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CLINICAL ARTICLE

Contraceptive use among female sex workers in three Russian cities

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ABSTRACT

Objective: To determine the prevalence of, and factors associated with, use of non-barrier contraception (intra-uterine device, hormonal contraceptives, and female sterilization) among female sex workers (FSWs) in three Russian cities. **Methods:** A secondary analysis of data from a cross-sectional survey of FSWS aged 18 years and older from Kazan, Krasnoyarsk, and Tomsk was undertaken. Participants had completed a one-time computer-based survey in 2011. Among the 708 with a current contraceptive need, logistic regression was used to evaluate factors associated with use of non-barrier contraceptives. **Results:** Use of non-barrier contraceptives was reported by 237 (33.5%) FSWS. Use of non-barrier contraceptives was associated with being in sex work longer (≥ 4 years vs < 1 year: adjusted odds ratio [AOR] 4.70; 95% confidence interval [CI] 1.51–14.66) and having a non-paying partner (AOR 2.02; 95% CI 1.32–3.11). Odds of non-barrier contraception were reduced among FSWS who had ever worked with a pimp/momka (AOR 0.46; 95% CI 0.24–0.87), who had experienced recent client-perpetrated violence (AOR 0.19; 95% CI 0.07–0.52), or reporting consistent condom use (AOR 0.30; 95% CI 0.16–0.54). Only 13 (5.5%) of the 237 FSWS using non-barrier contraception reported consistent condom use. **Conclusion:** Only one-third reported use of non-barrier contraception, suggesting substantial unmet contraceptive needs. FSWS are an important target population for family planning, reproductive health counseling, and care.

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1. Introduction

Globally, female sex workers (FSWs) are at increased risk of HIV [1], and research on this population focuses heavily on infectious disease [1–4]. However, FSWS across various geocultural settings also experience unintended pregnancy and abortion [5–11]; there is a need to understand reproductive health in this population. The limited data available suggest low levels of reliable contraception use among FSWS [5–8,11,12]. FSWS' abilities to obtain and use contraception are probably compromised by barriers to health care, including stigma and discrimination [10,13]. Individuals further marginalized through drug use, early initiation of sex work, and low levels of control over condom use could experience greater unmet contraceptive need than others do [5,9]. Control over working conditions probably relates to contraception and reproductive health; past evidence shows increased risk of abortion among FSWS working with a pimp or brothel, facing high client volumes, or who have experienced forced unprotected sex [8,14].

Understanding contraception patterns among FSWS is particularly crucial in Russia given its high national unmet need (17%) and

unintended pregnancy rate (33%) [15]. Moreover, Russia has the highest rate of induced abortion in Eastern Europe/Central Asia, at 950.94 per 1000 live births [16]. Recent evidence from Moscow illustrates that over half of FSWS have experienced an induced abortion, and only 12% report using a non-barrier contraceptive method [11]. Concern persists for FSWS' use of ineffective and potentially hazardous pregnancy prevention methods, such as douching [11,13].

HIV prevention efforts for FSWS and other high-risk groups focus heavily on condom promotion [17]. When used properly, condoms offer the dual benefit of sexually transmitted infection (STI)/HIV prevention and pregnancy prevention. These benefits are reliant on adherence, with a first-year unintended pregnancy rate of 2% for women using male condoms perfectly as compared with 15% for more typical, intermittent condom use in real-world conditions [18]. More efficacious contraceptive methods exist, such as oral contraceptives (8% unintended pregnancy rate) and the copper intrauterine device (IUD) (0.8% unintended pregnancy rate) [18]. These effective and female-controlled methods are efficacious in part because they are not coital-dependent (i.e. they do not require action at each sexual act) [18,19]. Female-controlled, non-barrier methods are particularly relevant for FSWS who experience high levels of violence and control [2,4], which can undermine condom use [20]. Thus, clarifying and promoting FSWS' use of non-barrier contraceptive methods—specifically hormonal

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methods, IUDs, and sterilization where voluntary and appropriate—is critical given their comparative advantage in preventing unintended pregnancy.

Thus, the aim of the present study was to explore the prevalence of, and factors associated with, use of non-barrier contraception (oral contraceptive pills, IUD, hormonal injectables or implant, or female sterilization) among FSWs in three Russian cities. It is hoped that the findings can inform more tailored outreach, services, and management of family planning for this unique population.

2. Materials and methods

The present study was a secondary analysis of a cross-sectional survey focusing on HIV prevention conducted in 2011 with FSWs in Kazan, Krasnoyarsk, and Tomsk, Russia. Eligible participants were women aged 18 years and older who reported trading sex for money, drugs, or shelter in the previous 3 months. The present secondary analyses of anonymous data were deemed exempt from ethics approval by the Johns Hopkins Bloomberg School of Public Health Human Subjects Committee.

Full details of the parent study have been reported previously [4]. Briefly, participants were recruited via respondent driven sampling, which has been shown to be successful in hard-to-reach populations [21]. Consistent with respondent driven sampling methods, initial “seeds” were selected from the target population with the assistance of local non-governmental organizations (NGOs) and were to serve as the first round of study participants and initiate recruitment. All study activities were conducted by an in-country research team with logistical assistance from outreach staff. Study activities predominantly took place within the office or clinic of the local NGO—namely, the Simona Clinic in Kazan, Krasnyi Yar in Krasnoyarsk, and Belaya Siren Project in Tomsk, all of which are affiliated with the GLOBUS HIV prevention effort. Additionally, outreach workers were accompanied to enable data collection in the context of street-based outreach (but in a separate and private location).

After eligibility was determined and verbal informed consent obtained, FSWs completed a 20–30-minute confidential survey and underwent HIV screening. Participants self-administered the computer-based survey with a paper-based option upon request. All questions were written in English, professionally translated into Russian, reviewed by native speakers, piloted, and then edited as necessary. Participants were then given up to five recruitment cards with which to recruit other FSWs. All participants were given a small material gift as an incentive for participation.

These procedures generated a sample of 754 participants. The present analytic sample was restricted to include only those with a current contraceptive need, as assessed via the question “How important is it to you to avoid getting pregnant now?” Respondents indicating that it was “not at all important” ($n = 32$) were excluded from the current analysis, as were 14 individuals who provided incomplete data on this item. Therefore, the final sample reflects 708 FSWs with a current contraceptive need.

The primary outcome for the present analysis, use of non-barrier contraceptive method, was assessed by one item: “I am going to read you a list of different methods that women may use to prevent pregnancy. For each method I mention, please tell me if you are currently using it. Some women use more than one method, so you can say more than one.” Participants endorsing use of female sterilization, oral contraceptive pills, IUDs, hormone injectables, or the implant were classified as users of non-barrier contraceptive methods. Additional options included male and female condoms, the diaphragm, withdrawal, emergency contraception, douche, the rhythm method, and foam/jelly. Consistent male condom use was defined as “always” using condoms during vaginal sex with both non-paying partners and clients. Although there were no missing data for consistent use with partners, 25 (3.5%)

refused or did not report on consistency with clients; these women were classified as inconsistent users.

Demographic characteristics assessed included age, nationality, possession of registration papers, education, number of children, and socioeconomic status (SES). Low SES was indicated by having “below the minimum necessary to live” or being “just able to meet basic living needs.” Women were deemed to have a high SES when they had “finances to meet most/all needs.” Risk behaviors assessed included the number of non-paying partners, alcohol or drug use (i.e. “alcohol,” “legal drugs or those purchased in a pharmacy,” or “illegal drugs such as heroin, mak (injected opium), cocaine, marijuana”), and inconsistent condom use in the past 6 months. Sex work conditions assessed included sex work venue (i.e. street-based vs non-street venues [e.g. internet or escort services]), duration of sex work, and history of having worked with a pimp or momka. Women were deemed to have been exposed to sex worker-targeted HIV prevention programming prevention program if they either talked to a GLOBUS-affiliated outreach worker or went to a clinic in the past year (i.e. an outreach worker or clinic visit to one of the three participating NGOs). Physical violence perpetrated by clients and non-paying partners was assessed by single items drawn from the Conflict Tactics Scale [22], specifically by asking participants whether they had been “hit, pushed, slapped, or otherwise physically hurt.” Small amounts of missing data (<5%) were recoded to the most conservative value.

Prevalence of contraceptive use, including any method and specific types (e.g. barrier and non-barrier methods), were calculated as simple proportions of the study sample. χ^2 analyses assessed differences in use of non-barrier contraceptive methods on the basis of demographics, sex work conditions, and violence exposures. Univariate and multivariate logistic regression models were constructed to evaluate factors associated with non-barrier method use; factors identified as significant at a $P < 0.05$ in unadjusted analyses and/or thought to be potential confounders were included in the model. Analyses were conducted using Stata version 12 (StataCorp, College Station, TX, USA), and complex survey design adjustments were used to accommodate the respondent driven sampling strategy [23].

3. Results

Contraceptive use was common among the 708 participants (Table 1). Approximately one-third were using a non-barrier

Table 1
Contraception use ($n = 708$).^a

Method	No. (%)
No contraception	7 (1.0)
Non-barrier method	237 (33.4)
Oral contraceptive pills	173 (24.4)
Intrauterine device (IUD)	64 (9.0)
Sterilization	11 (1.6)
Hormone injection	5 (0.7)
Hormonal implant	1 (0.1)
Barrier method	690 (97.5)
Male condoms ^b	675 (95.3)
Consistent male condom use ^c	75 (10.6)
Female condoms	49 (6.9)
Diaphragm	1 (0.1)
Emergency contraception	71 (10.0)
Other methods	163 (23.0)
Withdrawal	134 (18.9)
Douche	64 (9.0)
Rhythm method	8 (1.1)
Foam/jelly	2 (0.3)
Other	0

^a Methods used are not mutually exclusive.

^b All reporting using male condom for pregnancy prevention, not adjusted by consistency of use.

^c Includes respondents using male condoms “always” in vaginal sex with clients and partners.

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