Published in final edited form as:

Int J Gynaecol Obstet. 2012 May ; 117(2): 173–177. doi:10.1016/j.ijgo.2011.12.019.

Sex trade among young women attending family-planning clinics in Northern California

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Abstract

Objective—To describe the prevalence and nature of sex trade in a clinic-based sample of young women and to evaluate associations with sexual and reproductive health.

Methods—A cross-sectional survey was conducted with women aged 16–29 years (n=1277) presenting to family-planning clinics in Northern California, USA.

Results—Overall, 8.1% of respondents indicated a lifetime history of trading sex for money or other resources. Sex trade was associated with unintended pregnancy (adjusted risk ratio [ARR] 1.27; 95% confidence interval [CI], 1.09–1.48), multiple abortions (ARR 1.63; 95% CI, 1.19–2.23), STI diagnosis (ARR 1.46; 95% CI, 1.27–1.68), and unwanted sex (vaginal ARR 3.64; 95% CI, 2.39–5.56; anal ARR 4.99; 95% CI, 2.17–11.50). Of the women ever involved in sex trade, 12 (37.3%) reported that their first such experience was before they were 18 years of age.

Conclusion—Approximately 1 in 12 participants had been involved in sex trade, illustrating the presence of patients with this history within the family-planning clinical setting. Sex trade was associated with multiple indicators of poor sexual and reproductive health. Family-planning clinics may represent an underused mechanism for engaging this high-risk population.

Keywords

Reproductive health; Sex trade; Sexual risk; STI/HIV; Unintended pregnancy; Violence

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Conflict of interest

The authors have no conflicts of interest.

1. Introduction

Women who trade sex for money, drugs, and other resources consistently demonstrate health concerns spanning substance use, mental health problems, violence, and sexually transmitted infection (STI)—including HIV [1-4]. These complex intersections are likely to reflect an interaction and accumulation of social vulnerability. Research to date has used varied terms for the experience, including transactional sex [5,6], survival sex [7], sex trade [8,9], sex work [10,11], and prostitution [2,12]. The current article takes a behavioral focus and uses the overarching umbrella of “sex trade,” while acknowledging the range of underlying experiences with regard to context, degree of formality, frequency, and resources received [13].

Given the documented health risks, the dearth of clinic-based investigation of sex trade experiences is surprising. An estimated 32%-41% of women in substance use treatment report sex trade [9,12], demonstrating this population’s engagement with the healthcare system. Transactional sex has also been noted among prenatal clinic patients in South Africa [6]. Family-planning clinics represent a setting in which clinicians may encounter women involved in sex trade, given the inherent sexual risk, coupled with STI/HIV-related health concerns, among those involved [5,9,11].

Moreover, little comparative investigation has sought to compare the health of women involved in sex trade with similar women without such a history. The majority of health-related research in this area draws solely on women involved in commercial sex, prostitution, or sex work [2,14-16] and lacks a comparison group. Thus, the extent to which sex trade experiences should be considered a unique sexual and reproductive health threat remains unclear. The small body of comparative research has involved primarily high-risk samples (e.g. patients entering substance use treatment [12] and injection drug users [17]). Overall, sex trade has been associated with mental health symptoms [12], substance use [6], and violence victimization [6,9,10,18], with mixed results concerning STI/HIV [6,9,10,12,17,18]. Such investigation has not been extended to major reproductive health concerns such as unintended pregnancy and abortion.

Greater understanding of the prevalence and nature of sex trade experiences may enhance our ability to provide sensitive, informed care. If indicated, clinical settings that provide sexual and reproductive health care may serve as an access point for identification of, and engagement with, this hard-to-reach population.

The aims of the present study were to assess the prevalence of sex trade; assess associations of sex trade with sexual risk, unwanted sex, STI diagnosis and reproductive health, and clinical care seeking; and describe the nature of sex trade among those involved, among a large sample of young adult women attending urban family-planning clinics.

2. Materials and methods

A cross-sectional survey of English- and Spanish-speaking female patients in 5 freestanding family-planning clinics affiliated with Planned Parenthood in Northern California, USA, was conducted from August 1, 2008, to March 31, 2009 [19]. Upon arrival, all women were screened for age eligibility (i.e. 16–29 years). Informed consent procedures and survey administration were conducted privately. Data were collected via audio computer-assisted self-interview; participants were then screened for distress and received a local resource list and a \$15 prepaid debit card. All materials were available in English or Spanish; materials were developed in English, professionally translated to Spanish, and refined further after piloting with a range of native Spanish speakers. All procedures were approved by human

subject research committees at the University of California Davis School of Medicine, Harvard School of Public Health, and Planned Parenthood Federation of America.

All measures were self-reported. The primary exposure of interest—sex trade—was assessed via a single behavioral item (“have you ever traded sex or sexual acts in exchange for money, drugs, gifts or shelter?”), consistent with prior research [10,12,18]. All measures were pilot tested by 2 senior members of the research team; pilot testing of the sex trade item revealed that participants equated this assessment with prostitution and confirmed the presence of street-based sex workers in the sample. However, it was felt that the term “sex trade” was most appropriate to convey a broad range of potential sex trade experiences.

Single items assessed recent (past 3 months) sexual risk (multiple current sexual partnerships, multiple sex partners, anal sex); recent unwanted vaginal and anal sex (e.g. “in the past three months did you ever have anal sex when you did not want to?”); STI history, ever and in the past 3 months (i.e. “have you ever been told by a doctor or other health care professional that you had an STD, for example, Chlamydia, gonorrhea, syphilis, herpes, genital warts, Hepatitis B or crabs?”); reproductive health (number of unintended pregnancies and abortions); and clinical care seeking, including history of HIV testing, history of STI testing, multiple STI tests, pregnancy tests, and use of emergency contraception within the past 3 months. Participants indicated their reason for current clinical visit from a list of response options. Finally, participants indicating sex trade were asked a series of related items: age at first sex trade; client condom refusal; client use of violence or force for sex; history of being offered more money for unprotected sex; and, among those reporting sex trade in the past 3 months, average number of clients per week and involvement of a “pimp” (i.e. “do you share your earnings with a person who arranges clients for you or provides protection for you?”). Demographic covariates assessed included age, race/ethnicity, education level, and immigrant status.

Lifetime prevalence of sex trade was calculated; demographic differences were assessed via χ^2 analysis, with significance set at $P < 0.05$. Prevalence estimates were calculated for sexual risk, unwanted sex, STI, reproductive health outcome, and clinical care-seeking behavior, both for the total sample and based on sex trade exposure. Log-binomial regression models were used to estimate the adjusted risk ratio (ARR) and 95% confidence interval (CI) for the association of sex trade involvement with all outcomes, adjusting for age, race, nativity, and recruitment site; respondents indicating no history of sex trade involvement served as the referent group. Descriptive statistics were calculated to describe sex trade experiences among those involved.

Post hoc analyses evaluated associations of recency of sex trade with all outcomes; χ^2 analyses evaluated differences based on current (i.e. within the past 3 months) exposure to sex trade compared with past (i.e. prior to the past 3 months) involvement among those ever involved. Adjusted risk ratios and 95% CIs were estimated for the association of both past and current sex trade involvement; respondents indicating no history of sex trade involvement served as the referent group. Analyses were conducted using SAS version 9 (SAS Institute, Cary, NC, USA).

3. Results

Of the 1479 eligible women identified, 1319 (89.2%) agreed to participate. Current analyses excluded participants reporting no history of sexual activity ($n=31$) or missing data on sex trade ($n=11$), giving a final sample of 1277.

The prevalence of lifetime history of sex trade was 8.1% (Table 1). Black women were the most likely to report such a history (13.7%; $P < 0.001$) and immigrant women were less likely

than their US-born counterparts (3.0% vs 8.9%, respectively; $P=0.004$). No differences were observed based on age or education.

Sex trade was associated with a range of risk behaviors and poor health outcomes (Table 2). Relative to those not involved, women reporting sex trade were more likely to have multiple current sex partners (18.5% vs 6.0%; ARR 3.03; 95% CI, 1.89–4.86), multiple recent partners (47.1% vs 19.4%; ARR 2.39; 95% CI, 1.88–3.04), and recent anal sex (27.5% vs 13.8%; ARR 2.05; 95% CI, 1.45–2.89). They were also significantly more likely to have experienced recent unwanted vaginal sex (23.5% vs 6.7%; ARR 3.64; 95% CI, 2.39–5.56) and unwanted anal sex (7.8% vs 1.8%; ARR 4.99; 95% CI, 2.17–11.50). Sexual and reproductive health concerns in the form of STI diagnosis (ARR 1.46; 95% CI, 1.27–1.68), unintended pregnancy (ARR 1.27; 95% CI, 1.09–1.48), multiple unintended pregnancies (ARR 1.52; 95% CI, 1.11–2.07), and multiple abortions (ARR 1.63; 95% CI, 1.19–2.23) were also more prevalent for this group.

In post hoc analysis, associations of sex trade with sexual risks, unwanted sex, and STI diagnosis were observed among participants indicating current sex trade (i.e. within the past 3 months) and those indicating a prior history of sex trade (i.e. prior to the past 3 months) (Table 2). By contrast, only recent experiences of sex trade (i.e. in the past 3 months) were associated with unintended pregnancy (ARR 1.72; 95% CI, 1.39–2.14) and multiple unintended pregnancies (ARR 1.94; 95% CI, 1.16–3.22); no heightened risk for either outcome was detected based on prior history of sex trade without recent involvement. Similarly, only recent sex trade was associated with having had an abortion (ARR 1.72; 95% CI, 1.29–2.28), with no heightened risk observed among women with a past history of sex trade.

Sex trade was associated STI/HIV-motivated clinical care seeking (35.9% vs 22.0%; ARR 1.61; 95% CI, 1.22–2.12) (Table 3). A lifetime history of HIV testing was also more common among this group (92.1% vs 72.4%; ARR 1.09; 95% CI, 1.03–1.16). Women involved in sex trade were more likely to have visited the clinic multiple times in the past 3 months for STI testing (11.0% vs 5.1%; ARR 2.13; 95% CI, 1.11–4.07) and for pregnancy testing (21.0% vs 13.8%; ARR 1.66; 95% CI, 1.11–2.49).

Among those reporting sex trade ($n=103$; Table 4), 12 (37.3%) indicated that their first such experience was before they were 18 years of age (range, 10–29 years). Potential threats to condom-protected sex were common, with 42 (40.8%) reporting being offered more money for unprotected sex and 31 (30.1%) reporting a history of client condom refusal. Client violence or use of force to obtain sex was reported by 17 (16.5%). Thirty-one (30.1%) indicated that they had traded sex within the 3 months prior to the survey. Of these respondents, pimp involvement was reported by 5 (16.1%).

4. Discussion

Approximately 1 in 12 (8.1%) of the young women in the present family-planning clinic-based sample reported having traded sex for money or other resources, illustrating the presence of patients with such a history in this setting. Sex trade implied risk for multiple indicators of poor sexual and reproductive health, including recent unwanted vaginal and anal sex. Those involved in sex trade were more likely to present for STI/HIV concerns and to report multiple recent visits for pregnancy and STI testing. The current findings advance the small but growing body of comparative research indicating the major health threats associated with sex trade [5,6,9,10,12,18]. Moreover, they demonstrate the relevance of sex trade experiences to a range of sexual and reproductive health concerns.

Women involved in sex trade have long been recognized as a population at risk of STI/HIV; findings of elevated risk for STI and sexual risk behavior (e.g. anal sex) confirm these concerns. Advancing the knowledge base, the evidence illustrates heightened risk for multiple unintended pregnancies and abortions based on sex trade. Recent evidence from other settings demonstrates unmet reproductive healthcare needs among women in sex work [20,21]. Together, these data strongly indicate that the historic focus on STI/HIV among women in sex work may overlook significant reproductive health needs for this population.

Sex trade conferred risk for violence and coercion, with those involved demonstrating a 3- to 4-fold heightened risk for unwanted sex. Within the context of sex trade, violence, forced sex, and condom-related coercion (i.e. client condom refusal and being offered more money for unprotected sex) were common, echoing prior evidence of high levels of violence against women in sex work [3,4]. Findings indicate significant threats to women's ability to protect and prioritize their sexual and reproductive health by compromising their agency (i.e. their ability to assert their preferences concerning how and when sex occurs, and with what protection). Finally, more than one-third of women involved indicated that their first such experience was before the age of 18, adding to previous work demonstrating youth among those in sex trade [22].

The current evidence of young women with a sex trade history in family-planning clinics holds clinical implications. This setting may be a venue for identifying and engaging this hard-to-reach population for clinical and social services. To date, physicians report feeling inadequate in responding to the needs of those in sex trade [23], and those involved are often reluctant to initiate disclosure [24]. Prior research with women in street-based prostitution indicates that sensitive acknowledgment of sex trade seems to be both acceptable and welcomed [14], and stigma and fear of judgment can pose barriers to accessing needed services and obtaining follow-up care [14,16]. Thus, nonstigmatizing provider acknowledgment and discussion of sex trade may facilitate patient adherence and, subsequently, improve health outcomes for this vulnerable population. Given the stigma associated with sex trade, particularly street-based sex work [4,14,16], the need for sensitivity cannot be overstated.

Several limitations should be noted. The single-item behavioral sex trade assessment suffered the central limitation affecting comparative work in this area—that is, positive responses may reflect a variety of qualitatively different experiences, ranging from single instances of sex trade for material goods to established patterns of trading sex for money or drugs. The pilot phase confirmed the presence of street-based sex workers in the sample and participants' interpretation of this item as sex work; some participants may have interpreted it as receiving freely offered financial or material support in an ongoing sexual relationship. Similarly, the term "unwanted sex" is likely to reflect a broad range of experiences. Foregone care has been documented among women in street-based prostitution [14,15]; the present clinic-based sample may not be generalizable to broader populations of women in sex work. Pimp-controlled women have reported limited ability to access services [4]; thus, the observed prevalence of pimp involvement should be interpreted with caution. Several relevant health outcomes were not assessed; further research should include complete physical and mental health assessments, and integrate clinical indicators (e.g. STI/HIV test results). Further research is needed to understand better the racial/ethnic disparities observed, as well as those related to immigrant status. Finally, the present study was conducted in a singular geographic region; further work should explore the potential for regional variation across associations identified.

A high prevalence of sex trade was identified among young women in the present sample, with approximately 1 in 12 participants reporting such a history. Sex trade, both past and

recent, was associated with increased risk for multiple indicators of poor sexual and reproductive health, including unintended pregnancy, unwanted sex, and abortion. The current findings underscore the need to identify and assist women involved in sex trade with regard to health issues such as STI/HIV, as well as reproductive health issues, and they highlight the potential value of such efforts within the family-planning clinical setting.

Acknowledgments

E.M. and J.G.S. received funding from the National Institute of Child Health and Human Development (R21 HD057814-02). M.R.D. received funding from Harvard University Center for AIDS Research (HU CFAR NIH/NIAID fund P30-AI060354). E.M. received a University of California Davis Health System Research award and a Building Interdisciplinary Research Careers in Women's Health award (BIRCWH, K12 HD051958; National Institute of Child Health and Human Development, Office of Research on Women's Health, Office of Dietary Supplements, National Institute of Aging).

References

- [1]. Rekart ML. Sex-work harm reduction. *Lancet*. 2005; 366(9503):2123–34. [PubMed: 16360791]
- [2]. Farley M, Cotton A, Lynne J, Zumbek S, Spiwak F, Reyes ME, et al. Prostitution & trafficking in nine countries: an update on violence and post-traumatic stress disorder. *J Trauma Practice*. 2003; 2(3):33–74.
- [3]. Dalla RL, Xia Y, Kennedy H. "You just give them what they want and pray they don't kill you": street-level sex workers' reports of victimization, personal resources and coping strategies. *Violence Against Women*. 2003; 9(11):1367–94.
- [4]. Nixon K, Tutty L, Downe P, Gorkoff K, Ursel J. The everyday occurrence: violence in the lives of girls exploited through prostitution. *Violence Against Women*. 2002; 8(9):1016–43.
- [5]. Dunkle KL, Wingood GM, Camp CM, DiClemente RJ. Economically motivated relationships and transactional sex among unmarried African American and white women: results from a U.S. national telephone survey. *Public Health Rep*. 2010; 125(Suppl 4):90–100. [PubMed: 20626196]
- [6]. Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntyre JA, Harlow SD. Transactional sex among women in Soweto, South Africa: prevalence, risk factors and association with HIV infection. *Social Sci Med*. 2004; 59(8):1581–92.
- [7]. Chettiar J, Shannon K, Wood E, Zhang R, Kerr T. Survival sex work involvement among street-involved youth who use drugs in a Canadian setting. *J Public Health (Oxf)*. 2010; 32(3):322–7. [PubMed: 20061578]
- [8]. Cavanaugh CE, Hedden SL, Latimer WW. Sexually transmitted infections among pregnant heroin- or cocaine-addicted women in treatment: the significance of psychiatric co-morbidity and sex trade. *Int J STD AIDS*. 2010; 21(2):141–2. [PubMed: 20090001]
- [9]. El-Bassel N, Simoni JM, Cooper DK, Gilbert L, Schilling RF. Sex trading and psychological distress among women on methadone. *Psychol Addict Behav*. 2001; 15(3):177–84. [PubMed: 11563794]
- [10]. Cohan DL, Kim A, Ruiz J, Morrow S, Reardon J, Lynch M, et al. Health indicators among low income women who report a history of sex work: the population based Northern California Young Women's Survey. *Sex Transm Infect*. 2005; 81(5):428–33. [PubMed: 16199746]
- [11]. Brahme R, Mehta S, Sahay S, Joglekar N, Ghate M, Joshi S, et al. Correlates and trend of HIV prevalence among female sex workers attending sexually transmitted disease clinics in Pune, India (1993-2002). *J Acquir Immune Defic Syndr*. 2006; 41(1):107–13. [PubMed: 16340482]
- [12]. Burnette ML, Lucas E, Ilgen M, Frayne SM, Mayo J, Weitlauf JC. Prevalence and health correlates of prostitution among patients entering treatment for substance use disorders. *Arch Gen Psychiatry*. 2008; 65(3):337–44. [PubMed: 18316680]
- [13]. UNAIDS. UNAIDS Guidance Note on HIV and Sex Work. http://data.unaids.org/pub/BaseDocument/2009/jc1696_guidance_note_hiv_and_sexwork_en.pdf. Published 2009
- [14]. Jeal N, Salisbury C. A health needs assessment of street-based prostitutes: cross-sectional survey. *J Public Health*. 2004; 26(2):147–51.

- [15]. Jeal N, Salisbury C. Health needs and service use of parlour-based prostitutes compared with street-based prostitutes: a cross-sectional survey. *BJOG*. 2007; 114(7):875–81. [PubMed: 17567420]
- [16]. Kurtz SP, Surratt HL, Kiley MC, Inciardi JA. Barriers to health and social services for street-based sex workers. *J Health Care Poor Underserved*. 2005; 16(2):345–61. [PubMed: 15937397]
- [17]. Spittal PM, Bruneau J, Craib KJ, Miller C, Lamothe F, Weber AE, et al. Surviving the sex trade: a comparison of HIV risk behaviours among street-involved women in two Canadian cities who inject drugs. *AIDS Care*. 2003; 15(2):187–95. [PubMed: 12856340]
- [18]. Edwards JM, Iritani BJ, Hallfors DD. Prevalence and correlates of exchanging sex for drugs or money among adolescents in the United States. *Sexually Transm Infect*. 2006; 82(5):354–8.
- [19]. Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, et al. A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. *Contraception*. 2011; 83(3):274–80. [PubMed: 21310291]
- [20]. Sutherland EG, Alaii J, Tsui S, Luchters S, Okal J, King'ola N, et al. Contraceptive needs of female sex workers in Kenya - a cross-sectional study. *Eur J Contracept Reprod Health Care*. 2011; 16(3):173–82. [PubMed: 21413869]
- [21]. Todd CS, Nasir A, Raza Stanekzai M, Scott PT, Strathdee SA, Botros BA, et al. Contraceptive utilization and pregnancy termination among female sex workers in Afghanistan. *J Womens Health (Larchmt)*. 2010; 19(11):2057–62. [PubMed: 20879869]
- [22]. Silverman JG. Adolescent female sex workers: invisibility, violence and HIV. *Arch Dis Child*. 2011; 96(5):478–81. [PubMed: 21357241]
- [23]. Khan A, Plummer D, Hussain R, Minichiello V. Does physician bias affect the quality of care they deliver? Evidence in the care of sexually transmitted infections. *Sex Transm Infect*. 2008; 84(2):150–1. [PubMed: 17974595]
- [24]. Cohan D, Lutnick A, Davidson P, Cloniger C, Herlyn A, Breyer J, et al. Sex worker health: San Francisco style. *Sex Transm Infect*. 2006; 82(5):418–22. [PubMed: 16854996]

Table 1

Demographic characteristics and associations with lifetime history of sex trade (n=1277)

	Sample, % ^a	No sex trade history, % ^b	Sex trade history, % ^b	P value
Total	100.0	91.9	8.1	
Age, y				0.139
16–19	32.1	92.9	7.1	
20–24	43.9	92.7	7.3	
25–29	24.0	89.3	10.8	
Race/ethnicity				<0.001
Black	28.1	86.4	13.7	
Hispanic	29.8	97.4	2.6	
White	22.6	91.0	9.0	
Other	19.6	92.8	7.2	
Nativity				0.004
US born	84.0	91.1	8.9	
Immigrant	16.0	97.0	3.0	
Highest level of education attained				0.181
Below high school	22.4	89.4	10.6	
High school or general equivalency diploma	34.2	92.6	7.4	
College or higher	43.4	92.9	7.1	

^a Column percentage.^b Row percentage.

Table 2
Associations of sex trade with recent sexual risk, unwanted sex, STI diagnosis, and reproductive health (n=1277)

	Any sex trade history			Timing of sex trade		
	Sample, %	No sex trade history, %	Any sex trade history, %	ARR ^a (95% CI)	Prior sex trade (prior to past 3 months), % (n=72)	Current sex trade (past 3 months), % (n=31)
Recent sexual risk (past 3 months)						
Multiple current sex partners (≥2)	7.0	6.0	18.5	3.03 (1.89–4.86)	15.3	25.8
Multiple sex partners (≥2)	21.6	19.4	47.1	2.39 (1.88–3.04)	37.5	70.0
Anal sex	14.9	13.8	27.5	2.05 (1.45–2.89)	22.5	38.7
Recent unwanted sex (past 3 months)						
Unwanted anal sex	2.3	1.8	7.8	4.99 (2.17–11.50)	5.6	12.9
Unwanted vaginal sex	8.0	6.7	23.5	3.64 (2.39–5.56)	19.4	33.3
STI						
STI diagnosis (ever)	39.1	36.4	69.6	1.46 (1.27–1.68)	67.6	74.2
Recent STI diagnosis (past 3 months)	15.1	13.6	32.7	2.28 (1.67–3.10)	31.9	34.5
Reproductive health						
Unintended pregnancy (any)	41.3	40.0	55.9	1.27 (1.09–1.48)	49.3	71.0
≥2 (vs none)	17.4	16.3	29.4	1.52 (1.11–2.07)	29.6	29.0
Abortion (any)	36.9	36.3	43.1	1.08 (0.87–1.34)	36.6	58.1
≥2 (vs none)	15.9	14.8	28.4	1.63 (1.19–2.23)	26.8	32.3

Abbreviations: ARR, adjusted risk ratio; CI, confidence interval; STI, sexually transmitted infection.

^a Adjusted for age, race, nativity, and recruitment site.

^b Small cell sizes prohibited adjusted analyses; thus, unadjusted relative risk is presented.

Table 3

Associations of sex trade with clinical care seeking (n=1277)

	Sample, %	Sex trade history, %	No sex trade history, %	ARR ^a (95% CI)
Motivation for current visit ^b				
STI/HIV related	23.1	35.9	22.0	1.61 (1.22–2.12)
General OB/GYN	50.4	58.3	49.7	1.15 (0.97–1.37)
Contraception	41.3	37.9	41.6	0.91 (0.70–1.18)
Abortion related	11.0	10.7	11.1	0.84 (0.46–1.55)
EC	8.5	7.8	8.5	1.05 (0.53–2.10)
Ever tested for HIV	74.0	92.1	72.4	1.09 (1.03–1.16)
Ever tested for STI	84.8	97.1	83.7	1.04 (0.99–1.09)
Multiple STI tests, past 3 months	5.5	11.0	5.1	2.13 (1.11–4.07)
Multiple pregnancy tests, past 3 months	14.3	21.0	13.8	1.66 (1.11–2.49)
Multiple EC use, past 3 months	10.7	12.0	10.5	1.21 (0.69–2.12)

Abbreviations: ARR, adjusted risk ratio; CI, confidence interval; EC, emergency contraception; STI, sexually transmitted infection.

^a Adjusted for age, race, nativity, and recruitment site.^b Not mutually exclusive.

Table 4

Nature of sex trade experiences among those involved (n=103)

	No. (%)
Traded sex in the past 3 months	31 (30.1)
First experience of sex trade was before 18 years of age	12 (37.3)
History of being offered more money for unprotected sex	42 (40.8)
History of client condom refusal	31 (30.1)
History of client violence or force for sex	17 (16.5)
Among those reporting recent sex trade (n=31)	
Involved with pimp	5 (16.1)
Number of trade partners per week ^a	
1–2	16 (59.3)
3–9	8 (29.6)
≥10	3 (11.1)

^a n=27 (4 respondents did not provide data regarding number of clients).