Methods A probability-sample survey undertaken 2010–2012 (Natsal-3) using a combination of computer-assisted personal- and self- interviewing (CAPI/CASI). Participants rated themselves as 'greatly', 'quite a lot', 'not very much' or 'not at all' at risk of getting an STI (excluding HIV) given their current sexual lifestyle. We analysed weighted data on risk perception and behaviour from sexually-active individuals aged 16–44 (3391 men, 4966 women), and used multinomial regression to calculate relative risk ratios (RRRs) for rating oneself as greatly/quite a lot or not very much at risk (both compared with not at all at risk).

Results Most participants (64% of men, 73% of women) rated themselves as 'not at all at risk' of STIs, 30% of men and 23% of women as 'not very much at risk', and 6% of men and 4% of women as 'greatly/quite a lot at risk'. After adjustment for age, increasing risk perception was associated with reporting risk behaviours in the past year (RRRs for men presented for illustration, associations for women were generally similar): 1 new condomless partner (RRR 5.97 [4.24–8.40] for 'greatly/quite a lot' and 2.60 [2.08–3.25] for 'not very much', both compared with 'not at all at risk'), same-sex partners (RRR 19.85 [8.56–46.03] for greatly/quite a lot, 7.11 [3.99–12.66] for 'not very much'), and concurrent partners (RRR 16.21 [10.27–25.59] for greatly/quite a lot, 5.77 [4.10–8.11] for 'not very much'). However, these behaviours were also reported by a substantial proportion of those not rating themselves as at risk. For example, 27% of men and 26% of women who self-rated as 'not very much at risk', and 10% of men and 9% of women who self-rated as 'not at all at risk' reported 1 new unprotected partner in the past year. Similarly, 18% of men and 12% of women who self-rated as 'not very much at risk' reported concurrent partnerships in the past year.

Conclusion Most participants did not perceive themselves as being at risk of STIs, however many of these people reported sexual behaviours that are strongly associated with STI acquisition. Health promotion efforts should take account of mismatches between perceived and actual risk.

O07.4 CHALLENGES OF IMPROVING REPRODUCTIVE HEALTH LITERACY: LEARNINGS FROM PRACTITIONERS CARING FOR HUMANITARIAN ENTRANTS FROM BURMA

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Introduction In 2015, among 65.3 million displaced worldwide were 1.53 million people displaced from Burma, awaiting resettlement. Primary care practitioners (PCP) in settlement areas of Melbourne, Australia, have limited understanding of reproductive health literacy of refugees from Burma. Prior to migration they face significant human rights violations creating a culture of silence, and have no experience of informed decision making or voluntary consent. Based on this need articulated by PCP, we examined factors affecting sexual health literacy, to determine areas of priority and potentially effective strategies for delivering sexual health education to this refugee group.

Methods We conducted 27 semi-structured interviews on sexual health consultations with PCP involved with refugees from Burma. A conceptual framework based on principles of "humanization", and "sustainable development" underpinned interview guide development. Interviews were audio-recorded and transcribed. Content and thematic analysis followed independent coding and consensus discussion by team members.

Results Preliminary analysis suggests that although people from Burma originate from the same country, their diverse cultural and linguistic backgrounds impacts the entire spectrum of reproductive health related literacy. Knowledge of people who had lived in the plains appeared greater compared to people from hills or remote areas. Time in refugee camps and access to schooling also affects health literacy. All PCP prioritised winning the trust of patients over preventive health endeavours. PCP noted that Burmese refugees were not embarrassed by sexual health discussions and were eager to learn about it. Finally, 'word of mouth' was the most effective health engagement strategy. Actively involving clients in communication activities such as using drawings of reproductive organs to stimulate discussions were helpful.

Conclusion Health education delivered using culturally appropriate strategies focusing on patient engagement will definitely improve the uptake of reproductive health services.

O07.5 PREDICTORS OF RESPONSIVENESS AMONG AMERICAN INDIAN ADOLESCENTS TO A COMMUNITY-BASED HIV RISK-REDUCTION INTERVENTION

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Introduction American Indian/Alaska Native (AI/AN) adolescents suffer disparities in sexually transmitted infection, HIV/AIDS and unintended pregnancy. Deficits in culturally relevant risk-reduction interventions exacerbate sexual health inequalities. Our tribal-academic partnership evaluated a culturally congruent HIV risk-reduction intervention called: Respecting the Circle of Life (RCL) through a randomised controlled trial. This analysis assesses individual level predictive factors for unresponsiveness to the RCL program.

Methods 267 AIs ages 13–19 participated; data was collected at baseline, immediately post, 6- and 12 months post-intervention. Regression analyses examined how baseline levels of 5 factors, established as pre-requisites for behaviour change, predicted responsiveness to the RCL program including: HIV prevention/treatment knowledge, belief condoms prevent pregnancy/infection, condom use intention, condom use self-efficacy, and partner negotiation on condom use.

Results The strongest intervention impact was observed immediately post-intervention. RCL had greater impact on all 5 factors among low and medium initial scorers. Overall, high initial scorers in HIV prevention/treatment knowledge and belief that condoms prevent pregnancy/infection were predictive of unresponsiveness to RCL. Specifically, never skipping school was predictive of unresponsiveness to RCL for HIV/AIDS knowledge; female gender was predictive of unresponsiveness for condom belief; and high baseline HIV/AIDS knowledge was predictive of unresponsiveness for condom use intention.