would have received formal sex education before the age of 17 and have lost their virginity before the age of 18. Their main sources of sex education would be parents or guardians, doctors, books, the Internet, partners or college/university.

Peter Roach added: “While in the real world the person meeting all these criteria may not exist, there will be many individuals who have at least some of the characteristics and the profile is a useful way of linking the

data analysis of this study with what might happen in real life.”

Professor Carl Latkin of the Department of Health, Behavior and Society at Johns Hopkins University in Baltimore, USA, said a key question raised by the study findings is how to make discussions about sexual health more normative.

He commented: “The Durex Network study results point to the important role of peers and parents in sex education.

“Social marketing and school-based sex education programmes may want to consider methods of not only disseminating accurate information, but also of promoting discussions about sexual health and sexual confidence among peers and family members to make the topics socially acceptable and healthy norms sustainable.” ■

The 2008 Face of Global sex report is available to download on <http://www.durexnetwork.org/en-GB/research/faceofglobalsex/pages/default.aspx>

Differing minds on age of consent

Current amendments in age of consent laws around the world may reflect changing social landscapes but worldwide disparities remain



line with England, Scotland and Wales. Members of Northern Ireland’s Legislative Assembly had opposed the change claiming it could encourage sexual predators from across the border in the Republic of Ireland, where the age remains at 17.

As had been the case in Canada, the age of consent for heterosexual intercourse on the UK mainland dates back more than a century or more.

The first English law was introduced in 1275 to prohibit men from having intercourse with girls under the age of 12. This remained in force for 600 years until the age was raised to 13 in 1875. Ten years later it was raised again to 16 as the proper time at which a girl “could be considered capable of consenting to her ruin”.

There still remains a wide divergence of opinion from country to country

on the question of what should be regarded as the right age at which young people are mature enough to make up their own minds about sex.

It varies in Europe from 13 years in Spain to 18 in Malta, while some countries also take gender into account. Austria takes a different approach to boys (16) and girls

(14) and Cyprus has an even wider variance with its minimum ages for boys (13) and girls (17).

The USA also has a disparity from state to state. Some, like California, have set a flat age of consent at 18 for either gender while others such as South Carolina have a legal minimum of 14 for boys and 16 for girls.

Similar differences are found in Africa, where in Angola the age is just 12 for boys (15 for girls) compared to 18 for either gender in Kenya, Rwanda and Tanzania.

Traditional culture plays a significant part in a country’s perception of the right age of consent. In strict Muslim countries pre-marital sex is against the law regardless of age.

However, whatever the legal age of consent may be, sexual health charities worldwide believe sex education at a young age is essential.

Simon Blake, Chief Executive of the UK-based charity Brook, said: “Sex and relationships education from a young age, together with access to sexual health services before young people start having sex, is vital to ensure that all young people have the knowledge and skills to make the choices that are right for their own sexual health.” ■

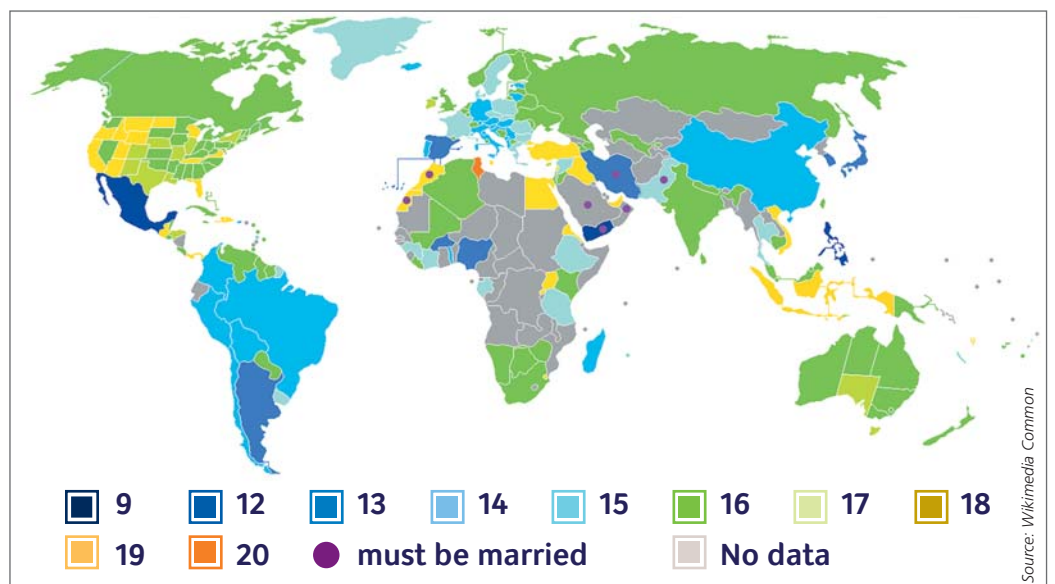
CANADA HAS amended its criminal code to raise the age of sexual consent from 14 to 16 years in its first change in the law since 1892.

The move, introduced by the ruling Conservative government, had support from the police and child advocacy groups who said it would help prevent adults from preying on children, particularly in the age of the Internet.

Under the “close-in-age” provision, the new code still allows sexual contact with peers provided a person under 16 (and 12 or older) has sex with someone less than five years older and the older person is not in a position of authority.

While the Canadians have been raising the age limit, other countries have been looking to lower it.

In the UK, for example, the age of consent in Northern Ireland is being reduced from 17 to 16 to bring it in



Current age of consent for heterosexual sex worldwide

Source: Wikimedia Common

Parents should talk more about sex

Record unplanned pregnancy, STI infections and abortion statistics among teenagers have recently brought sex education back into the limelight

Sexual health talks can be facilitated through repetition and frequent, informal chats between parents and children from an early age



WHILE NATIONAL sexual health policies and sex education provision are under public scrutiny in many countries including the UK, the USA and India, attention is also turning to other key stakeholders in the provision of sex education: parents.

But while parents seem an obvious source of sexual health information for their children, their actual role in the matter is less than straightforward.

In 1997, a study by King and Lorusso, published in the *Journal of Sex & Marital Therapy*, had already demonstrated certain discrepancies between what parents believe they are achieving when talking about sex with their children and what the children would actually like to know.

The research was carried out among University of New Orleans students and their parents. When they were asked whether they had ever had a meaningful discussion about sex with their parents, more than half of the students answered no. Yet in 60 per cent of these negative responses, one or both parents said that they believed they had had such a discussion.

Building on these findings, further studies have been carried out more recently, looking deeper into the importance of parent-child sex discussions and the difficulties that surround them.

A review of studies by Strasburger of the Department of Pediatrics, University of New Mexico School of Medicine, published in 2006 in *Pediatrics*, highlights that “the research is clear about parents’ role in teens’ sexual activity. If parents discuss their expectations that teens will delay intercourse, teens have to take that opinion into serious consideration and may, in fact, begin intercourse later.

“However, if parents do not discuss sex with their children and teens, particularly the need for responsibility and the need for birth control, then the media will pick up the slack.”

The study also points out that the media is often seen as a “super-peer” by young people, adding further pressure by making sexual intercourse seem like normative behaviour while glossing over protection from STIs and unplanned pregnancies. All the more reason for parents to stay in the hot seat.

Another study focusing on ways of improving communications is that produced in February 2008 by Dr Martino, a behavioural scientist at Rand Corp in Pittsburgh, USA.

Dr Martino’s findings suggest that facts of life talks between parents and children can be much more effective if they are managed

as a series of discussions covering a range of topics, rather than a lengthy one-off talk.

The report, published in *Pediatrics*, indicates that a continuous, repetitive, wide-ranging conversation about sex is the best approach.

“We found that kids whose sexual communication with their parents involved more repetition felt closer to their parents, better able to communicate with them in general and about sex in particular and they perceived that their discussions about sex happened more easily and with more openness in comparison to kids whose communication involved less repetition,” Dr Martino said.

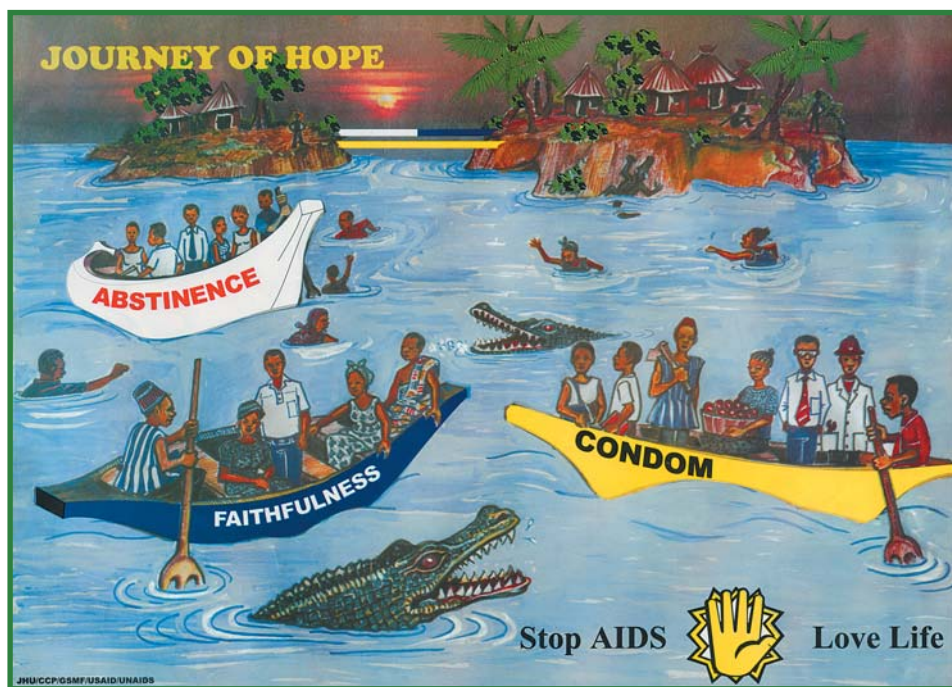
“We think that having these repeated discussions is so important because it helps kids to better understand the information.”

Lack of preparation is one cause for discomfort. Dr Martino says parents should not be worried to admit they feel uncomfortable talking about sex or to gather information on a topic and get back to their children with the right answers.

Seeking the answers has not always been easy for parents but it is becoming simpler thanks to the wide range of pamphlets, books and Internet sites now available to give guidance for talking to children of all ages about sexual matters. ■

American plan for sex education approaching rebirth

The fact that America has significant global influence is unquestioned. However, the policies through which it exerts that influence are under constant scrutiny



A poster entitled "Journey of Hope" promotes abstinence, fidelity and condom use as part of the Stop AIDS Love Life campaign in Ghana

ONE POLICY that has been accepted as beneficial to large numbers of the world's most vulnerable people is PEPFAR: the President's Emergency Plan for AIDS Relief. Announced in 2003 by President George W. Bush, PEPFAR is a \$15 billion programme conceived to fight a growing HIV/AIDS crisis in some of the poorest parts of the world.

Within PEPFAR is an expectation that beneficiaries of the plan uphold the principles of sexual abstinence and fidelity to prevent the transmission of HIV/AIDS. While the efficacy of abstinence is questioned consistently, both within the USA and around the world, abstinence remains at the foundation of US domestic and foreign policies.

A new PEPFAR bill has been making its way through Congress, versions of which have been approved by The House of Representatives and the Senate. This would continue the health initiative's work until 2014 and triple its existing budget.

While Democrats and Republicans agree, largely, that PEPFAR has been a success,

some have taken the opportunity to question to what degree, if any, abstinence alone should be stipulated as a desired method of protection from HIV/AIDS transmission.

The anticipation of a new president in the White House adds spice to the question: for how long will PEPFAR continue to promote abstinence?

Earmarked for abstinence

From the 2003 announcement, PEPFAR outlined an initial spending request of \$15 billion to provide for the treatment of existing sufferers and for programmes focusing on the prevention of new cases of HIV. When complete, the final budget will have grown to \$18 billion.

Congress required that one third of the monies earmarked by it for programmes that would help to prevent the transmission of HIV/AIDS was for the teaching of sexual abstinence until marriage.

Always central to PEPFAR has been its denial of funds for family planning and birth

control. In 2005, the bill's architects took a controversial step by relaxing the prevailing AB policy – AB is for abstinence and be faithful. They introduced a rule that would allow the distribution of condoms to high-risk groups, such as prostitutes and couples where one partner was already known to be infected, as a prevention measure.

The emphasis has remained firmly on abstinence, but it opened a route for discussion with organisations involved in family planning and reproductive health.

Advocates for abstinence defend its record within the USA heartily. In July 2007, Valerie Huber, executive director of the National Abstinence Education Association, wrote in *USA Today*: "Abstinence programs offer a holistic approach, teaching teens how to build healthy relationships, increase self-worth and set appropriate boundaries in order to achieve future goals. Abstinence education shares the realities of sexually transmitted diseases and the best way to prevent them. Accurate information about contraception is provided, but always within the context of abstinence as the healthiest choice. The realistic limitations of condoms are shared but without the explicit demonstration and advocacy that characterizes 'comprehensive' programs."

In April 2008, Christine Kim and Robert Rector of The Heritage Foundation presented to journalists a comprehensive review of 21 studies of the effectiveness of abstinence and virginity pledge programs. Kim said: "The overwhelming majority of prior studies of abstinence education report positive results."

She claimed: "Sixteen out of 21 studies of abstinence education found youths who received abstinence education had lower rates of sexual activity or other positive behaviors, when compared to youths who did not receive abstinence training."

But experts from the American Public Health Association and US Institute of Medicine told

Continued on page 7

Continued from page 6

Congress in April 2008 that scientific studies have not found that abstinence-only teaching works to cut pregnancies, sexually transmitted infections or the age when sexual activity begins.

“There is evidence to suggest that some of these programs are even harmful and have negative consequences by not providing adequate information for those teens who do become sexually active,” Dr Margaret Blythe of the American Academy of Pediatrics told The Congress Committee on Oversight and Government Reform.

And according to a study published in March 2008 by the US Centers for Disease Control and Prevention, almost two-thirds of female adolescents in the US have had sex by the time they reach their senior year of high school and one in four girls has an STI. The centre lists people under the age of 25 as the fastest growing group for new cases of HIV/AIDS. In terms of pregnancy, teen birth rates were up 3 per cent between 2005 and 2006 after 15 years of decline.

The jury remains out on whether the USA experience of abstinence justifies the commitment to it globally.

PEPFAR objective

The objective of PEPFAR has been to treat and prevent the transmission of HIV/AIDS. According to the USA’s “Global AIDS Act”, it is the “sense of Congress” that an effective distribution of funds includes 20 per cent for prevention of HIV/AIDS. Abstinence has been a core component of the prevention element of PEPFAR.

For those who want to see the end to abstinence being prescribed as the best way of preventing the transmission of infection, the reauthorisation of PEPFAR would offer little hope – at least for the short term.

On 11 July this year, a Statement of Administration Policy from the Executive Office of the President said: “The Administration believes it is particularly important that [PEPFAR] retains a meaningful funding requirement of the evidence-based, balanced ‘Abstinence, Be Faithful and correct and consistent use of Condoms’ approach to prevention of sexual transmission of HIV.”

New bill

While the reauthorisation of PEPFAR would ensure a \$48 billion fund to continue work,

it is unlikely that the incumbent president would approve a significant change on abstinence-only teaching.

However, both the House of Representatives and Senate versions of the legislation have, as a goal, the integration of reproductive health services, and provide for a more integrated approach to combating AIDS. This would include support for contraceptive services as long as these services are focused on stopping the transmission of HIV.

Specifically, the bill would allow (but not require) assistance to co-ordinate and integrate contraceptive services with HIV prevention, care and treatment programmes. In addition, the bill would maximise the capacity of healthcare and family planning providers in preventing HIV.



In both The House and Senate versions of the proposal for the new bill, the requirement to spend money on abstinence has been relaxed. There is, however, an obligation to spend at least 50 per cent of the money allocated to prevention of transmission on activities that will change people’s lifestyles and attitudes to sex. These activities include abstinence and fidelity programmes.

Senate delay

While The House of Representatives passed its version of the bill in April, Senator Coburn, with six other Republicans, blocked the legislation in Senate because of its perceived “mission creep” into health and development efforts, and concerns over cost.

They also wanted to amend the bill to guarantee that 55 per cent of PEPFAR funding continues to go towards treatment, including antiretroviral drugs.

However, on 16 July, the Senate voted to approve its version of PEPFAR

reauthorisation, and left the path clear for progressing the bill towards final presidential sign-off.

Considering its recent progress, PEPFAR reauthorisation is likely to be completed before a new president is in the White House. It is unlikely, therefore, to need the signature of presidential hopefuls John McCain or Barack Obama in order to enter law.

However, one of them will be driving the bill, will be requesting the release of funds from Congress with which to implement it and will need to ensure its success.

On the domestic US front, John McCain and Barack Obama don’t appear to agree on abstinence. Obama has been on record as being in favour of a more comprehensive approach to sex education and the management of sexual activity. McCain, however, is quieter on the issue. His responses to questions on the subject show him to believe in abstinence and the status quo.

Both men, though, support the new PEPFAR bill and are co-sponsors of it. It is unclear if they support its broad-brush objectives and are accepting a compromise.

In his Statement on the Global AIDS Reauthorization Bill on 17 June this year, Obama said: “Today, an estimated 33 million people around the world are living with HIV/AIDS, with over 4 million new infections in 2006 alone. HIV/AIDS is a global health crisis that demands a comprehensive and immediate response.” He added: “I am proud to co-sponsor this legislation.”

Now that the Senate has given approval, there is a strong chance that PEPFAR’s mission will continue and include an element of prevention as well as treatment of HIV/AIDS. Abstinence will remain an element of that policy, but with greater co-operation between PEPFAR and family planning groups, there is an opportunity for greater integration of the work that PEPFAR does.

With an increasing number of US dollars being pushed into the programme, the USA’s commitment to tackling the HIV/AIDS epidemic is assured. Questions remain, though, over the effectiveness of its policy. ■

The media – is it giving the right message?

Adolescents who have a diet of music, movies, TV and magazines have been found to be more likely to have sex between the ages of 14 and 16

A STUDY carried out in 14 middle schools in central South Carolina interviewed more than 1,000 black and white adolescents when they were 12-14 years old and again two years later.

The findings, published in the journal *Pediatrics* in 2006, showed that white 12-14 year olds who were widely exposed to sexual references in the media were 2.2 times more likely to participate in sexual activity within the next two years than their peers.

However, black teenagers appeared to be less influenced by what they see and hear in the media and more by perceptions of their parents' expectations and their friends' sexual behaviour.



The study commented that one of the strongest protective factors against early sexual behaviour was clear parental communication about sex. Both black and white youths were less likely to have engaged in sexual intercourse by the time they were 16 if they perceived strong parental disapproval.

Jane Brown, chief researcher for the study and a journalism professor at the University of Carolina-Chapel Hill, said that movies and music were found to be the most powerful influences. In particular, the

study analysed 170 songs that the teenagers listened to and found 40 per cent of the lyrics contained sexual content.

"Media is a powerful sexual educator, but not always in the best interest of our children," Brown commented.

"Clearly more research is needed to fully understand the relationship between exposure to sexual media content and adolescents' sexual behaviour.

"This is one of the first studies to establish the basic connection. It took many studies over a number of years to establish that violence in the media increased children's violent behaviour and to begin initiatives to reduce harmful effects.

"Given the consistent findings regarding media violence, it may be prudent not to wait decades to conclude that the media are also important sources of sexual norms for youths." ■

An increasing amount of research focuses on the role of the media in teenagers' social and sexual development, most of which confirm the present findings and further define their implications.

Challenges will further explore this topic in future issues.

Sexual health conferences and events

17th International AIDS Conference *Universal Action Now*

Date: 3 to 8 August 2008

Location: Mexico City, Mexico

Key theme: The conference theme – Universal Action Now – emphasises the need for continued urgency in the worldwide response to HIV/AIDS, and for action on the part of all stakeholders at the global, national, regional and local levels.

Contact: www.aids2008.org

24th IUSTI Conference on Sexually Transmitted Infections and HIV/AIDS

Date: 4 to 6 September 2008

Location: Milan, Italy

Key theme: The congress will focus on the latest developments in prevention and treatment for STIs and HIV/AIDS.

Contact: www.oic.it/iusti-europe2008, iusti-europe2008@oic.it

World Social Marketing Conference

Date: 29 and 30 September 2008

Location: Brighton, UK

Key theme: The conference offers the opportunity for policy makers, practitioners, and academics from across the world in different sectors to share their work, learn from each other and debate the ongoing development and application of social marketing. The programme will be split into three streams, academic, theory and policy and practical application.

Contact: www.tcp-events.co.uk/wsmc, nsmc@ncc.org.uk

Australasian Sexual Health Conference 2008

Diamond and Pearls

Date: 15 to 17 September 2008

Location: Perth, Australia

Key theme: Proposed presentations will include HPV/STIs/HIV, Syphilis, Chlamydia and Public Health.

Contact: www.sexualhealthconference.com.au, info@sexualhealthconference.com.au

10th Asia-Oceania Conference for Sexology

Sexual Health and Harmony

Date: 16 to 20 October 2008

Location: Beijing, China

Key theme: The conference will look into the future of the development trend and direction of sexology from the point of view of sexual education, STIs, AIDS and the industry of sexual medicine.

Contact: www.sexo-beijing.com

Challenges is an occasional publication produced by the Durex Network. While the articles are accurate summations of current sexual health matters, the views and opinions expressed are not those of the editor.

ISSN 1755-3814

To contact the Durex Network:

Peter Roach
Durex Network Vice President
SSL International PLC
35 New Bridge Street
LONDON EC4V 6BW

Email: peter.roach@ssl-international.com
<http://www.durexnetwork.org>