Abstract P2-S2.04 Table 1 Parental acceptability of contraceptive methods

Contraceptive method	Overall parental acceptability (N=261)	Parental acceptability if teen is very unlikely to have sex in next year (n=195)	Parental acceptability if teen has any likelihood of having sex in next year (n=62)	Differences in acceptability by likelihood of teen having sex
Condom	51%	43%	76%	p<0.001
Oral contraceptive pill (OCP)	59%	53%	75%	p<0.01
Depot medroxyprogesterone Acetate (DMPA)	46%	42%	58%	p<0.05
Patch	42%	39%	51%	NS
Implant	32%	30%	37%	NS
Intrauterine Device (IUD)	18%	17%	20%	NS
Emergency contraception (EC)	45%	39%	63%	p<0.001

NS=not statistically significant (p>0.05).

interact, or the women who provide these services. The Latino population in North Carolina has increased 400% since 1990; most of these are young, unaccompanied migrant men. HIV rates are four times higher for Latinos than for whites, yet very little is known about the risk factors that affect HIV/STD transmission within this population. To better understand the typology of sex work services available to Latino men in North Carolina, and the potential for HIV/STD transmission among sex workers and their clients, we conducted a rapid ethnographic assessment.

Methods We conducted 28 key informant interviews and field observations in four counties in May 2010. We asked key informants from state and local HIV/STD and rural/migrant health programs, community based organizations and law enforcement/legal aid agencies to describe the typology of sex work, mobility patterns of women involved in sex work, HIV/STD risk behaviours of sex workers and their Latino male clients, and the availability of sexual health services. Qualitative data were analysed using NVivo7.

Results Female sex workers target Latino migrant men in a wide variety of venues in urban and rural settings, directly soliciting clients where they live and work. Sex workers differ by ethnicity, venue, client occupation, and degree of mobility, with some sex workers appearing to be highly mobile throughout the region. Sex workers are predominantly Mexican, Dominican, and Central American women, but also include African-American and Caucasian women. Condom use appears to be relatively frequent among some sex workers and clients see Abstract P2-S2.04 Table 1; however, knowledge of HIV/STDs appears to be low among clients. There is a dearth of sexual health services available to sex workers and Latino migrant men.

Conclusions Latino migrant men and the female sex workers who serve them may be at increased risk for STD/HIV due to frequent mobility and lack of access to healthcare, including sexual health services. More research is needed to better understand how sex workers and clients interact in the South, and the risk and protective factors that affect HIV/STD outcomes. Recommendations included engaging local stakeholders to increase awareness of STD risk in these populations and address gaps in services.

P2-S2.05 MOBILISING FEMALE SEX WORKERS TO ACCESS OUTREACH AND MEDICAL SERVICES: A CASE STUDY FROM SOLAPUR DISTRICT, MAHARASHTRA, SOUTH INDIA

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Background Solapur in south India is a district to which large numbers of female sex workers (FSWs) migrate from nearby states. The district also holds a number of jatras (religious festivals), in which thousands of people assemble for a short duration of time at a specific location, and where FSWs find a ready market for their services. We are implementing an HIV prevention program in the district among approximately 2525 FSWs, with a view to reducing the transmission of HIV and STIs, and improving their health seeking behaviour.

Methods Services provided include condom promotion and distribution, and clinic visits for STI detection and treatment. Strategies used for mobilising the community include outreach planning using a peer-educator based approach, development of site-wise social and local hotspot analysis maps, provision of voluntary HIV counselling and testing services in public-private partnerships, and provision of night outreach clinics in brothels. Those FSWs accessing the program are registered with a unique identification number and each outreach contact or clinic visit is recorded using a standard format, with type of service rendered. Peer cards and clinic forms are used to record individual outreach and clinical services provided, and information is entered into a computerised database at local level. The system is web-enabled to avoid double counting, and local implementation units can access information on the provision of services to any particular FSW at multiple clinics across the district.

Results Over a nine-month period in 2010, 51% (1,298) of the FSWs visited the clinic each month, and 88% (2214) visited the clinic at least once in a quarter. 31% of newly identified FSWs received presumptive STI treatment within 1 month of initial contact. 86% of the women reported condom use at last sex with a commercial sex partner. 1,051 FSWs were tested for HIV, and 4% of them tested positive. 91% of positive FSWs were linked to care services, including assessment for anti-retroviral therapy.

Conclusions Mobilising the FSW community to utilise clinic services on a regular basis is a challenge, especially in a context of high levels of migration, with frequent turnover. This requires a multi-faceted strategy and effective outreach planning, using micro-plans at local site level. Providing health services close to the community and at convenient times is very important for achieving high levels of coverage.

P2-S2.06 BECOMING A SEX WORKER: THE NEXUS BETWEEN VIOLENCE, GENDER DISADVANTAGE AND POVERTY

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Background Community mobilisation of female sex workers is integral to India's HIV prevention strategy. Sex workers often become infected by HIV soon after initiation into sex work. The societal factors that propel women into sex work may also inhibit the self-efficacy/agency required to access healthcare and adopt safer sexual behaviour.

Methods In-depth interviews were conducted with sixteen purposively selected (based on HIV status, ethnicity, age, area, and type of sex work) female sex workers in Goa, India (December 2004—December 2005). We interrogated the life narratives to explore the nexus between the social context/risk environment and self-efficacy/agency.

Results The narratives showed a dynamic interplay between underlying vulnerabilities, precipitating factors, and the route through which women gain entry into the sex trade: The ubiquitous mitigating theme that emerged was violence in childhood and youth. This ranged from dysfunctional and violent family life, sexual violence, and violence from intimate male partners. The other underlying vulnerabilities that emerged from the narratives were also manifestations of gender disadvantage, namely being unwanted; sexual naïveté and young marriage/sexual initiation; repression of sexuality, desire and entrapment in loveless marriages; and lack of life skills and low self-esteem. The loss of social support through bereavement, abandonment or financial need, were the commonest events that precipitated entry into sex work. Becoming a sex worker was frequently an expression of agency in a context with few other economically viable choices for women. The clearest division in the route into sex work was between traditional caste-based sex workers (devadasi) and those who were either introduced by peers, or sold through a broker; however the underlying and precipitating factors for both routes were remarkably similar. Mostly, initiation was described as a complex process that was mediated through peers.

Conclusion The interplay between caste, economy, gender, and violence drives the initiation into sex work, which is one of the few viable choices for the women. HIV prevention interventions therefore need to work upstream to impact upon the context within which women enter sex work and downstream to strengthen their agency. The peers who introduce women into sex work are potentially important vehicles to deliver "HIV prevention services and reduce the adverse health outcomes of sex work."

P2-S2.07 IMPROVING SEXUALLY TRANSMITTED INFECTIONS (STI) PREVENTION STRATEGIES: FACTORS ASSOCIATED WITH STIS AMONG FEMALE SEX WORKERS IN INDIA

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Background Studies among high-risk groups (HRGs) have shown that the presence of STIs is associated with certain demographic and behavioural characteristics as well as exposure to HIV/STI prevention interventions. The objective of this study was to understand the correlates of STIs in female sex workers (FSWs) in India in order to improve STI programming for HRGs.

Methods During 2008—2009, 417 female sex workers were recruited from three STI clinics in two cities of India as part of an operations research to evaluate the effectiveness of STI prevention service package for sex workers under Avahan, the India AIDS Initiative of the Bill & Melinda Gates Foundation. Behavioural and clinical information along with biological samples were collected. Bivariate analysis of demographic and behavioural characteristics associated with the prevalence of common bacterial STIs- *Neisseria gonorrhoeae*, *Chlamydia trachomatis*, *Treponema pallidum* and *Trichomonas vaginalis* from the baseline data is presented in this paper.

Results At baseline 49.2% of the participants had a laboratory confirmed diagnosis for at least one of the four bacterial STIs. The significant factors associated with STI prevalence among FSWs were: inability to read or write (OR=2.2, p=0.002); not staying with a sexual partner (OR=1.5, p=0.036); typology of sex work: home-/hotel-based (OR=2.5, p=0.038) vs brothel-based and street-based (OR=3.1, p=0.004) vs brothel-based; regular or occasional consumption of alcohol (OR=1.9, p=0.002); poor knowledge of STI symptoms (OR=1.6, p=0.017); low self-risk perception for acquiring STIs (OR=1.6, p=0.031); less than 2 years in sex work (OR=1.8, p=0.008); no prior exposure to HIV/STI interventions (OR=2.0, p=0.001); and no STI check-ups in the past 6 months (OR=1.5, p=0.029) see Abstract P2-S2.07 Table 1.

Conclusions HIV/STI prevention programs for FSWs in India need to prioritise services for HRGs who have characteristics associated with STI prevalence. Additionally, awareness activities should promote the importance of regular STI check-ups, recognition and early treatment for STI symptoms.

Abstract P2-S2.07 Table 1 Factors associated with sexually transmitted infections among female sex workers in India

Factors	OR 95% CI	p value
Illiterate (can not read or write)	2.2 (1.3 to 3.7)	0.002
Not staying with a sexual partner	1.5 (1.0 to 2.4)	0.036
Typology		
Brothel-based	Reference	
Home/hotel-based	2.5 (1.0 to 6.7)	0.038
Street-based	3.1 (1.3 to 7.7)	0.004
Consume alcohol (regularly or occasionally)	1.9 (1.2 to 2.8)	0.002
Poor knowledge of STI symptoms	1.6 (1.1 to 2.4)	0.017
Low self-risk perception for acquiring STIs	1.6 (1.0 to 2.5)	0.031
New to sex work (less than 2 years)	1.8 (1.1 to 2.8)	0.008
No prior exposure to STI/HIV interventions	2.0(1.3 to 3.0)	0.001
No STI check-ups in past 6 months	1.5 (1.0 to 2.3)	0.029

P2-S2.08 CHANGING PATTERNS AND DRIVERS OF MIGRATION AMONG FEMALE SEX WORKERS OF NORTHERN KARNATAKA TO LARGE CITIES OF MAHARASHTRA, INDIA IN THE CONTEXT OF HIV/AIDS

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Background and Objectives The large number of FSWs from the rural areas of Northern Karnataka's three districts namely Bagalkot, Belgaum and Bijapur (3B districts) who migrate and work in Maharashtra cities particularly in Solapur, Poona, Bhiwandi and Mumbai in brothels and lodges. In this corridor" of migration and interconnected HIV epidemics, an attempt is made in this paper to specifically address the following objectives: 1. To assess the volume of sex worker migration from different sites and its annual turnover. 2. To describe the patterns of sex worker migration to and from the three districts of northern Karnataka and the large urban centres of Maharashtra.

Methods Mapping was conducted following enumeration of the units; visited each unit (brothels and in some areas also lodges and/or dhabas) where we had prior information that sex work was conducted and interviewed the unit manager (ie, brothel madam, lodge/ dhaba manager). The manager provided information regarding: the number of FSWs working in the unit at the time—total number, FSWs from Karnataka, FSWs from the 3B districts; number of FSWs from the 3B districts that worked in the unit in the previous year and how many of them had moved to another unit in the same area. Moreover, managers provided the place of origin, age