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HEALTH SEEKING BEHAVIOUR OF FEMALE
SEX WORKERS IN TAMIL NADU**

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REPRODUCTIVE HEALTH PRACTICES AND HEALTH SEEKING BEHAVIOUR OF FEMALE SEX WORKERS IN TAMIL NADU

William Rachna

INTRODUCTION

A **sex worker** (SW) is defined as someone who engages in sexual activity, for financial and/or other benefits.¹ Although men and transgender are also involved in this work, women form the majority among sex workers and are referred to as Female Sex workers (FSWs). The FSWs from low-income strata are being driven into this profession mainly by poverty, with one or more men behind this decision. They are exposed to various perils like health problems, violence, criminalisation, exploitation and marginalisation.

In this era of HIV/AIDS, FSWs are mainly looked upon as 'vectors of transmission', and treated as a potential hazard to the society. This focus, while bringing some attention and resources to this marginalised group, is concentrated on preventing STDs and is seen as a protection strategy for the society. FSWs are being given the attention, not because of concern that they acquire the diseases but because they are feared to have high potential to spread the disease to the society, which reinforces the patriarchal attitude of the society by protecting the men from infection whereas the women are far more vulnerable to this risk. This attention has also brought to light, the rights and livelihood issues surrounding their occupation; however there is still not enough focus on their womanhood and the related reproductive health issues. Thus the present HIV/AIDS interventions further marginalise this group of women.

NEED FOR THE STUDY

Until a few years back, most of the focus of health care related to sex work was on sexually transmitted infections, and this tended to view the sex workers exclusively in the role of infecting others in the society. Only in the last few years has the discourse included discussions in terms of how to help sex workers protect themselves from Sexually Transmitted Infections (STIs). Even now, the various programmes addressing them only attend to their sexual health needs and ignore the reproductive and other important health aspects like the general health and mental health thus rendering them more vulnerable to morbidity and mortality. The programmes working for them concentrate on condom promotion strategies, STI testing and treatment. As women, they have the basic right to health care, irrespective of the profession they are in.

Thus arises the need to study their reproductive health needs related to menstruation, contraception, abortion and pregnancy issues.

OBJECTIVES

The main objective of this research was to study the health practices and health-seeking behaviour of the FSWs for their reproductive health needs in terms of pregnancy and postpartum care, contraception, abortion, menstrual hygiene and gynaecological morbidity. Specific objectives were

1. To study the menstrual practices of FSWs
2. To study the use of contraception among FSWs
3. To study the health seeking behaviour of FSWs during pregnancy and post partum period
4. To study the abortion practices and
5. To study the Gynaecological morbidity among FSWs

RATIONALE

FSWs are marginalised and stigmatised to a great extent. They are denied their basic civil rights. This disenfranchised population lacks general access to not only basic health services but also are prone to various occupational health hazards. These hazards increase their health risks as they are at the mercy of the clients and the caretakers (brothel owners, lovers, pimps or madams), who might physically traumatise them by sexual assault, rape and physical abuse. They are also prone to extraordinary violence from other fronts. Their profession is criminalised, stigmatised and not considered an occupation, giving rise to more complications for these workers. They are also subjected to strong moral censure and the legal persecution; the police have become a source of harassment rather than a valuable source of support.² Once a FSW is created, even if she desires to step out of the profession, she is neither allowed by the people who are the reason for her entry nor by the people who support the profession like her clients and also by the society at large. In India, the society has no 'natural' capacities within itself to absorb the FSWs back into the mainstream.

If and when the access to health care is present, it is very limited and the only health aspect receiving focus for a FSW are health issues related to her sexual behaviour with her clients and her condom negotiation skills. The popular programmes currently in place (Targeted Intervention Programmes of NACO and HIV/AIDS programmes of SACS in different states,

Sonagachi project in Calcutta, Kamatipura programme by MSACS in Mumbai, STD prevention programmes of Bill and Melinda Gates Foundation and the AIDS Prevention and Control programme of USAID) are all based on this concept. As sex work tends to be regarded behaviour and not an occupation, sex workers are often not recognised as legitimate parties to discussion of their condition of employment.³ They are treated as objects of programme rather than contributors to them. So the absolute narrow focus on their sexual behaviour and STIs and HIV/AIDS obscure the other health problems that are prevalent among the FSWs and thus the other programmes targeting general population in total such as the RCH programme ignore their other reproductive health needs. The general health, reproductive health issues like menstruation, abortion, pregnancy, lactation and other related issues are generally overlooked. Thus, the FSWs are doubly vulnerable as already being a marginalised community, now combined with the narrow focus programmes for sexual health that would also not promote opportunities for pregnancy and abortion, thereby diminishing the ability to translate better sexual health to pregnancies that are safe. Also, the interface between the sexual health and the reproductive health could give rise to peculiar vulnerabilities and needs as the focus on better sexual health could result in diminishing reproductive health choices among this population.

Usually evidence indicates marginalised groups have diminished access. Poverty is almost universally associated with inequitable access to health services, particularly maternal health services. The burden of reproductive and sexual ill-health is greatest in the poorest countries where health services tend to be scattered or physically inaccessible, poorly staffed, resourced and equipped, and beyond the reach of many poor people. Too often, improvements in public health services disproportionately benefit the better off, and it is theoretically possible to achieve some of the international health goals without including the lowest income quintile and vulnerable population groups. As a prelude to fulfilling these needs, we need to document what their reproductive health needs are, what kind of access they have to resolve them and what kind of reproductive health outcomes they experience.

LITERATURE

Menstrual hygiene

The FSWs are ignorant of the hygiene practices that are to be undertaken during menstruation. Even if they are aware, they either cannot afford or they have no time to take care of themselves as the absence for even a day from work means an economic loss for the family. During work, they change fewer cloths per day and very rarely wash themselves, every time they change the cloth. Unhygienic habits in relation to menstrual protection could be a risk factor for reproductive tract infections.⁴⁻⁵

Coitus during menstruation

Some FSWs continue working during their menstrual cycles, which increases their susceptibility to various reproductive tract infections. This practice may emerge more consistently as a risk factor for the heterosexual transmission of HIV or other sexually transmitted infections in the future. Coitus associated with vaginal bleeding is a risk factor for sexually transmitted infections, including HIV. Reasons for this increased susceptibility, though unclear might be cyclic variations in vaginal microflora or local immunity as the serum complement-mediated anti-gonococcal effects are the lowest during menstruation.⁶ A study done among sexually active adolescent women revealed that coitus during bleeding suggested at least one explanation of increased rates of some STIs among them.⁷

A study in rural Gambia suggested little association between bacterial vaginosis in relation to sexual intercourse during menstruation.⁸ Bacterial vaginosis, an abnormal vaginal infection commoner than other STIs has been used in models to estimate an effect on HIV. Another study in Thailand found that 24% of HIV uninfected women had clinical BV when compared to 47% of those HIV infected (adjusted OR 4.0, 95% CI 1.7–9.4); although BV by Gram stain (Nugent score 7–10) was not statistically associated with HIV, abnormal vaginal flora (score 4–10).⁹

This aspect will emerge stronger if future epidemiological studies continue to bolster this finding, then public health efforts should promote abstinence during the menstrual period.¹⁰ It is to be noted that this practice of sex during menstruation is also associated with history of Chlamydia (Adjusted OR 1.6, CI 0.6-4.2).¹¹ Engaging in sexual intercourse during menstruation is also associated with longer/heavier bleeding patterns in some women.¹²

Douching^a

Vaginal douching increases the overall risk of pelvic inflammatory disease by 73% and the risk of ectopic pregnancy by 76% while frequent douching is modestly associated with cervical cancer.¹⁴ Douching is also found to be associated with endometritis and upper genital tract infection.¹⁵ A study done on the history, clinical findings, sexual behaviour and hygiene habits in women with and without recurrent episodes of urinary symptoms showed that sexual behaviour and hygiene had an etiological role in recurrent episodes of urinary symptoms with negative culture.¹⁶

^a Douching refers to the cleaning process of a body part or cavity for hygienic or therapeutic purposes with a stream of water, often containing medicinal or cleansing agents. It is also referred in the literature as 'genital cleansing'. Either water mixed with cleansing substances or milk is used to douche the vagina. Women douche for a variety of reasons, including removing menstrual blood, vaginal discharge, undesirable odours, or semen after sexual intercourse; to prevent or treat sexually transmitted or vaginal infections or pregnancy; and to enhance sexual pleasure or satisfaction by creating a feeling of cleanliness and "readiness" for sex.¹³

The practice of dry sex^b is generally incompatible with the use of condoms (which require lubrication to avoid breakage) making it more likely that STIs including AIDS will be transmitted. It may also result in vaginal inflammation and/or traumatic lesions that in turn may increase the transmission of STIs in other way. Since it decreases the sexual pleasure for women and increases their vulnerability to sexual diseases, it could be considered as a sexually biased behaviour.

It is practised among sex workers to attract clients and they use intra-vaginal substances to prevent vaginal discharge.¹⁷ Sex workers may engage in vaginal practices to clean the vagina between clients in order to remove “evidence” of previous clients; to ensure the sexual satisfaction of clients; and to prevent or treat infections.¹⁸ Sex workers’ increased risk for STIs, their greater perception of risk, and the greater likelihood that they will have vaginal symptoms are important reasons for the high prevalence of douching in this group.

Menstrual suppression

Some women also suppress their menstrual cycles, when they have to work. Suppression or postponement of the menstrual cycles was done mainly during religious ceremonies like temple festivals and peak tourist seasons, when there would be an influx of clients. Postponement would indirectly promote their profession, as it would facilitate the activity especially during these seasons. Mostly Oral Contraceptive Pills (OCPs) are used to suppress menstruation, as they are relatively easy to access and consume. The use of OCPs is found to cause pelvic pain, bloating, headaches.¹⁹ Oral contraceptives can also cause cervical ectopy, a condition in which a specific type of cell that lines the inside of the cervical canal extends onto the outer surface of the cervix, where exposure to sexually transmitted pathogens is greater. Also the progestins, thin the lining of the vagina leaving it susceptible to tears and abrasions through which the STI pathogens could enter the body. They also decrease the vaginal acidity, facilitating infection.²⁰

Conception

For FSWs, marriage is not for love/companionship but for protection and facilitation of their livelihood. FSWs can be married and living together with their husbands, living with their partners/lovers who also act as their ‘gate keepers’, divorced/widowed, or never married.²¹ FSWs also conceive and get pregnant in this context; while very few pregnancies are wanted

^b ‘Dry sex’ is the practice of removing vaginal secretions using herbs, leaves or powders before sexual intercourse, thus making the woman’s vagina dry and tight. This practice is supposed to generate extra sensation for the man during intercourse, but has the disadvantage that it is quite uncomfortable for the woman.

others are not wanted. Even the wanted pregnancies from the 'husbands' are also prevented due to the condom usage for STI and HIV/AIDS prevention, which by itself is becoming a problem.

Contraception

According to a study in Calcutta, 41.1% of FSWs had living children while 27.1% took precaution^c against pregnancy regularly; only 1.1% reported that their clients used condom.²² The awareness and use of condoms can be attributed to the various HIV/AIDS programmes in the country. Condom use with partners was less.²³ A trend linking the use of high-dose oral contraceptives and HIV-1 acquisition also was observed.²⁴ A recent study suggested that hormonal contraception could increase the infectivity of women with HIV. Increased shedding of HIV-1 genetic material from the cervixes of women using combined oral pills or DMPA was observed. Viral shedding increased as the dose of OCP increased.²⁵ Inconsistent condom use, however, was observed to be as risky as not using condoms at all.²⁶

Abortion

Abortion, an important health issue to women has stigma attached to it even when practised by others. So when it involves a FSW, many fold increase in the stigma is seen. Since unwanted pregnancies are an occupational hazard, the community is equipped to deal with such pregnancies through the use of abortions. In the study done at Calcutta, 46% had abortion.²² A study in Israel found that abortion was strongly related with age ($r=0.5$) and age of first sex work ($r=0.42$).²¹ A study from Cambodia reported that at least 25.5% had history of previous induced abortions, which are perceived to be risky and costly.²⁷

Obstetric issues

A study in Calcutta among sex workers revealed that 67.3% of them were pregnant.²² Some sex workers continued in the profession until the later stages of pregnancy. They did not consume nutritious or timely food resulting in under nourishment and gastritis. Due to stigma attached to the pregnancy, many did not seek health care nor did they attend antenatal clinics. Reasons for not seeking care might be due to the lack of time or economical constraints.²⁸ Their only hope of health care on many occasions were the madams or traditional healers. Some sought private care; privacy is maintained but it put an enormous financial strain on them; others sought care from government facilities.^{28,29}

^c Use of oral pills was found to be the most common practice against pregnancy

Sex workers returned to work as soon as possible, as their economic situation did not allow long absences. If allowed to carry their babies to the work place, they might breast-feed the baby rather irregularly. Otherwise, they left them with families or friends thus not able to breast-feed them. As a result, exclusive breast-feeding was for hardly a few months even while the WHO strongly recommends it for at least 6 months to be continued for 2 years or longer.³⁰

Partial breastfeeding or total lack of it adversely affects the growth and immunity of newborn babies. Women with a significant lifetime history of breastfeeding had lower rates of ovarian, endometrial, and breast cancer compared to general population. Lactation affects calcium metabolism, with increased bone density after weaning, and may eventually decrease a woman's risk of postmenopausal osteoporosis.³¹

Gynaecological issues

The most common morbidity prevalent in the general population are painful intercourse, upper/lower reproductive tract infections, upper/lower urinary tract infections, menstrual problems, and prolapse of the uterus.³² An ethnographic study of FSWs in Calcutta revealed that menstrual problems were found in 33.0% of FSWs, upper reproductive tract infections in 26.0%, lower urinary tract infections in 11.0%, leucorrhoea in 7.0%, and lower reproductive tract infections in 7.0%.³³ Poor hygiene, unsanitary living conditions associated with poverty and with limited access to well trained health care providers, increased women's exposure to reproductive tract infections.³⁴ Prevalence of human papilloma virus (HPV) was high among women who did not practice genital hygiene. Promiscuity was also found to be a significant factor. The presence of HPV increases the vulnerability of the women to various reproductive tract infections.³⁵⁻³⁶

Health care for sex workers

Literature identifying the FSWs agency to protect themselves from STIs is of more recent origin. Various programmes on FSWs attend to their sexual health needs and ignore the reproductive and other health aspects like the general health and mental health.³⁷ They also concentrate on condom promotion strategies, STI testing and treatment indicating the failure of the system not of the sex workers.³⁸ Lack of information appears to be a major barrier to general health care seeking behaviour. Some women did not even know where to get general health care while others knew but was placed it low on their priorities.³³ Many did not have health insurance or other medical aid and did not know how to obtain it.³⁸

A study in Tamil Nadu revealed that 65.0% of women who had symptoms of RTI never sought any kind of health care.³⁹ Women were reluctant to seek medical treatment due to lack of privacy, lack of a female doctor at the health facility, high cost of treatment, limited decision-making power and subordinate social status. Another study in Côte d'Ivoire indicated financial barriers to be the main reason for not visiting a public health centre when experiencing health problems.²⁹ Special clinics carried some stigma and also gave the police an opportunity to trace them.²⁸ Alcoholism, drug abuse and related problems were rampant among FSWs increasing their vulnerability resulting in increased morbidity.

METHODOLOGY

This cross sectional study to identify the reproductive health practices among female sex workers was conducted in two major towns - Rameshwaram, and Tirunelveli - in Tamil Nadu. Study population consisted of women, in the defined reproductive age group (15-45), currently working in the sex circuit as female sex workers; pregnant and lactating women were also included.

Sampling

It was hypothesised that they had morbidity or other health care needs (pregnancy care etc.) for which they would seek health care. Approximating reproductive health care needs to risks of gynaecological infections, the sample size was estimated based on the extent of gynaecological morbidities reported in Tamil Nadu in the National Family Health Surveys.⁴⁰ Among the ever-married women, 24.0% reported problems with vaginal discharge or symptoms of urinary tract infections. Assuming similar rates for FSWs, the required sample size of 280^d was estimated.

The collaborating NGOs had lists of brothel and lodge-based FSWs in these towns and were able to facilitate access to reach them. There were 300 registered lodge and brothel based FSWs in each of these towns. The required sample size was equally split between these two towns; every 2nd FSW in the list was selected and the person in-between was used as a substitute for missing or unavailable FSW.

Data collection

An interview schedule with mostly closed and a few open-ended questions was used in the study. Pre-testing was done in Pondicherry to check the clarity and practicality of the questions used. Necessary modifications were made to meet the objectives. The interview schedule, made in English, was administered in Tamil after translation.

^d $(1.96)^2 \times p \times q / \Delta^2 = (1.96)^2 \times (0.24) \times (0.76) / (.05)^2 \approx 280$

NGOs working in the field acted as 'gatekeepers'. FSWs were met before the actual data collection a couple of times and rapport was built. They were then approached at their worksites - the brothels/ lodges/peer's houses. They were interviewed at a time convenient to them. In case of street based workers or those who did not prefer work sites, NGO offices were used. Each interview took 20-30 minutes and data was collected during 26th June to 21st July 2005 by a single investigator. Confidentiality was ensured to each participant.

Data storage and analysis

Data entry was done with the help of a structured codebook in SPSS version 11.0. Data validation was done to check for errors in data entry. Descriptive analysis was carried out using the statistical package (SPSS 11.0 version for windows).

Ethical considerations

Informed consent was taken from FSWs individually and strict confidentiality was maintained. They could refuse to participate in the study at any point during the study without any adverse implications. For those who were willing to participate but not willing to sign the consent, oral consent was taken in the presence of a third person available and acceptable to the interviewee but was not interviewed.

RESULTS

Socio-demographic profile of the FSWs

Average age was 32.6 (range 19-46) years; 9.6% were below 25 years and 42.0% were above 35 years. About 90.0% were married while 4.3% were unmarried; 6.8% were divorced/separated. Over 50.0% were illiterate; the literacy rate for the state in 2001 was 64.4%.²³ Betel nut chewing was prevalent among 28.1%, while 14.9% consumed alcohol, 2.8% were addicted to other substances, and 0.7%.

Professional experience and income

Mean age of their first penetrative sexual encounter was 16.7 years (SD \pm 2.9 years) Twenty six percent of them were in the profession for more than 10 years while 19.2% had less than 5 years' experience. Poverty or financial reasons such as unemployment of family members, alcoholism of spouse/father, sudden loss of the earning member, and debt pushed 48.4% into the profession; 42.7% were pressed into this profession by family members. One FSW from Tenkasi said "*my mother was in it, so I ended up here*", another from Tirunelveli said "*it was a means of earning easy money*", and third from Pramakudi said " *I like the job*

pattern'. Over 40.6% continued in the profession due to pressure from family while 34.0% stayed on owing to own preference, and 11.0% due to pressure from brothel owners and others like rowdies, job broker etc.

Many (42.3%) of them practised sex work from several towns simultaneously; however, 33.5% worked in their own town, 21.7% preferred the neighbouring town, and 2.7% operated in tourist places. They used their own/friends'/rental places, brothels, and open space for sex work; 17.8% used open space. Thirty-one percent of FSWs were involved in the work full-time; for 63.7%, it was part-time while 5.3% took it up occasionally. Commonly reported other professions for the part-timers were beedi rolling (27.4%), construction work (19.0%), agricultural work (16.2%), domestic work (14.0%), vendors (11.2%), and other work (12.3%). One-third of them worked for more than 20 days a month; 6.1% worked for less than 10 days. Mean monthly income from sex work was estimated as Rs.1,056/- (SD \pm Rs. 1.034/-); 26.7% earned in excess of Rs.1,500/- whereas 17.8% earned less than Rs. 500/-. On the average, 69.3% of their total monthly income came from sex work.

Clients

On an average, each FSW served 3.6 paying clients and 1.0 paying client per day. Clients were of two types - paying and non-paying; non-paying clients were their pimps/managers, and local rowdies; occasional free encounters with paying clients, husbands, or lovers were not considered as non-paying. Over 80.0% catered to both paying and non-paying clients while 18.1% catered exclusively to paying clients.

Menstrual practices

Mean age of menarche for this group of women was 14.2 years (SD \pm 1.4); 27.4% attained menarche at 15 years with 95.4% having a history of regular cycles. During menstruation, 85.0% used cloth (old saris, *lungis*, or waste cloth), which was washed, dried, and reused many times. Some (7.1%) used cotton rolled in cloth while 7.8% used sanitary napkins. About 16.0% of women used the same cloth during the entire day while 39.3% changed it twice, and 45.0% changed it 3 or more times. During menstruation, 41.8% never washed themselves while changing the cloth, 31.1% washed sometimes and 27.1% washed every time.

Forty-five percent had sexual intercourse during menstruation; 55.7% of them practised douching after sexual intercourse and 31.8% used condoms. For douching, they reported using either old cloth soaked in water, dettol or flushing the vagina with soap water and later wiping it dry; a few of them even reported using talcum powder to increase dryness before the next sexual encounter.

Postponement was usually done when there was an increased probability of work (with increased clients) during festivals, vacation, and the tourist season; 35.7% practiced menstrual suppression using pills (49.0%) and injectables (51.0%) prescribed by doctors, (20.0%), caretakers 34.0%, or the pharmacy (45.0%).

Pregnancy

About 2.5% of FSWs were pregnant at the time of the study while 86.8% were pregnant at some point of time earlier; 5.0% reported primary/secondary infertility. Due to inadequate number of pregnant women at the time of the study, most recent pregnancy was taken into account for analysis of pregnancy experience. However, it should be kept in mind that each pregnancy occurred under different circumstances at difference time points and hence, they were not strictly comparable. Average age at the most recent pregnancy was 24.4 years and that of the second most recent was 21.9 years; 54.1% of the most recent pregnancies received 3-4 antenatal check-up. The places of ANC and delivery are given in Table-1. Reasons for not receiving ANC are reported in Table-2. Surprisingly, about 70.0% of FSWs were not aware of the need for ANC, FFA, and TT. Lack of financial resources was another major reason for not receiving ANC, FFA, and TT.

Abortion

About 30.0% of FSWs had the experience of abortion. Mean duration of the pregnancy at the time of abortion was 63 days. Main stated reason for abortion was that they did not want the child (92.4%). Those seeking abortion were accompanied by friends (49.4%), madam (18.9%), family members (14.5%), husband/lover (10.8%), and neighbour (8.4%). They had their abortion performed at a private hospital (27.7%), home (26.5%), home of the traditional healer (16.9%), others' home (4.8%) and government hospital (2.7%). Over 50.0% received care from a qualified provider, 28.9% traditional healer, 13.3% neighbour, 2.4 pharmacist, and 4.8% others; 47.0% had pain and bleeding after abortion; 13.3% had bleeding, and 7.2% had pain. Average spending on each abortion was Rs. 597/- (range Rs. 0-4,000/-) in addition to losing 10.4 working days.

Contraception

Contraception is a vital issue for the sex workers as the exposure to the risk of pregnancy is higher than the general population. They were familiar with condoms (92.1%), intrauterine contraceptive device - Copper T (86.1%), permanent methods (50.4%), oral pills (4.3%), and injectables (2.5%); 2.9% knew about natural methods.

Table-1
Place of ANC/Delivery (no. of women)

Place of ANC/ Delivery	Most recent pregnancy (%)*		Previous pregnancy (%)	
	ANC	Delivery	ANC	Delivery
Government hospital	81 (58.7)	124 (50.0)	60 (56.6)	88 (43.3)
Private hospital	53 (38.4)	42 (16.9)	42 (39.6)	42 (20.7)
Home	0 (0.0)	77 (31.0)	0 (0.0)	69 (34.0)
NGO hospital	2 (1.4)	3 (1.2)	2 (1.9)	2 (1.0)
Traditional healer's home	2 (1.4)	2 (0.8)	2 (1.9)	1 (0.5)
Others	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.5)
Average cost (Rs)	NA	1897	NA	NA
Mean work days lost	0	36.7	0	33.7

* Figures in parentheses are column percentages

Table-2
Reasons for not receiving ANC, FFA, and TT (no. of women)

Reasons	ANC (%)*		FFA (%)		TT (%)	
	Most recent	Previous	Most recent	Previous	Most recent	Previous
Not aware	80 (69.0)	69 (71.9)	88 (69.8)	75 (75.8)	81 (68.6)	72 (75.0)
No money	17 (14.7)	12 (12.5)	18 (14.3)	11 (11.1)	18 (15.3)	11 (11.5)
No time	10 (8.6)	8 (8.3)	11 (8.7)	9 (7.1)	11 (9.3)	7 (7.3)
Family did not allow	6 (5.2)	4 (4.2)	5 (4.0)	3 (3.0)	5 (4.2)	3 (3.1)
Shy/inhibited	1 (0.9)	1 (1.0)	1 (0.8)	1 (1.0)	1 (0.8)	1 (1.0)
Others	2 (1.7)	2 (2.1)	3 (2.4)	2 (2.0)	2 (1.7)	2 (2.1)

* Figures in parentheses are column percentages

Peer/friends/madams were an important source of information about contraceptives (51.2%) and NGOs were another major source of information (43.2%). Although over 70.0% preferred condoms but only 54.3% actually used them. On the other hand, only 10.0% preferred permanent methods but 40.7% used them. Female condom gives control to the women in a sexual encounter and is globally found to be popular among FSWs; but, only 29.6% of the FSWs were aware of it. NGOs (67.5%) and madams (32.5%) were the sources of knowledge for those who were aware of it. None of them was actually using it, as it was too expensive and unavailable.

Reproductive morbidity

About 1.8% of FSWs reported that they were HIV positive. Painful intercourse was reported by 11.4% with only one-eighth (12.5%) actually seeking care (75.0% pills and 25.0% injections) spending Rs.308/- per month. Upper reproductive tract infection was found in 33.5%, of which only 12.8% sought care (pills 1.7% and injections (8.3%) from pharmacy (50.0%), government facility (33.4%), and others (16.6%) spending Rs.166/- per month. Lower reproductive tract infection was found in 46.8%; 20.6% received care (pills 95.0%, injections 3.7%) from government facility (50.0%), private facility (33.3%), pharmacy (11.1%), and caretakers (3.7%). Care seeking reproductive health problems is provided in Table-3. Menstrual problem was found in 5.0%; 14.3% received care. Over 20.0% had LUTI; 14.0% sought care. About 2.9% reported other symptoms but none sought any care.

Table-3
Care seeking for reproductive health problems (%)

Condition	FSWs (%)	% seeking care	Health care		Provider		Other		Exp. per month (Rs.)
			Pill	Injection	Govt	Pvt	Pharmacy	Other	
Painful intercourse	11.4	12.5	75.0	25.0	50.0	50.0	-	-	308
URTI	33.5	12.8	91.7	8.3	33.4	50.0	-	16.6	166
LRTI	46.8	20.2	96.3	3.7	51.9	33.3	11.1	3.7	78
Menstrual problems	5.0	14.3	100.0	-	50.0	-	50.0	-	10
LUTI	20.4	14.0	100.0	-	50	25	25	-	67
UUTI	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
Others	2.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0

Health care seeking was quite low; 85.6% did not seek any care for their sickness. Lack of resources was the main reason (Table-4). This could indirectly point to the power dynamics between these marginalised groups and the rest of the society and the stigmatising nature of this occupation. Inhibition or shyness to seek health care was reported in almost all the disease conditions, the highest proportion (42.9%) seen in painful intercourse.

Table-4
Reasons for not seeking health care (% of women)

Reasons	Painful Intercourse	URTI	LRTI	Menstrual problem	LUTI	UUTI
Not aware	0.0	0.0	1.0	8.3	0.0	0.0
No money	25.0	53.7	44.2	25.0	51.0	33.3
Lack of time	25.0	15.9	23.1	25.0	20.4	66.7
Not allowed by family	3.6	2.4	1.9	0.0	2.0	0.0
Shy/Inhibited	42.9	22.0	26.9	33.3	20.4	0.0
Others	3.6	6.1	2.9	8.3	6.1	0.0

Determinants of care seeking

A simple bi-variate analysis using chi-square was undertaken for each of the variables discussed earlier - age, partnership, education, type of worker; nature of work; income earning, HIV status; menstrual hygiene practices and pregnancy experience and outcomes - abortion and contraception use. 'Reproductive morbidity' here is defined as an experience of any one of the morbidity conditions - painful intercourse, URTI, LRTI, menstrual problems, LUTI, UUTI and prolapse during 3 months preceding the interview. 'Health care seeking' refers to a positive response to questions on treatment. The relationship between age, partnership status, education and type of worker with their experiences of reproductive morbidity and health care seeking was examined. Social and demographic characteristics were not significantly associated with reproductive morbidity or health care seeking. Results are provided in Table-5.

Age did not have any influence on reproductive morbidity although the morbidity was high for unmarried FSWs; morbidity was also high among illiterates. Part-timers and occasional workers were more affected by morbidity than the full timers probably due to safe sex practices

among full timers. FSWs aged below 25 years sought care more than others, for whom it was almost similar. Unmarried and divorced FSWs too had higher care seeking; same is true for literates and part-timers.

Table-5
Factors contributing to health care seeking

	Reproductive Morbidity			Health care seeking		
	Experienced (%)	No Experience (%)	Total (no.)	Sought (%)	Not Sought (%)	Total (no.)
Age						
< 25	63.0	37.0	27	23.5	76.5	17
25-29	64.1	35.9	84	9.6	90.4	41
30-34	63.9	36.1	72	10.9	89.1	46
35 +	59.3	40.7	118	17.1	82.9	70
Total	61.9	38.1	281	14.1	85.9	174
χ^2 / P	$\chi^2 = 0.593$	$P = 0.898$		$\chi^2 = 2.76$	$P = 0.429$	
Partnership status						
Unmarried	83.3	16.7	12	20	80	10
Married	60.8	39.2	250	13.2	86.8	152
Divorced/ Separated	63.2	36.8	19	25.0	75.0	12
Total	61.9	38.1	281	14.4	85.6	174
χ^2 / P	$\chi^2 = 2.479$	$P = 0.290$		$\chi^2 = 1.541$	$P = 0.463$	
Education						
Literate	59.2	40.8	130	16.9	83.1	77
Illiterate	64.2	35.8	151	12.4	87.6	97
Total	61.9	38.1	281	14.4	85.6	174
χ^2 / P	$\chi^2 = 0.743$	$P = 0.389$		$\chi^2 = 0.710$	$P = 0.399$	
Worker status						
Full-time	55.2	44.8	87	10.4	89.6	48
Part-time	65.4	34.6	179	16.2	83.8	117
Occasional	60.0	40.0	15	11.1	88.9	9
Total	61.9	38.1	281	14.4	85.6	174
χ^2 / P	$\chi^2 = 0.2603$	$P = 0.272$		$\chi^2 = 1.020$	$P = 0.601$	

As the number of clients increased, the proportion of FSWs experiencing reproductive morbidity and seeking health care also increased (Table-6). Morbidity was not influenced by income although income increase did influence care seeking at least at the lower level of income.

The relationship between reproductive morbidity, health care seeking and menstrual practices (protection used, frequency of change, washing, sexual intercourse, and douching, and condom use) was examined and the results are in Table-7.

Table-6
Experiences of reproductive morbidity, and health care seeking
by number of clients and income earning

	Reproductive Morbidity			Health care seeking		
	Experienced (%)	No Experience (%)	Total (no.)	Sought (%)	Not Sought (%)	Total (no.)
No. of Clients						
< 5	57.0	43.0	158	13.3	86.7	90
5 - 10	68.3	31.7	123	15.5	71.0	84
Total	61.9	38.1	281	14.4	85.6	174
χ^2 / P	$\chi^2 = 3.766$	$P = 0.052$		$\chi^2 = 0.162$	$P = 0.6687$	
Total income per month (Rs.)						
< 999	55.0	45.0	40)	9.1	90.9	22
1,000-1,999	61.1	38.9	175	13.1	86.9	107
2,000-2,999	71.2	28.8	52	21.6	78.4	7
3,000-3,999	54.5	45.5	11	16.7	83.3	6
> 4000	66.7	33.3	3	0.0	100.0	2
Total	61.9	38.1	281	14.4	85.6	174
χ^2 / P	$\chi^2 = 3.020$	$P = 0.554$		$\chi^2 = 2.585$	$P = 0.629$	

Type of menstrual protection did not contribute to reproductive morbidity. Health care seeking increased with the use of better forms of menstrual protection indicating that those who were

better off sought more health care. Frequency of protection change, up to four per day, resulted in a decline in proportion of women experiencing reproductive morbidity. Sex during menstruation, condom use, washing, douching, and menstrual suppression were not significantly associated with reproductive morbidity. Others, except type of protection and menstrual suppression, were not associated with health care sought too.

Influence of ANC for pregnancies, place of delivery; experience of abortion and current contraceptive use (particularly condoms) on reproductive morbidity and health care seeking was also examined. Results are given in Table-8. Reproductive morbidity was similar for those who had and did not have ANC. However, care seeking was high among those who received ANC. All who had delivered at traditional healers' homes and half of those who delivered at home experienced reproductive morbidity. Women who had aborted before 90 days had increased morbidity. Care seeking was more for those who aborted during the second trimester. Health care seeking was least among those who aborted at home and this could be a reflection of their poor access to health services. Pharmacists contributed less to the morbidity probably due to lesser intra-uterine intervention involved.

Table-7
Reproductive morbidity and health care seeking in relation to menstrual hygiene practices

	Reproductive Morbidity			Health care seeking		
	Experienced (%)	No Experience (%)	Total (no.)	Sought (%)	Not Sought (%)	Total (no.)
Type of Protection						
Cloth	61.8	38.2	238	11.6	88.4	147
Cotton in cloth	60.0	40.0	20	33.3	66.7	12
Sanitary napkin	68.2	31.8	22	26.7	73.3	15
Total	62.1	37.9	280	14.4	85.6	174
χ^2 / P	$\chi^2 = 0.395$	$P = 0.821$		$\chi^2 = 6.291$	$P = 0.043$	
Frequency of cloth change						
1	50.0	50.0	44	9.1	90.9	22
2	59.1	40.9	110	13.8	86.2	65

3	70.0	30.0	80	17.9	82.1	56
4	68.6	31.4	35	12.5	87.5	24
≥ 5	63.6	36.4	11	14.3	85.7	7
Total	62.1	37.9	280	14.4	85.6	174
χ^2 / P	$\chi^2 = 8.803$	$P = 0.185$		$\chi^2 = 4.037$	$P = 0.672$	
Washing during change						
Yes, always	60.5	39.5	76	8.7	91.3	46
Yes, sometimes	62.1	37.9	87	22.2	77.8	54
Never	63.2	36.8	117	12.2	87.8	74
Total	62.1	37.9	280	14.4	85.6	174
χ^2 / P	$\chi^2 = 0.145$	$P = 0.930$		$\chi^2 = 4.203$	$P = 0.122$	
Sexual intercourse						
Yes	61.9	38.9	155	12.5	87.5	96
No	62.4	37.6	125	16.7	83.3	78
Total	62.1	37.9	280	14.4	85.6	174
χ^2 / P	$\chi^2 = 0.006$	$P = 0.937$		$\chi^2 = 0.607$	$P = 0.436$	
Use of condoms during menstrual sex						
Yes	64.0	36.0	89	15.8	84.2	57
No	61.3	38.7	191	13.7	86.3	117
Total	62.1	37.9	280	14.4	85.6	174
χ^2 / P	$\chi^2 = 0.201$	$P = 0.654$		$\chi^2 = 0.139$	$P = 0.709$	
Suppression of menstruation						
Yes	58.0	42.0	100	6.9	93.1	58
No	64.4	35.6	180	18.1	81.9	116
Total	62.1	37.9	280	14.4	85.6	174
χ^2 / P	$\chi^2 = 1.135$	$P = 0.287$		$\chi^2 = 3.947$	$P = 0.047$	

Table-8
Reproductive morbidity and health care seeking in relation to pregnancy, its outcomes and contraceptive use

	Reproductive Morbidity			Health care seeking		
	Experienced (%)	No Experience (%)	Total (no.)	Sought (%)	Not Sought (%)	Total (no.)
ANC for most recent pregnancy						
Yes	58.7	41.3	138	19.8	80.2	81
No	61.5	38.5	117	5.6	94.4	72
Total	60.0	40.0	255	13.1	86.9	153
χ^2 / P	$\chi^2 = 0.213$	$P = 0.644$		$\chi^2 = 6.762$	$P = 0.09$	
Place of delivery of most recent child						
GH	58.9	41.1	124	12.3	87.8	73
PH	66.7	33.3	42	14.3	85.7	28
Home	61.0	39.0	77	13.3	86.7	47
Charitable hospital	33.3	66.7	3	0.0	100.0	1
Trad. healers' home	100	0.0	2	0.0	100.0	2
Total	60.7	39.3	248	12.7	87.3	151
χ^2 / P	$\chi^2 = 3.043$	$P = 0.551$		$\chi^2 = 0.511$	$P = 0.972$	
Place of abortion						
GH	61.1	38.9	18	9.1	90.9	11
PH	78.3	21.7	23	16.7	83.3	18
Friend's place	100	0.0	4	0.0	100.0	4
Home	68.2	31.8	22	6.7	93.3	15
Trad. healers' home	71.4	28.6	14	0.0	100.0	10
Others	100	0.0	2	0.0	100.0	2
Total	72.3	27.7	83	8.3	91.7	60
χ^2 / P	$\chi^2 = 4.023$	$P = 0.546$		$\chi^2 = 3.154$	$P = 0.676$	

Person performing abortion						
HCP	69.0	31.0	42	13.8	86.2	29
Neighbour	90.9	9.1	11	0.0	100.0	10
Traditional healer	70.8	29.2	24	5.9	94.1	17
Pharmacist	50.0	50.0	2	0.0	100.0	1
Others	75.0	25.0	4	0.0	100.0	3
Total	72.3	27.7	83	8.3	91.7	60
χ^2 / P	$\chi^2 = 2.660$	$P = 0.616$	$\chi^2 = 2.538$	$P = 0.638$		
Currently using contraceptives						
Condoms	61.2	38.8	152	14.0	86.0	93
Copper T	50.0	50.0	14	-	100	7
Permanent methods	64.9	35.1	114	15.2	83.8	74
Total	62.1	37.9	280	14.4	85.6	174
χ^2 / P	$\chi^2 = 1.309$	$P = 0.520$	$\chi^2 = 1.391$	$P = 0.499$		

Woman using condoms and permanent methods of contraception reported more morbidity than those using Copper-T. This could be attributed to the intra-vaginal practices that are feasible to those using condoms and permanent methods, which could lead to increased susceptibility to infections. There is not much difference when it came to health care and the variety of contraceptives used.

Morbidity and health care seeking were higher among those who did not use condoms consistently with clients. Those who never used condoms with their partners reported higher morbidity levels than those who did. Health care sought was similar for all. Likewise, women who did not use condoms with either reported more morbidity and health care seeking behaviour than those who used condoms. Condom use with partners was significantly associated with the experience of reproductive morbidity with those who did not use condoms with partners reporting the highest levels. This clearly implies that even women like FSWs who are able to negotiate condom usage with clients, are not able to do so with partners and this renders them more vulnerable to reproductive morbidity conditions.

DISCUSSION AND CONCLUSION

This study identified reproductive health practices and health care seeking of female sex workers in Tamil Nadu. Various health practices during menstruation, contraception, abortion, pregnancy and gynaecological morbidity were looked into along with health care seeking. Reported morbidity and its relation to various practices were analysed.

Findings indicated that about 75.0% used cloths as their hygiene protection during menstruation and only 7.9% (14.0% among general population⁴¹) used sanitary napkins. Lack of resources was a major constraint, as they need to spend significant amount on sanitary napkins.⁴¹ Cloth can be hygienic if managed appropriately; but due to lack of time, and privacy, and inaccessibility to water, toilets, soap, and storage places, more often resulted in unhygienic management of menstruation, which in turn, might cause reproductive morbidity.⁴²

Over 50.0% of FSWs had sex during menstruation, which is associated with Chlamydia¹¹ and longer/heavier bleeding patterns.¹² It also enhances the risk of contracting STIs. Douching was practised by 55.0% of FSWs to enhance the clients' sexual pleasure by creating a feeling of cleanliness and "readiness" for sex.¹³ Use of aerated cola drinks for vaginal douching has been reported.⁴³ Vaginal douching increases the risk of pelvic inflammatory disease, ectopic pregnancy, cervical cancer, endometritis and upper genital tract infection.¹⁴⁻¹⁵

Menstrual suppression was practised by about 30.0% of FSWs and only 20.0% of it was with appropriate prescription. Oral contraceptive pills used for menstrual suppression causes pelvic pain, bloating and severe headaches¹⁹ and decreases vaginal acidity, facilitating infection.²⁰ Suppression was also associated with increased health care seeking behaviour in the present study.

About 50.0% of FSWs, who were pregnant earlier, did not receive antenatal care, FFA tablets, and tetanus vaccinations due to lack of awareness. Over 90.0% of FSWs breast-fed their child exclusively for 3.6 months with a total duration of 6.3 months. This is below the WHO recommendation of exclusive breast-feeding for at least 6 months and continuation for 2 years or more. Because FSWs cannot afford to stay away from their work for long, their breastfeeding was inadequate. At least one episode of gynaecological morbidity was reported by 61.9% of FSWs. However, only 14.4% sought care from government and private facilities.

A third of FSWs aborted once or more times in the past. Due to criminalisation of their occupation, financial constrains, and increased frequency of the conception rates, they were

constrained to opt for cheap and unsafe abortions from less than fully qualified practitioners. Over 40.0% had abortion at their own or traditional healers' homes and from less than fully qualified practitioners. Several unsafe methods of abortion such as consumption of sesame seed juice, and papaya were reported. One FSW even reported use of 'stick dipped in milk'. They appeared to be totally ignorant of the hazards of unsafe abortion practices. The most frequent complications of unsafe abortions have been reported to be incomplete abortion, sepsis, haemorrhage and intra-abdominal injury, such as puncturing or tearing of the uterus.⁴⁴ Long-term health problems caused by unsafe abortion are chronic pelvic pain, pelvic inflammatory disease, tubal blockage and secondary infertility. Such problems limit their productivity, constrain their ability to care for children, and adversely affect their sexual and reproductive lives.⁴⁵ Condom use with clients was 87.0% and with partners was 62.0%. Although they practiced safe sex with clients, they may have sexual/reproductive morbidity due to unprotected sex with partners.

In conclusion, results presented here provided evidence to government programmes and NGOs to come out of their narrow focus concerning the sexual health of female sex workers. The concern is not as much about the sex workers' well-being, but the protection of society from 'dangerous infections' that sex workers are capable of spreading. Hygienic menstrual practices, use of contraception, access to safe abortion services and pregnancy care need to receive adequate attention.

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