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.