wider variety of studies. Greater use of this technology should be an area of interest in further adolescent STD research.

Social and behavioural aspects of prevention poster session 9: Women

P2-S9.01 THE IMPACT OF CUSTOMS AND SEXUAL PRACTICES ON YOUNG MAASAI WOMEN'S ABILITY TO NEGOTIATE THEIR SEXUAL AND REPRODUCTIVE HEALTH IN RELATION TO HIV AND AIDS IN LOITOKITOK, KENYA

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J N Matogo. *eMentoring Africa, NRB, Kenya*

This research investigated the ways in which Maasai culture, as practiced in a rural and relatively isolated area of Kenya, impacted upon the transmission of HIV/AIDS. The author focused her field research on women aged 16–25, and a range of cultural practices contributing to and influenced by gender roles in Maasai society. Local practice has been addressed and recommendations made in relation to the position of the Maasai community in the wider political economy and Kenya's ethnos cape.

The study also investigated strategies the women considered appropriate, practical and effective to cope with these risks. The field study was conducted in the Loitokitok district of Kenya.

Methodology The research is within a qualitative paradigm. Choice of methodology was mainly based on ethic consideration of research within cultural context of Maasai Indigenous people. Data was generated through use of focus group discussions, semi structured interviews and informal observation methods. An extensive review of the literature was also conducted. The influence of gender based customs and practices are highlighted in a number of scholarly works, Governmental and non-governmental documents with regard to women's vulnerability to Sexually Transmitted Infections (STIs).

The researcher maintained an "insider-outsider" position and a participatory role in order to try to identify the current state of Maasai women's reproductive health at the grass roots level.

Findings Research findings have found that there is a challenge in young pastoralist women's reproductive health autonomy. Their risk of STIs especially HIV infection is strongly determined by cultural and sexual practices that are gender related.

Existing customs and practices tend to be more repressive to the women's autonomy in sexual health matters as men hold power in most important roles in society.

Conclusions The study does not call for cultural change or reformation of traditional culture within the Maasai community; rather it appeals for transformation of customs and practices that cause harm on women's reproductive health. Valuable cultural practices and intentions that recognise women and celebrate their womanhood should be encouraged in a way that is not physically or psychologically daunting experience on their wellbeing.

To this end, the understanding and knowledge of the Maasai worldview is critical to the intervention of Maasai women's reproductive health rights. A more cultural approach to Maasai women's reproductive health is suggested to be more effective. In relation to the adoption of STI prevention measures, Maasai culture plays a key role towards identification of preventive measures and strategies.

P2-S9.02 SYPHILIS AND PREGNANCY: SOCIAL PORTRAIT OF THE DISEASE IN BELARUS

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I Tsikhanouskaya. *Vitebsk State Medical University, Vitebsk, Belarus*

According to the statistical data in Belarus pregnant women made of 8—17% of all women with confirmed syphilitic infection. About 15% women have primary syphilis, 30%—secondary, and 55%—latent syphilis. Aim of study. Study the social structure and concurrent pathology in pregnant women with confirmed syphilitic infection in Belarus.

Methods 95 case histories of pregnant women with confirmed diagnosis of syphilitic infection where analysed during 2003—2008. Middle age of women was 25.5±51 years.

Results Middle gestational period when syphilitic infection was registered was 21.5±20.4 weeks (in 1—12 weeks—in 10,5% of women; in 13—24 weeks—in 56.8%, in 25—36 weeks—in 30.5%, and in 37—40 weeks—in 2.2%). Concurrent STI where registered in 66.3% of women: trichomoniasis in 11.1%, urogenital candidiasis—in 25,4%, urogenital chlamydiasis—in 12.7%, mixed infection (chlamydia and ureoplasma) in 4.8%. Anaemia was registered in 25.1% of cases, fetoplacental insufficiency—in 7.1% of cases. From all women 67.3% where not officially married and their partners where not checked up as far as they where working outside Belarus. Only 8 women (8.4%) mentioned occasional sexual contacts. Unemployed women made of 52.6% of studied patients. Majority of employed women (64%) worked as unskilled workers. Others where academics—6.67%, medical professions—8.89%, students—8.89%, others—6.67%.

Conclusion Syphilitic infection in Belarus is detected quite late (usually 13—36 weeks). High percentage of pregnant women in Belarus are women with low social status and poor education.

P2-S9.03 THE SEX LIVES OF EMERGENCY CONTRACEPTION USERS IN THE USA, 2006–2008

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M Habel, J S Leichliter. *CDC, Atlanta, USA*

Background Previous research indicates that emergency contraception (EC) users are less likely to have visited a gynaecologist in the past 12 months, and are more likely to report ever having an STI compared to non-users; however, studies examining this unique population have been outside of the USA Given FDA-licensure of EC behind-the-counter, this is the first US study to use a nationally representative sample of reproductive aged women (15–44) to explore whether EC users represent a missed opportunity for STI counselling and screening.

Methods Data were collected through in-person interviews and through audio computer-assisted self-interview. Using a sample of 7356 women, sexual behaviour variables for which there were significant bivariate differences ($p<0.10$) for lifetime EC users were examined in a multiple logistic regression model controlling for demographics often associated with sexual behaviour including age, race/ethnicity, marital status, poverty level, and geographic location.

Results Overall 10% (704) of the sample had ever used EC; less than 3% had used it within the past 12 months. Most women had only used EC once (62%). Primary reasons for use were not using a birth control method (46%) and worry that birth control would not work (42%). Most EC users had received EC from a family planning clinic (51%). More EC users obtained EC from a drug store drug store (23%) than a private doctor's office (17%); most received EC without a prescription (69%). Demographic factors associated with lifetime EC use included: age 20-24/25-29 years (AORs=3.3; 2.4), never married (2.1), income 150% above the poverty level (1.6), and living in an urban-suburban area (1.6). Lifetime EC users were almost twice as likely to have had >4 lifetime partners. In bivariate analyses lifetime EC use was associated with receiving STI services in the past 12 months and having had a pap, but in the model became insignificant.

Conclusions Contrary to previous findings, EC users were no more likely than non-users to have received STI counselling or screening, despite greater numbers of sex partners. However, with licensure of behind-the-counter ECs, this research indicates that some women are accessing ECs without a prescription at drug stores rather than a provider's office, representing a missed opportunity for screening. These