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The Role of a Regular Sex Partner in Sexually Transmitted Infections and Reinfections: Results From the Study of Female Entertainment Establishment Workers in the Philippines

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Abstract

Objective—The main objective of this study is to understand the association between living with a regular sex partner, risk-taking behaviors, and one's history of sexually transmitted infections (STIs).

Methods—Data on sexual behavior and STI histories were obtained from 876 Filipina entertainment establishment workers (FEEWs) through a large-scale participatory research survey.

Results—About one-third of FEEWs live with a regular sex partner. Single FEEWs are significantly more likely than partnered FEEWs to engage in commercial sex. Being single, engaging in commercial sex, and using condoms inconsistently, in turn, are significantly associated with a positive STI history.

Conclusion—These results suggest that living with a regular sex partner is an independent and protective factor against having an initial STI and subsequent reinfection. Programmatic strategies aimed at reducing STIs among entertainment establishment workers through promoting safer sex behaviors could potentially benefit by including a component that addresses sexual networks.

Female sex workers have played a major role in the spread of HIV in Southeast Asia.¹ As legal pressures escalate and as customers perceive this pressure, commercial sex-related activity is transitioning out of the brothels. This then encourages greater numbers of entertainment-based workers, also known as indirect sex workers, to operate in entertainment venues such as beer gardens, bars, nightclubs, karaoke TV centers, massage parlors, or disco dance establishments.² Their main work is not paid sex, but several researchers have studied the risky sexual behaviors of these workers such as excessive commercial sex contacts with inconsistent condom use.^{3–5} Increasing attention has been directed to the roles of their sex partners in STI and HIV contraction.⁶ Yet, it is not clear whether having a regular sex partner is associated with risky sexual behaviors and acquiring sexually transmitted infections (STIs).

Several behavioral characteristics may increase the likelihood of having an STI for female entertainment-based workers living with a regular sex partner. They are more likely to have unprotected sex with their regular sex partner than their casual partner or client.^{7–9} These

women are at increased risk of infection if their partner is an injecting drug user and/or engages in bisexual relations^{5,10,11} In addition, age, education level, income, and some sex work-related characteristics are associated differentially with partner status and in turn are associated with sexual and protective behaviors; consequently, affecting sexual health outcomes among these women.^{10,12–19}

Although research demonstrates that repeated STIs facilitate HIV and AIDS contraction through several biologic mechanisms,^{20,21} most existing studies have focused on the acquisition of an STI for female entertainment-based workers using cross-sectional data. The current study uses an 8-month retrospective STI medical history from Filipina entertainment establishment workers (FEEWs) to increase our understanding to STI reinfections. The main objective of this analysis is to explore the association between living with a regular sex partner and STI history (STI and reinfection) in an establishment sample of female workers. That is, conceptually, living with a regular sex partner is the focal independent variable associated with the focal dependent variable, STI history. This relationship is hypothesized and explained, in part, by a set of variables that characterize sexual and protective behaviors, which in turn are associated with STI history.

Methods

Study Population

FEEWs are conventionally referred to as *guest relation officers*.⁴ Unlike street or brothel-based sex workers, these women are indirect sex workers who predominantly host or entertain male customers within the confines of an entertainment establishment by serving drinks, carrying on conversations, or other similar nonsexual activities. FEEWs primarily receive small salaries and/or commissions based on the quantity of food and drinks ordered as well as the number of hours they spend with customers. The FEEWs working at night clubs, disco bars, beer gardens, and karaoke bars usually negotiate the sexual activities which take place off-premise, whereas commercial sex is sometimes an immediate follow-up to a massage by FEEWs who are *masahistas* (a female masseur in the Philippines) working in a massage parlor. These negotiated sexual activities of FEEWs, unfortunately, often expose them to extraordinary risks of STI/HIV, which is likely to contribute to the epidemic spread of STIs, particularly HIV through the direct effects of these activities and through acquiring ulcerative STIs, which facilitate HIV transmission.²²

STI Testing

A local ordinance in the city of our study site requires all FEEWs to be registered and undergo free STI examinations on a routine basis in Social Hygiene Clinics (SHCs).²³ Clinic data were used to determine the prevalence of STI. Clinic staff determined the presence of STI infections through wet-mount microscopy and Gram staining. An STI was defined as any of the following diagnoses as recorded by the SHC medical officials: *Neisseria gonorrhea*, bacterial vaginosis, *Trichomonas vaginalis*, or mucopurulent cervicitis.

Questionnaire and Interview Procedure

Researchers from the University of the Philippines and UCLA jointly developed a structured sociobehavioral questionnaire on FEEWs.²³ The survey consisted of 134 items and obtained basic demographic data and information on sexual behaviors. All instruments were in Tagalog and then back translated into English, with over 98% agreement. Fifty-one trained interviewers conducted face-to-face interviews with FEEWs at the SHCs, entertainment establishments, and women's residences. Personal interviews were conducted in the native dialect, Tagalog, with FEEWs and the response rate was over 98%.

Data

The current study is based on secondary data analysis of the baseline assessment collected in 1994 to 1995. The methodology of the larger retrospective panel longitudinal study has been described elsewhere.^{23,24} Briefly, all entertainment establishments were selected in 4 islands (southern Luzon, Cebu, Ilo-Ilo, and northern Mindanao) of the southern Philippines. Sites with few ongoing HIV/AIDS prevention programs were selected and each of the surveyed communities has a SHC. Although a longitudinal panel survey was conducted to evaluate the effectiveness of the structural interventions,^{23,24} sociobehavioral risk information was captured at the baseline assessments. The current analyses, thus, only used data that included face-to-face interviews with FEEWs and their retrospective SHC records. Among these FEEWs, only those who reported being sexually active and participated in both the baseline survey and the STI screening program in a SHC were included in this study. This selection yielded a total of 876 FEEWs in the current analyses.

The questionnaires, procedures, and individual consent forms were approved by both the UCLA Office for the Protection of Research Subjects and the University of the Philippines Human Subject Protection Committee. Informed consent also allowed investigators access to laboratory results of all SHC visits.

Measurement

The outcome variables for this analysis were *STI history*, ever having an infection, and subsequent reinfection over an 8-month period. According to medical records, STIs included chlamydia, syphilis, gonorrhea, and other STIs. The outcomes were coded dichotomously, where women found to have an STI were coded as $Y = 1$ and $Y = 0$ otherwise. Reinfection was defined as being diagnosed with another infection at least 1 month after the first one identified, 1 = reinfected and 0 = no.

The focal independent variable for our study was whether a FEEW had a *regular sex partner* (defined as either a husband or boyfriend). Other independent variables of interest were sexual and protective behaviors. A measure of *commercial sex engagement* was based on information from several questions about sex work-related activities. Respondents were asked, "In the past month, did you work at a job where people pay to have sex with you?" Respondents who indicated yes were asked to specify with whom they usually had sex. From these questions, commercial sex engagement was coded into 4 categories: (1) none, (2) Filipinos only, (3) foreign customers only, and (4) both Filipinos and foreigners. This polytomous variable was entered into the regressions as a set of dummy variables with "Filipinos only" as the omitted reference category. A measure related to *consistent condom use* was based on the following question, "How often do you use condoms when you have vaginal sex?" Responses with a 5-point scale ranged from never to always. Consistent condom users were individuals who reported always using condoms and were coded as 1; inconsistent condom use included other responses (never, occasionally, somewhat often, and very often) and was coded as 0.^{25,26} Finally, *ever using condoms with a client* was measured dichotomously. Additional control variables, namely, sociodemographic characteristics (i.e., age and educational attainment) and sex work background (i.e., weekly wage through establishment work, work duration, and occupation) were included in the model.

Analyses

Analyses were conducted by STATA version 8.2.²⁷ Univariate tabulations were conducted to characterize the distribution of the FEEW sample population. Bivariate analyses with χ^2 tests presented group differences in sexual-risk behaviors between FEEWs with and without a regular sex partner. To address our research questions, we further employed 2 related multivariate analyses. First, we investigated the partner status effects on protective behaviors

(consistent condom use and ever putting condoms on a client), controlling for individual sexual practice and sociodemographic characteristics. Due to binary outcomes 2 separate logistic regression models were estimated. For the second analyses, we examined the effects of partner status and sexual and protective behaviors on the odds of ever having had a STI or a subsequent infection, adjusting for individual sociodemographic characteristics; again, logistic regressions were employed.

Individual sociodemographic variables were hypothesized to operate as confounding variables in the relationship between partner status and protective behaviors and STI history.^{10,12–19} Individual socioeconomic status consisted of various social variables and variables such as education, income, and occupation were hypothesized to influence individual sexual behaviors and subsequent sexual health but through different social pathways.^{13–16,18} In analytical models all these individual characteristics were retained even though wage and educational attainment variables were positively correlated with each other ($r = 0.22$). All analyses were computed using robust standard errors, which accounted for the clustering of respondents within establishments. *P* values at 0.05 or less were considered statistically significant.

Our data included 8-month retrospective assessments of STIs. Conceptually, survival analyses were appropriate to address the effects of explanatory variables of interest on having an STI and repeated infection. Instead, we used logistic regression models with binary outcomes of STI history variables for 3 reasons related to the problems with appropriateness of capturing an STI occurrence in a *standard* timeframe for each of FEEWs. First, employment at entertainment establishments was somewhat tentative where FEEWs may leave and return back to work from time to time. Second, SHC visit schedules for FEEWs differed across their work establishments; some had weekly routines and others had bimonthly schedules. Third, when individual medication-taking information was not available, incomplete cure of an STI may have been misclassified as a reinfection.

Results

Sociodemographic Characteristics

As shown in Table 1, the sample consisted of 31% entertainers, 32% dancers, 29% massage parlor workers, and 9% in “other” entertainment business occupations. Thirty-seven percent of FEEWs were between ages 21 and 25, 31% were over 26, and 32% were 20 or younger. Forty percent of the sample had 7 to 9 years of schooling, and 17% had only 6 or fewer years of schooling; 43% had over 9 years of schooling. Twenty-nine percent of FEEWs reported a weekly wage of less than 500 pesos (approximately \$19 USD) while 53% reported a weekly wage of greater than 1000 pesos (approximately \$38 USD). Over 70% of the FEEWs in our study had been employed in their current establishments for less than 1 year.

The partnered FEEWs were significantly older (relatively concentrated around ages 21–25), employed longer at their current establishments, and more likely to work as a dancer or *masahista* compared to the single FEEWs. FEEWs with a regular sex partner were less likely to engage in commercial sex with foreign clients and were also less likely to have an STI during the data collection period. Educational attainment, weekly wages, protective behaviors (consistent condom use and ever put condoms on clients), and STI reinfections did not differ by partner status at the 0.05 significance level.

Sexual and Protective Behavior

Over 70% of FEEWs reported engaging in commercial sex. Less than one-third of FEEWs used condoms consistently and about half reported ever using condoms with a client. Both

of these protective behaviors did not significantly differ by partner status (Table 2). However, controlling for individual sociodemographic characteristics, FEEWs who engaged in commercial sex with foreign clients only were more likely to practice protective behaviors compared to those who had sexual relations with local clients only. Specifically, FEEWs with foreign clients were almost twice as likely to practice safe sex (OR = 1.86; 95% CI 1.06–3.24) and 3 times as likely to put condoms on their clients (OR = 3.31; 95% CI 1.48–7.40) in comparison to those FEEWs who typically engaged in sex with local clients.

Sexually Transmitted Infection and Reinfection

STI history was significantly different for FEEWs by partner status (Table 3). Living with a regular sex partner was protective of ever having an STI (OR = 0.66; 95% CI 0.49–0.89) and subsequent infection (OR = 0.69; 95% CI 0.48–0.99), adjusting for sexual and protective behavior and individual sociodemographic characteristics. In addition to sexual and protective behaviors, commercial sex activity was significantly associated with STI history; as the likelihood of engaging in commercial sex increased, so did the odds of ever having an STI and reinfection. Women who consistently used condoms had significantly lower odds of ever having an STI (OR = 0.72; 95% CI 0.51–0.99), but did not differ for the risk of reinfection. Interestingly, the odds of having a positive STI history were significantly lower among FEEWs aged 21 to 25 than those aged 20 years or younger although educational attainment, work duration, and occupation did not have significant associations with sexual history.

Discussion

This study suggests that living with a regular sex partner is associated with a significantly decreased likelihood of having an STI and repeated infection. Specifically, FEEWs who lived with a regular sex partner were less likely to ever have an STI or acquire a reinfection with odds around 31% to 33% lower than women without a regular sex partner. The direction of the association between STI history and partner status is contrary to what may be expected in light of the correlation between partner status and risk factors for STI history. One possible explanation for the association between partner status and STI history among these FEEWs is that partnered women may be more *faithful* to their relationship than single women. In a separate multivariate analysis, we found that women who lived with a regular sex partner had lower odds of commercial sex engagement than those who did not (OR = 0.62; 95% CI: 0.42–0.90; $P = 0.01$). Several studies suggest that a sexually conservative culture and a certain level of social cohesion ensures sexual discipline in the Philippines, which may contribute to practicing less riskier sexual behaviors of partnered FEEWs as well as the low HIV prevalence rate in the Philippines.²⁸

The finding that reinfection is significantly associated with partner status but not consistent condom use raises a legitimate question about the argument of a “behavioral surrogate” for STI incidence.²⁹ Even though consistent condom use decreased the odds of ever having an STI in this analysis and other studies,^{26,29} to reduce STI and HIV contraction it is important to pay attention to reinfection as well as consistent and correct condom use.^{24,30} In additional analyses, we found that among 65 FEEWs who reported having a condom fall off inside the vagina during sexual intercourse, 46% had a STI, as compared to 33% of women who did not have a condom fall off. Similarly, 23% of FEEWs who ever had a condom fall off during sexual intercourse had a repeated STI, as compared to 20% of women who did not. We were unable to investigate this effect on accurate condom use in multivariate analyses because one-third of respondents ($n = 292$) had missing information about the appropriate usage of condoms. It remains to be shown by future research how appropriateness of condom use is related to STI outcomes.

Not surprisingly, these results indicate that STI reinfection was strongly associated with commercial sex involvement.^{19,31} Consistent with a previous study,³² we found that FEEWs who had commercial sex with foreigners only seemed less likely to have an STI and reinfection when compared with those who had sex with local clients as this relationship was not statistically significant. Reinfection with an STI represents a failure of primary and secondary prevention activities, suggesting a need for the prevention work in clinic or community setting to be reinforced and enhanced. In particular for establishment-based sex workers who engaged in commercial sex, potential strategies include directing intensive interventions such as counseling, health education, and condom promotion as well as introducing proactive follow-up assessments. Also, initiating intensive partner notification involves social and sexual network information. Identifying and targeting high-risk groups within the sexual network context, that is, those who repeatedly have an STI, may be another effective strategy for controlling the spread of STIs.

Although our research provides new information regarding the relationship between partner status and history of STD in an establishment sample of FEEWs, there are still several limitations to this study. First is the problem of underestimating STIs. The STI status of FEEWs in this study does not include other potential private sources of medical examination, such as private physicians or other clinics. In separate analyses, we also found that the likelihood of a FEEW attending her scheduled SHC visits was approximately 65% during the 8-month study periods. It seems likely that FEEWs may have had STIs diagnosed in clinics other than the SHCs used in this study leading to an underestimation of infections and/or reinfections. However, we do not anticipate this being a large concern as the majority of FEEWs was hypothesized to use the free SHC as a source of screening and diagnosis. Another concern is simple laboratory microscopic tests in STI testing. Some evidence has demonstrated that microscopic diagnosis is about 60% to 70% sensitivity. Again, this would mean that STIs might have been underestimated in this study. Although it may be challenging, for countries such as Philippines that use STI surveillance and treatment as a means to stave off a HIV epidemic, it is essential to use methods to detect STIs effectively.

Second is the problem of endogeneity between partner status and individual sexual and protective behaviors. Cross-sectional studies cannot disentangle issues of simultaneous causation. Third, although we controlled for sociodemographic factors, we were not able to control for some important partner-related characteristics such as partner's age, education, and risky sexual practices; nor were we able to control for couple dynamics and sexual experiences. STI and reinfection may be associated with factors along sexual networks, which are also associated with partner status.³¹ Fourth, we excluded about one-fifth of establishment-based FEEWs who never attended a STI screening program. When compared with the distribution in our analytical sample, women excluded were less likely to live with a regular sex partner (26%) and engage in commercial sex (41%). They also tended to be younger and more educated. If the rate of infection was extremely high among the women excluded from the analysis, then our results may be biased. Lastly, because women were asked to respond to questions about sexual activities that are private, social desirability may occur. A previous study has validated the effect of social desirability on self-reported condom use.²⁶

In sum, we found that living with a regular sex partner was significantly protective against an STI and reinfection. To our knowledge, this is the first report of a negative association between living with a regular sex partner and acquiring an STI or reinfection among establishment-based workers. The findings imply that programmatic strategies aimed at reducing and controlling STIs among FEEWs would be better to consider a component that addresses sexual partnerships and networks. For example, such programs incorporate strategies that improve a FEEW's understanding to her relationship characteristics and

further promote healthy sexual lives. Given that FEEWs who were single also report risky sexual behaviors, it would be better for program planners to be aware of the associations between multiple individual and relationship factors and accordingly adopt a comprehensive framework aimed at promoting healthy sexual relationship and reducing risky sexual practices. Future research is needed to gain a better understanding of this association in a broader sexual relationship context.

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TABLE 1

Sociodemographic Characteristics, Self-Reported Sexual and Protective Practices, and History of STI and Reinfection Among Filipina Entertainment Establishment Workers Living With and Without a Regular Sex Partner

Variable	Sex Partner Status		Total (N = 876)
	Living With a Regular Sex Partner (N = 289)	Not Living With a Regular Sex Partner (N = 587)	
Socioeconomic characteristics (%)			
Age category (yr)			
≤20	26.30	35.09	32.19
21–25	38.06	36.29	36.87
26–54	35.64	28.62	30.94
Years of schooling			
≤6	19.38	16.18	17.24
7–9	39.45	40.37	40.07
10–11	35.29	33.73	34.25
≥12	5.88	9.71	8.45
Weekly wage in pesos			
≤500	28.72	29.64	29.34
501–1,000	17.65	17.89	17.81
1,001–1,500	24.91	23.17	23.74
≥1,501	28.72	29.30	29.11
Work duration in months			
≤3	19.03	31.35	27.28
4–6	24.91	21.98	22.95
7–12	22.84	21.98	22.26
≥13	33.22	24.70	27.51
Occupation			
Hospitality girl	22.49	34.92	30.82
Dancer	37.02	29.64	32.08
Masahista	33.22	26.24	28.54
Other*	7.27	9.20	8.56
Sexual and protective practices (%)			
Self-reported commercial sex			
Engaged in none	31.83	28.79	29.79
Engaged with local clients only	41.18	40.20	40.53
Engaged with foreign clients only	4.50	9.88	8.11
Engaged with both local and foreign clients	22.49	21.12	21.58
Consistent condom use	30.45	31.69	31.28
Ever put condoms on clients	53.63	51.28	52.05
STI histories (%)			
Ever had an STI [†]	33.22	41.40	38.70
Ever had a reinfection	14.53	18.40	17.12

Variable	Sex Partner Status		Total (N = 876)
	Living With a Regular Sex Partner (N = 289)	Not Living With a Regular Sex Partner (N = 587)	
Total	32.99	67.01	100.00

Percentage may not add up to 100 due to rounding.

* Other occupations included waitress and receptor.

[†] An STI was defined as any of the following diagnoses as recorded by the SHC medical officials: *Neisseria gonorrhea*, bacterial vaginosis, *Trichomonas vaginalis*, or mucopurulent cervicitis.

TABLE 2

Percentage, Adjusted Odds Ratio (AOR) and 95% CI for Regular Sex Partner Status, Sexual Practice, and Sociodemographic Characteristics Associated With Protective Behaviors Among Filipina Entertainment Establishment Workers

Variable	Consistent Condom Use		Ever Put Condoms on Clients	
	%	AOR	%	95% CI
<i>Main explanatory variables</i>				
Sex partner status				
Not living with a regular sex partner (reference)	31.69	—	51.28	—
Living with a regular sex partner	30.45	0.89	53.63	1.11 (0.77–1.59)
Self-reported commercial sex				
Engaged with local clients only (reference)	35.21	—	62.54	—
Engaged in none	3.45	0.08*	6.90	0.05* (0.02–0.10)
Engaged with foreign clients only	52.11	1.86*	74.65	3.31* (1.48–7.40)
Engaged with both local and foreign clients	54.50	1.52	86.24	3.44* (1.99–5.96)
<i>Sociodemographic characteristics</i>				
Age (yr)				
≤20 (reference)	31.56	—	43.97	—
21–25	32.51	0.99	53.25	1.55 (1.00–2.42)
26–54	29.52	0.54*	59.04	0.92 (0.55–1.53)
Years of schooling				
≤6 (reference)	25.83	—	56.29	—
7–9	30.48	1.17	47.58	0.60 (0.34–1.08)
10–11	32.67	1.21	55.33	1.06 (0.58–1.94)
≥12	40.54	2.13	51.35	0.62 (0.27–1.43)
Weekly wage in pesos				
≤500 (reference)	21.79	—	47.08	—
501–1,000	14.74	0.77	29.49	0.63 (0.37–1.08)
1,001–1,500	40.38	2.04*	61.06	1.97* (1.11–3.46)
≥1,501	43.53	1.90*	63.53	1.61 (0.82–3.16)
Work duration in months				
≤3 (reference)	25.10	—	37.24	—

Variable	Consistent Condom Use			Ever Put Condoms on Clients		
	%	AOR	95% CI	%	AOR	95% CI
4-6	28.86	1.08	(0.65-1.80)	43.78	1.13	(0.69-1.85)
7-12	32.31	1.05	(0.61-1.82)	54.87	1.75*	(1.08-2.84)
≥13	38.59	1.25	(0.81-1.93)	71.37	3.00*	(1.56-5.80)
Occupation						
Hospitality girl (reference)	14.07	—	—	30.37	—	—
Dancer	35.23	1.73	(0.93-3.21)	50.18	1.08	(0.57-2.07)
Masahista	52.00	4.05*	(1.98-8.29)	87.20	9.65*	(4.55-20.44)
Other	9.33	1.26	(0.50-3.12)	20.00	1.46	(0.67-3.20)

* $P \leq 0.05$.

Percentage, Adjusted Odds Ratio (AOR) and 95% CI for Regular Sex Partner Status, Sexual and Protective Practices and Sociodemographic Characteristics Associated With History of STI and Reinfection Among Filipina Entertainment Establishment Workers

TABLE 3

Variable	Ever Had an STI			Ever Had a Reinfection		
	%	AOR	95% CI	%	AOR	95% CI
<i>Main explanatory variable</i>						
Sex partner status						
Not living with a regular sex partner (reference)	41.40	—	—	18.40	—	—
Living with a regular sex partner	33.22	0.66*	(0.49–0.89)	14.53	0.69*	(0.48–0.99)
<i>Sexual and protective practices</i>						
Self-reported commercial sex						
Engaged with local clients only (reference)	42.54	—	—	21.13	—	—
Not engaged	29.50	0.59*	(0.35–0.99)	8.43	0.39*	(0.19–0.81)
Engaged with foreign clients only	36.62	0.76	(0.35–1.64)	14.08	0.62	(0.26–1.47)
Engaged with both local and foreign clients	44.97	1.12	(0.72–1.75)	22.75	1.02	(0.59–1.77)
Consistent condom use	37.96	0.72*	(0.51–0.99)	19.34	0.81	(0.51–1.27)
Inconsistent usage (reference)	39.04	—	—	16.11	—	—
Ever put condoms on clients	42.32	1.19	(0.75–1.88)	21.93	1.42	(0.79–2.55)
Never put condoms on clients (reference)	34.76	—	—	11.90	—	—
<i>Sociodemographic characteristics</i>						
Age (yr)						
≤20 (reference)	42.55	—	—	18.44	—	—
21–25	30.96	0.59*	(0.40–0.87)	13.62	0.58*	(0.38–0.89)
26–54	43.91	0.94	(0.58–1.51)	19.93	0.74	(0.41–1.31)
Years of schooling	38.41			19.21		
≤6 (reference)						
7–9	39.89	1.08	(0.68–1.72)	13.68	0.71	(0.38–1.31)
10–11	37.67	1.05	(0.65–1.69)	19.33	1.14	(0.64–2.05)
≥12	37.84	1.09	(0.55–2.16)	20.27	1.29	(0.57–2.89)
Weekly wage in pesos	42.02			18.29		
≤500 (reference)						

Variable	Ever Had an STI			Ever Had a Reinfection		
	%	AOR	95% CI	%	AOR	95% CI
501–1,000	41.67	1.07	(0.70–1.63)	18.59	1.24	(0.72–2.12)
1,001–1,500	33.65	0.64*	(0.43–0.97)	13.94	0.64	(0.34–1.19)
≥1,501	37.65	0.78	(0.50–1.21)	17.65	0.81	(0.46–1.42)
Work duration in months						
≤3 (reference)	37.24	—	—	13.81	—	—
4–6	35.82	0.96	(0.66–1.40)	16.42	1.24	(0.67–2.31)
7–12	37.44	0.96	(0.65–1.43)	15.90	1.13	(0.65–1.98)
≥13	43.57	1.21	(0.75–1.94)	21.99	1.57	(0.90–2.72)
Occupation						
Hospitality girl (reference)	35.19	—	—	13.33	—	—
Dancer	40.21	1.42	(0.84–2.41)	16.37	1.30	(0.69–2.46)
Masahista	43.20	1.26	(0.71–2.24)	23.20	1.42	(0.68–2.94)
Others	30.67	1.07	(0.57–2.01)	13.33	1.45	(0.66–3.22)

* $P \leq 0.05$; Percentage may not add up to 100 due to rounding.