

Poster presentation

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BECOMING A SEX WORKER: THE NEXUS BETWEEN VIOLENCE, GENDER DISADVANTAGE AND POVERTY

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Background Female sex workers (FSWs) in India remain most vulnerable to contracting HIV immediately after initiation into sex work. We explored the process of initiation to inform interventions.

Methods In-depth interviews were conducted with sixteen purposefully selected FSWs in Goa (December 2004–December 2005). The life narratives were interrogated using grounded theory.

Results The narratives showed a dynamic interplay between underlying vulnerabilities, precipitating factors, and how women entered sex work: The ubiquitous mitigating theme that emerged was violence: dysfunctional and violent family life; sexual violence; and violence from intimate male partners. Other underlying vulnerabilities were also manifestations of gender disadvantage: being unwanted; sexual naïveté; early sexual debut; entrapment in loveless marriages; and lack of life skills. Loss of social support through bereavement and abandonment or financial need, were the commonest events that precipitated entry into sex work. The clearest division in the route into sex work was between traditional caste-based sex workers (devadassi) 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.

Conclusion The interplay between caste, economy, gender, and violence drives entry into sex work. HIV prevention interventions must work upstream on the context within which women enter sex work and downstream to strengthen their agency. The peers who introduce women into sex work are potential vehicles to “deliver” HIV prevention services. Ultimately, the challenge is to ensure that the structural vulnerabilities that prevent effective HIV prevention early after entry into sex work do not also become barriers preventing FSWs from accessing HIV treatment.

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IS A 100% ANTENATAL HIV TESTING POSSIBLE?

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Background Antenatal HIV testing in the UK has been a resounding success and is credited with reducing the rate of mother to child HIV transmission.

Aims To explore the characteristics of women who did not have the HIV test at booking, the reasons for declining and adherence to local policy on re-offering tests later in pregnancy. Between April 2010 and April 2011 a review of maternity case notes was carried out.

Results 6723 women were booked in early pregnancy in the relevant time period and 33 (0.5%) of these women did not have a documented HIV test. Notes were only available for 32 of these women.

31/32 (96.8%) of the women were UK born, 27 (84.4%) partners were UK born. 11 (34.4%) women were pregnant for the first time. 13 (40.6%) women had no documentation of a HIV test within a year of booking. There was no documentation of intravenous drug use in any of the women or their partners. 7 (21.9%) women did not have any other blood borne virus testing done and none of these women had a recent documented HIV test either. Only in 8 (25%) women was there documentation of reasons for declining. 5 (12.5%) women were re-offered screening at about 28 weeks gestation in line with local policy with 4 (80%) accepting. 6 of 18 women were offered testing on admission to the labour ward and 2 (33.3%) were tested.

Discussion The maternity unit has a policy for dealing with women declining HIV testing in pregnancy and achieved a 99.6% acceptance rate. This study shows that there are some problems with documentation of previous testing, risk assessment and consistently re-offering of the screening tests later on in pregnancy. When the test was re-offered later on in pregnancy there was a high acceptance rate emphasising the benefit of this approach. In view of these results further training of midwives with an emphasis on HIV risk assessment and re-offering testing later on in pregnancy will be implemented.

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CARE OF HIV+ WOMEN AGED 50 AND OVER: CAN WE DO BETTER?

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Background The prevalence of ageing HIV infected females continues to increase due to greater survival, delayed diagnosis and new infections; management of specific issues in this group becomes more challenging.

Aims/Objective To identify the specific care issues for women at and above 50 years.

Method Female patients aged 50 and over were identified from a female cohort of 828 and data collected retrospectively from case notes and electronic patient records.

Results and Discussion The sample consisted of 124 (15% of 828) women, mean age 52 y, range 50–75 y; 83% black ethnicity, 40.3% diagnosed at 50 y or over. CD4 counts, mean 217 cells/ μ l indicating 71% late diagnoses and 42% with advanced/very advanced HIV. 22.6% of the sample had attended hospital before and missed the opportunities for early diagnosis suggesting wider testing even in elderly. 4.5% women had premature menopause compared to <1% in the general population, 7.1% early menopause, 28% had menopausal symptoms, 10% had HRT. On opportunistic testing of BMD tests, 5/8 women had evidence of osteoporosis/osteopenia. 54% of the whole group had vitamin D deficiency. 38% had abnormal cervical cytology, of which 16.5% were high grade. A high degree of obesity (48%) and other co-morbidities (90%) identified.

Conclusions Special care for premature/early menopause including early counselling regarding reproductive options, wider HIV testing regardless of age, screening for osteoporosis, breast and cervical cancer, holistic approach in the management of obesity and other co-morbidities. Consideration needed as to how care is provided for this group within current health care settings.

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ROUTINE ENQUIRY FOR DOMESTIC VIOLENCE, ALCOHOL AND DRUG USE IN A SEXUAL HEALTH CLINIC

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Background Addressing domestic violence (DV) against women is highlighted in the 2011/12 NHS Operating Framework. Genitourinary medicine is cited as one of the services where victims of abuse may present. Alcohol and drug use are recognised as factors affecting sexual risk taking behaviour. Routine enquiry for DV (women only) and drug and alcohol use was implemented in this service in June 2011.

Aims To audit if routine enquiry for DV, alcohol and drug use was done and identify interventions when DV was disclosed or if risk taking was found to be affected by drug or alcohol use.