P01.02 A REGIONAL SEXUAL AND REPRODUCTIVE HEALTH CAMPAIGN PROVIDING CLINICAL EDUCATION AND HEALTH PROMOTION ACTIVITIES IN 2015 FOR ABORIGINAL HEALTH SERVICES AND COMMUNITIES IN THE WESTERN DISTRICT OF VICTORIA

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Introduction Providing sexual and reproductive health services for Aboriginal communities in regional Victoria can be a challenge. High rates of Chlamydia, Hepatitis C and unplanned pregnancies are a concern for communities. Victorian Aboriginal Health Services (AHS) partner with state based specialist organisations to assist with clinical education of the AHS workforce and the communities' health promotion needs. A partnership between the Dhauwurd Wurrung Elderly and Community Health Service (DWECH) in Portland, Victorian Aboriginal Community Controlled Health Organisation (VACCHO), Wulumperi Unit Melbourne Sexual Health Centre (MSHC) and Family Planning Victoria (FPV) strives to address these ongoing needs in 2015.
Methods Clinical education was organised by DWECH for four AHS in the region and was delivered by MSHC and FPV at DWECH. Participants were Nurses and Aboriginal Health Workers from DWECH (Portland), Gunditjmara Aboriginal Cooperative (Warrnambool), Kirrae Community Health Service (Framlingham) and Windamara Aboriginal Cooperative (Heywood). The aim of the education was to increase workforce capacity by educating local AHS staff about clinical sexual and reproductive health topics and available health promotion resources.
Results The Deadly Sexy Heath Kit (health promotion resource for AHS staff) developed by VACCHO and health promotion programs developed by MSHC (Young Peoples Sexual and Reproductive Health, Sacred Sistas, Deadly Dudes) were delivered in the region to Aboriginal Communities. The individual AHS in the region will monitor their client attendance and service delivery over the 2015 period. It is expected that the AHS will see an increase in screening for Chlamydia and Hepatitis C and sexual and reproductive health awareness as a result of the health promotion activities delivered to the communities.
Conclusion Ongoing clinical sexual and reproductive health education and support of the AHS workforce and targeted health promotion programs will improve the sexual and reproductive health needs of the Aboriginal communities living in the western district of Victoria.
Disclosure of interest statement Nil.

P01.03 ENCOURAGING ABORIGINAL GAY MEN TO TEST FOR HIV

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Introduction ACON has commenced development of a campaign to encourage Aboriginal gay men and other homosexually active men to test for HIV. The campaign need was identified in response to unique health and community issues presented by Aboriginal gay men.
Methods Campaign strategic development involved a series of quantitative research projects, using in-depth interviews and small focus groups with Aboriginal gay and other homosexually active men.
Results Initial quantitative research found:

- identity was complex and varied considerably for individuals, is dependent on context and is layered between sexual and ethnic identities;
- considerable concerned about the confidentiality of HIV testing services and the cost testing;
- HIV testing education programs need a sophisticated approach to targeting Aboriginal gay men and not necessarily relying on Aboriginal representation.

The final round of quantitative research found that:

- Confidentiality was seen as the most important theme. Aboriginal gay men were highly concerned about being discrete and anonymous;
- Cost also emerged a key barrier to testing, with a need to be assured that HIV testing would be cost free; and
- Aboriginal gay men also rejected the notion that HIV testing education materials should necessarily be tailored. While there was an acknowledgment that there was a place for targeted prevention education materials for Aboriginal people, it was also considered that a HIV testing materials should not single out and therefore potentially alienate the Aboriginal gay men.

Conclusion Developing and delivering HIV Testing education materials to Aboriginal Gay men presents complex challenge to HIV educators. A relatively small and highly mobile community, lower health literacy and issues of shame mean HIV Testing education materials need to consider a range of different strategies, including targeting materials specifically to meet the needs identified by Aboriginal gay men.
Disclosure of interest statement The ACON is funded by the NSW Ministry of Health. No pharmaceutical grants were received in the development of this study.

P01.04 WITHDRAWN

P01.05 EQUITY IN ABORIGINAL HIV HEALTH CARE DELIVERS THE GOODS

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Introduction Confusion exists with regard to the delivery of equal or equitable services. Far from providing the same care to all our clients we have delivered an enhanced, culturally secure service to a small cohort of Aboriginal people living with HIV. This paper evaluates the impact of this program. Our hypothesis is that this model of care results in improved outcomes. This paper seeks to present this model of HIV care and outline the results as a consequence of this care.
Methods Data were collected with regard to the type and number of occasions of service, medication compliance, HIV viral loads, CD4 counts, mortality and pregnancy outcomes.
Results From 1994 primary care was provided to the cohort by four doctors, demonstrating low staff turnover for a regional

area. All of the current cohort of 16 people are actively engaged with the service. The most common type of service delivered was for follow up with over 350 contacts provided over 12 months. On average there were four contacts per case per month ranging from one to 30. Ninety-four percent are on medication 62.5% with undetectable HIV viral loads, and 62.5% with satisfactory CD4 counts. Since 1994 twelve of the cohort has died and there have been ten new notifications. There have been 30 pregnancies with two positive babies.

Conclusion Although challenges in obtaining ideal outcomes persist, a holistic service delivery characterised by the development and continuation of relationships with the service provided has resulted in complete engagement of this cohort and has achieved positive outcomes in 62.5% of cases. This model of care, although labour intensive, delivers results similar or better than those seen internationally in hard to reach populations It demonstrates that equal outcomes can be achieved when equitable services are provided in a culturally appropriate manner.

Disclosure of interest statement None No pharmaceutical grants were received in the development of this study.

P01.06 ROLES OF NGOS/CSOS IN HIV/AIDS PREVENTION, TREATMENT, CARE AND SUPPORT FOR MOBILE POPULATION IN GREATER MEKONG SUB-REGIONS

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Introduction Thailand is a major destination for labour markets in Greater Mekong regions. Health services and medical treatment particularly HIV/AIDS treatment are important areas where migrant workers and their dependents have fallen through the cracks for both official and unofficial migrants working in Thailand. For official migrants there are Migrants health insurance package which cover the health services, Anti-Retroviral Treatment however for unofficial migrants is a huge obstacles and fear in accessing health care services. Civil Society Organisations in Thailand have attempted to fill some of these gaps particularly for unofficial migrants in HIV/AIDS prevention related to HIV and AIDS in mobile populations.

Methods Around 50 CSOs/NGOs in Greater Mekong Subregions including countries like Myanmar, Cambodia, Laos, Vietnam, Thailand and China were contacted to participate in the project "Strengthening CSOs/NGOs in HIV/AIDS for Mobile Population in Greater Mekong Sub-regions" to help labour migrants access HIV/AIDS prevention, treatment, care and support. These NGOs were involved in capacity building of PLHIV peer networks, cross border meetings, cross learning visits to learn and share good practices in the region.

Results Almost 40 CSOs/NGOSs were participated in the project with an aim to help unofficial migrants access HIV/AIDS prevention, treatment, care and support. There are informal referral assisted by NGOs/CSOs. However, migrants with very low income are unable to afford to pay for and hence do not take medicine regularly. NGOs/CSOs shared their experiences and recommendations on making freely available Anti-Retroviral Therapy available in the source, transit and destination.

Conclusion HIV/AIDS prevention, treatment, care and support services should be available to migrants despite of their nationality and mobility. This requires policy level changes to scale up migrant's friendly referrals and communication approach in terms of ARVs treatment.

Disclosure of interest statement The project was supported by Asian Development Bank.

P01.07 YOUNG QUEENSLAND SUDANESE'S SEXUAL HEALTH KNOWLEDGE AND BEHAVIOURS MAY PLACE THEM AT RISK – CULTURALLY INFORMED SEXUALITY EDUCATION IS NEEDED

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Introduction Young people who have experienced forced migration are vulnerable in relation to their sexual health, however, little is known about their sexual health literacy and behaviours post resettlement. This study explored the sexual health knowledge, attitudes, and beliefs of young Sudanese Queenslanders along with the patterns of sexual behaviour and sexuality education of this predominately refugee background group.

Methods Conducted in partnership with the target community using a convergent parallel mixed methods design, this study involved a convenience sample of 16–24 year old Sudanese Queenslanders completing an anonymous self-administered written survey. Descriptive, correlational, and Multivariate Analysis of Variance statistics were conducted.

Results Of the 229 participants (Mean age = 19.2 years), 95 males (63.8%) and 45 females (57.0%) self-reported they had experienced sex. The mean HIV knowledge score (M = 6.8, 12 item, Cronbach's α = 0.83) was higher than the mean STI knowledge score (M = 3.6, 11 item, Cronbach's α = 0.67), importantly however, both were low. The majority had sought sexual health information (61.1%) and self-reported they were confident talking about sex with partners (72.1%). They were notably less confident talking about sex with parents (27.9%). A third (31%) reported a HIV test. The aggregated Sexual Risk Behaviour Score (25 items, Cronbach's α = 0.9, range 7 to 70, M = 27.91, SD = 14.1) suggested generally low levels of risk behaviour. However, there was inconsistent condom use, minimal hormonal contraception use (9.3%), and 3.1% reported sex leading to an STI, 9.0% reported a pregnancy, 33.1% had experienced unwanted sex, and 32.9% had practiced anal sex.

Conclusion There was clear evidence of behaviours that place this group at increased risk of negative sexual health outcome suggesting a strong need for culturally informed sexual health education and interventions that address these aspects early within the resettlement experience.

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