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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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 ethnoscape.

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 ethical 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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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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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 (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

findings suggest future research on EC access and possible expansion of STI screening programs into real world settings, such as pharmacies.

Abstract P2-S9.03 Table 1 Prevalence of lifetime emergency contraception (EC) use

	n	(%) SE	Population total (weighted n)
Ever used EC (n=6326)			
Yes	704	(9.7) 0.9	5,117,887
No	5623	(90.2) 0.9	48,055,234
Used EC in past 12 months (n=6327)			
Yes	175	(2.1) 0.3	1,156,443
No	6151	(97.8) 0.9	52,068,403
No of times ever used (n=703)			
1	431	(61.9) 3.6	3,180,161
2	160	(24.3) 2.4	1,248,453
3+	112	(13.8) 3.0	709,209
Primary reasons for EC use*(n=703)			
Worried birth control method would not work	271	(42.3) 4.3	2,188,726
Didn't use birth control that time	345	(45.8) 3.5	2,369,367
Other reason	87	(11.8) 1.3	610,641
Where received EC (n=449)			
Private doctors/HMO	74	(16.5) 1.2	905,108
Community Clinic/FP clinic/school-based Clinic	232	(50.8) 4.3	2,228,311
Hospital facility or urgent care	29	(6.2) 1.1	342,076
Friend, partner, or spouse	13	(2.3) 0.6	123,784
Drug store	95	(23.1) 2.5	1,266,920
Other place	6	(1.0) 0.2	57,439
Obtained EC with a Rx (n=144)			
Yes	49	(31.4) 2.3	764,194
No	95	(68.6) 2.3	1,645,951

*First reason mentioned for the last (or only) time used EC.

†Population totals reflect US women age 15–44 years.

P2-S9.04 CONDOM NON-USE IS ASSOCIATED WITH LOW PERCEPTION OF RISK FOR STIS IN YOUNG SEXUALLY ACTIVE WOMEN

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Background Research indicates perception of risk is necessary for adoption of health protective behaviour. Many studies report optimistic bias in risk perceptions, ie, actual risk exceeds perceived risk. This study assessed the relationship between sexual risk behaviours and perceived risk for acquisition of an STI in a cohort of sexually experienced young women.

Methods Female Marine Corps recruits volunteered to participate in a cognitive-behavioural intervention to decrease STIs and unintended pregnancies that took place during Recruit Training (RT). Data are from the follow-up questionnaire (median=9.8 months post RT) for women who reported vaginal/anal sex since RT (N=1192). Perceived risk was assessed by, I think my chance of getting an STI during my next 6 months in the Corps is about. (0%, 1%, 5%, then 10%–100% in 10% jumps). Sexual risk behaviours since completing RT included # sex partners (1/2/3/4/5+), # casual partners (0/1/2/3+), % of time used condoms during sex (100/90–99/60–80/50/10–40/0), frequency of sex after drinking alcohol/using drugs (never/almost never/sometimes/usually or always), and whether any partner had an STI or was having sex with others (no/possible/yes). Bivariate relationships between sexual risk behaviour and perceived risk were evaluated using negative binomial regression.

Results Perceived risk was low (mean=6.05). All risk behaviours were significantly associated with perceived risk ($p<0.001$). In general, perceived risk increased as behavioural risk increased except for condom use. Pairwise comparisons show the 0% group mean (2.41) is higher than for the 100% group (1.47, $p<0.05$), but lower than the 90–99% group (3.96, $p<0.05$), and much lower than the 60–80%, 50%, and 10–40% groups (9.03, 8.88, and 11.05 respectively; all $p<0.001$). Restricting the analysis to participants with multiple partners or to unmarried women yielded the same results. Associations between sexual risk behaviour and two other measures of perceived risk (own risk relative to other female Marines, risk of behaviour for getting an STI; not shown) parallel the results described here.

Conclusions There is a major disconnect between women's perception of risk and their condom use, the most effective means for preventing common STIs. Since women must negotiate with and rely on male sexual partner(s) for condom use, future research should further examine social and contextual factors that influence young women's perceptions of risk in relation to condom use.

P2-S9.05 QUALITATIVE ASSESSMENT OF ANAL INTERCOURSE AND RECTAL LUBRICANT USE AMONG WOMEN IN LOS ANGELES

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Background There is increasing evidence that anal intercourse (AI) is a relatively common sexual practice among women. Although AI has a high probability of transmission of STIs/HIV, circumstances surrounding AI and the potential risk context among women are not well understood.

Methods Between May and August 2008, we recruited 30 racially and ethnically diverse women (10 African American, 10 Latina, and 10 White) age 18 years and older through community outreach efforts in Los Angeles, CA. Women underwent an in-depth interview that examined their intravaginal and anal practices. In this analysis we focus on identifying differing contextual meanings associated with AI through emergent themes and explore differences in these themes by race/ethnicity.

Results The majority of women reported experience with anal intercourse with a substantial number reporting recent experience with AI (ie, in the past year). While there were discussions of AI from women describing casual or transactional sexual partnerships, most women reported AI in the context of serious relationships. AI had varied meanings for women such as an expression of deeper intimacy, a representation of partner's pleasure, and a method for increased sexual gratification. In terms of what AI means in relation to other sexual acts, very few women reported having only AI and in fact it was considered going all out" and generally followed oral and vaginal sex. It is unclear if the women associated STI risk with AI practices since consistent condom use with AI was rare and those who reported condom use noted it as a strategy to improve "cleanliness" (unrelated to STIs) and reduce discomfort so that AI was "not so rough." Lubricant use for AI, including saliva, petroleum jelly, and baby oil was common and at least one woman specifically reported on the use of "spermicide jelly." Each of the race/ethnic groups provided support for the themes identified suggesting that the groups may not differ much regarding some of the contextual factors surrounding anal intercourse.

Conclusions These findings highlight that AI is common among women, particularly among those in serious relationships suggesting a need to reframe AI as not just risk behaviour but as a sexual health issue. While condom use with AI is not common, the use of anal