Reproductive Health Concerns of Women With High Risk Sexual Behaviors

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Abstract

Introduction: Expansion of reproductive health services and addressing its different aspects in national and international levels is an important step towards ensuring family and public health. Female sex workers are a vulnerable population that are exposed to high risk sexual behaviors and increased incidence of co-morbid health problems. This study aims to identify the concerns of women with high risk sexual behaviors. Clarifying different aspects of reproductive health and its problems in female sex workers can assist relevant authorities to plan and intervene on reproductive health and to provide more effective solutions on this issue.

Methods: A qualitative study was conducted using a conventional content analysis approach. Snowball sampling was performed in 20 volunteer women with high risk sexual behaviors through in-depth semi-structured interviews conducted in drop-in centers, triangle centers, etc. The data were analyzed through conventional content analysis using the MAXQDA software.

Results: Five main categories and 13 subcategories emerged during the interviews. The main categories included violence, fear, and lack of knowledge, stigma, and psychological problems. Women with high risk sexual behaviors have several reproductive health concerns, including unwanted pregnancy, abortion, STIs *(Sexually transmitted infections)*, HIV, etc. In addition, different types of violence and threats against women, intimidation, objectification, stigma, unresponsiveness of counselling centers, patriarchal culture, gender inequality, etc. were observed in these women.

Conclusion: The study revealed that women in this study experienced deep problems of reproductive health and little attention is paid to them by authorities. Proper planning and appropriate solutions should be provided to solve the problems of these women and the society.

Reproductive rights encompass some components of human rights already recognized in national laws, international documents related to human rights, and other United Nations agreements. These rights rest on the right to attain the highest standards of reproductive and sexual health and include decision-making about reproduction without any discrimination, pressure, and violence (Mirzaei & Olfati, 2014).

Reproductive health is defined as a state of complete physical, mental, and social well-being in relation to the reproductive system and its processes, and not merely the absence of diseases and infirmity (Farajkhoda et al., 2013). Reproductive health development and

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addressing its different aspects in national and international levels is an important step towards the provision of public and family health (with a focus on women's health) (Mirzaei & Olfati, 2014). The extent of reproductive health services indicates the importance of this area of health services. In general, sexual and reproductive health, which originate from human rights, are an important part of medical ethics and should be practiced for all people, especially women, regardless of age, marital status, ethnicity, political views, race, religion, socioeconomic status, disabilities, etc. (Farajkhoda et al., 2013).

Health-threatening behaviors are one of the most important health and psychosocial challenges (Afshani et al., 2015). High risk sexual behavior in vulnerable populations is one of the risky behaviors that have received attention from health organizations, law enforcers, and policy-makers as one of the most important problems of the society (Mahmoodi et al., 2014).

Female sex workers are a vulnerable population across the world exposed to high risk sexual behaviors (Tafazoli et al., 2015). Social and ethical crimes like prostitution or sexual abuse are of the most important ethical disorders that have spread due to lenient notions about sexual relations despite knowledge of the damages and risks, leading societies toward corruption (Fatehi et al., 2010).

Today, most countries take into account prostitution, in any forms, a social and historical phenomenon and take proper actions to control it. Moreover, the statistics of female sex workers are clear in many countries and certain regulations and rules apply to their activities. However, prostitution has a criminal appearance in Iran and exposes the society to perturbation and increasing insecurity because these women make contact with their clients in the streets before the eyes of pedestrians. From a sociological point of view, inattention to prostitution may have devastating effects because closing the eyes to the criminal behaviors of these women makes the adolescents and youth get used to them gradually, depreciates the abnormal aspects of these behaviors, and pushes more women into this abyss over time (Sherafatipour, 2006).

Several studies found increased incidence of reproductive health problems like unwanted pregnancy, abortion, stillbirth, morbidity, and mortality in women with high risk sexual behavior (like sex workers) and their children, indicating inadequate reproductive health services and lack of knowledge in these women (Karamouzian et al., 2016; Katz et al., 2015; Khani et al., 2014; Luchters et al., 2016; Wahed et al., 2017; Weldegebreal et al., 2015). Among the above problems, the main crisis the world is facing regarding women with high risk sexual behavior is human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/

AIDS) (Khodayari-Zarnaq et al., 2016). It is estimated that about one-eighth (11.8%) of the female sex workers in developing countries are HIV-infected while according to the reports of 28 countries, only 58% of these women have access to human immunodeficiency virus/ sexually transmitted infections (HIV/STIs) preventive services on average. Therefore, the World Health Organization (WHO) and United Nations Programme on HIV/AIDS (UNAIDS) emphasize that integrated healthcare services for HIV/AIDS prevention should focus on high risk populations like female sex workers (Busza et al., 2016; Gomez et al., 2016; Mishra et al., 2016; Tafazoli et al., 2015). Despite differences in statistics provided by official and unofficial organizations regarding the extent of sexual corruption, nobody denies their existence in Iran. There are disputes in the statistics of social corruption, especailly sexual corruption, among analyses conducted on social high risk behaviors in Iran but they agree that these corruptions exist and are a threat to the Iranian society (Meshkin-Ghalam, 2005–2011). Women with high risk sexual behavior are a reality of the society we live in and cannot be denied. According to experts, these women are considered as hidden layers of the society because if their activities are revealed (for example extramarital sexual relationships), the results would be nothing less than rejection from family, prison, heavy punishments, etc. (Larki et al., 2014; Simbar et al., 2003). About 80,000 female sex workers live in Iran according to official reports and the average age of entry for girls into prostitution is 16-22 years, which is decreasing according to some researchers. In line with the number of female sex workers, high risk sexual behaviors and their adverse reproductive health consequences are on the rise, too. Therefore, scientific study of the problems of girls and women with high risk sexual behavior is the first step towards decreasing/overcoming the above threats (Larki et al., 2014).

The reproductive health status (concerns) of the women with high risk sexual behavior in the cultural, social, and economic contexts of different societies can be expressed and prioritized in different forms. According to the available information, it seems that due to some cultural sensitivities and the fact that the reproductive health status of women with high risk sexual behaviors has been considered a taboo, no study has provided a deep and comprehensive understanding of the reproductive health status of these women. Therefore, it is necessary to conduct the qualitative studies to evaluate the experiences and perceptions of the reproductive health of women with high risk sexual behaviors and their needs.

From a sociological point of view, to prevent the moral decadence of the youth as well as the threats to public health, it is important to address the reproductive

health concerns and needs of women with high risk sexual behavior. Furthermore, although a large body of evidence suggests that these women's high risk behaviors have serious devastating effects on the health of the men, women, family, and society. It seems that no comprehensive study has been conducted in this regard in Iran and there is a lack of information, especially related to the cultural context of the Iranian society. Therefore, this qualitative study was conducted to evaluate the reproductive health of women with high risk sexual behavior to improve their reproductive health as well as the reproductive health of the family and society.

Methods

Qualitative Method

This qualitative study was conducted using a conventional content analysis approach. Content analysis is a method for analyzing written, verbal, or visual communication messages. According to Berelson, content analysis is "a research technique for the objective, systematic and quantitative description of the manifest content of communication" (Berelson, 1952); in other words, content analysis is a research tool for realistic, objective, and systematic assessment of the verbal characteristics of written or verbal communication messages and making deductions about non-verbal aspects like personal and social characteristics of the writer or speaker or their views and tendencies (Elo & Kyngäs, 2008; Vimal & Subramani, 2017).

Data Collection

Since exploring the concerns on sexual and reproductive health is a culture-based issue, we used qualitative research. Snowball sampling methods were selected for choosing participants. Data collection and sampling continued until data saturation was achieved. The inclusion criteria were age 15-45 years and a confirmed diagnosis of high risk sexual behavior.

In this study, 22 depth-semi-structured interviews were conducted with 20 women with high risk sexual behaviors (participant's number 1 and 6 were interviewed twice because enough information was not extracted in the first interview) in different drop-in and triangle centers, parks, and private offices. These interviews were guided according to an interview guide (What do you think about your reproductive health?; What are your concerns about your reproductive health?; How have high risk sexual behaviours affected your reproductive health?; Are there any health services available for you without discrimination?). During the interview, the interviewer used several recommended techniques to obtain more and purer information through providing a calm environment, requesting more explanation, requestioning, conjecture, and using non-verbal communication. In addition to recording the interviews, important points raised by participants were also written down.

The number of the interview sessions varied according to the participants' conditions and their answers to interview questions. The interviews were recorded with permission, transcribed verbatim, and checked with the interviewers to ensure their accuracy. The duration of the interviews varied from 45 to 90 minutes according to responses and participants' willingness (mean = 67 minutes).

Data Analysis

The data were analyzed through conventional content analysis using the MAXQDA software. In this research, simultaneously with data collection, the data were analyzed using a conventional content analysis approach and process using the method proposed by qualitative researchers as follows (Graneheim & Lundman, 2004):

1. The interviews were transcribed and read several times to obtain a general impression.
2. Different segments of the text were fractured into meaning units and assigned a code.
3. The codes were then population ed into similar categories and subcategories according to similarities and differences.
4. The categories were re-extracted from the hidden content of the transcripts and re-organized. The MAXQDA 10 software was used to manage the extracted data.

Trustworthiness

The criteria proposed by Guba and Lincoln(Guba & Lincoln, 1994), including credibility, dependability, confirmability, and transferability, were followed to ensure the accuracy and reliability of the data (Mohsenpour, 2012).

Credibility was established through member check and peer check. A member check was conducted by having some participants verify that the codes and categories were consistent with their expressed experiences. For peer checking, the coded interviews and all stages of data analysis were evaluated and confirmed by the research team. Transferability was assured by providing detailed descriptions of the participants, data collection, and process of analysis and findings as well as excerpts of the interviews. This description provides other researchers the opportunity to conduct similar studies. In addition, the excerpts of the interviews along with emerged cods and categories were given to some

professors that were familiar with the principles of qualitative research but were not involved in the study. They assessed the data, evidence, and findings and made necessary modifications and then confirmed the accuracy of the data. Finally, an accurate and reliable report was presented.

Results

In this study, 22 interviews were conducted with 20 women with high risk sexual behaviors, aged 16-45 years (participant's number 1 and 6 were interviewed twice because enough information was not extracted in the first interview). They had 1 to 3 children. Most of the women were unemployed and some of them were housewives. Their education level ranged from illiterate to bachelor's degree. The majority of the women were divorced and the rest were either single or married (Table 1). The codes extracted from the interviews were categorized into 5 main categories and 13 subcategories (Table 2).

Main Category 1: Violence

This main category had 4 subcategories, including sexual violence, psychological violence, physical violence, and financial violence

1-1: Sexual violence was one of the subcategories emphasized by almost all participants. It was expressed in the form of unconventional sexual relations, sexual abuse/sexual exploitation. Many participants talked about anal sex, which was requested by the majority of the clients. Participant number 5 said, "Most men want to have sex through "unconventional methods". We have to, for money, exercise their will."

1-2: Psychological violence was another subcategory of violence emphasized by the majority of the participants. It was described as family's lack of affection, sexual partner's lack of affection, and constant threats. Participant number 10 said, "Most of the clients curse, insult, and threaten...". Another participant (number13) told: when I became addicted, I had two children. When my husband found out, he divorced me. My family did not support me and they kicked me out of the house.

Table 2. Analysis Grid (MAXQDA Codebook).

Main category	Sub-category
Violence	Sexual violence
	Psychological violence
	Physical violence
	Financial violence
Fear	Unwanted pregnancy
	Sexually transmitted diseases
	Rape
Lack of knowledge	Methods of contraception
	Pregnancy care
Stigma	Feeling discriminated
	Feeling abandonment
Psychological problems	Depression
	Feeling of an object only for sex.

Table 1. Characteristics of the Participants.

Number	Age	Drug addiction	Number of children	Marital status	The economic situation	Employment status	Education
1	20	**	1	Divorced	Undesirable	Unemployed	Secondary school
2	16	—	—	Single	Undesirable	Unemployed	Diploma
3	18	**	—	Single	Undesirable	Unemployed	Diploma
4	22	**	1	Divorced	Undesirable	Unemployed	Secondary school
5	25	—	2	Married	Somewhat desirable	Housewife	Illiterate
6	35	**	3	Divorced	Undesirable	Unemployed	Illiterate
7	25	—	—	Single	Undesirable	Unemployed	Secondary school
8	41	**	3	Divorced	Undesirable	Unemployed	Diploma
9	28	**	2	Divorced	Undesirable	Unemployed	Diploma
10	40	—	2	Single	Undesirable	Unemployed	Secondary school
11	29	—	2	Divorced	Somewhat desirable	Unemployed	Bachelor
12	33	**	2	Divorced	Undesirable	Unemployed	illiterate
13	44	**	2	Divorced	Undesirable	Unemployed	Secondary school
14	36	—	2	Divorced	Somewhat desirable	Unemployed	Bachelor
15	26	—	2	Divorced	Somewhat desirable	Unemployed	Bachelor
16	23	—	2	Married	Undesirable	housewife	Secondary school l
17	18	**	2	Single	Undesirable	Unemployed	Diploma
18	22	—	2	Divorced	Somewhat desirable	Unemployed	Bachelor
19	23	**	2	Divorced	Somewhat desirable	Unemployed	Illiterate
20	29	**	2	Divorced	Undesirable	Unemployed	Secondary school

1-3: Physical violence was another dimension raised by the majority of the women. It was described as beating and violence resulting in physical injury. In this regard, participant number 8 said, "Some clients, if we disagree with them, kick or punch us. A troubled partner once slapped me on the face that hurt for a long time." Another participant (number1) described, my partner always beats me and I have to live with him.

1-4: Financial violence was another subcategory emphasized by the majority of the women. It included sexual partner's/client's abuse and family's abuse. "Some men are really swindler. We fix money before we get to business but they don't keep their promise and pay less. We street women are really miserable, but call girls are way better off," said participant number 16. One of the participants (number 1) said, most times, less money was paid against the agreement, and sometimes no money was paid at all.

It should be mentioned that violence (physical, mental, sexual, financial) is the main factor disrupting the reproductive health of these women, can take away their will and authority in their life and cause them to go down more and more in corruption.

Main Category 2: Fear

Fear of different issues was a major concern of most women with high risk behaviors. This main category included three subcategories as fear of unwanted pregnancy, fear of STIs, and fear of rape.

2-1: Fear of unwanted pregnancy was the first subcategory emphasized by the majority of the women. Participant number 9 said, "I am afraid of becoming pregnant because if I get pregnant, I am in big trouble." Also another participant (number 1) I am afraid of having unwanted pregnancy, because once I got pregnant unintentionally, my family drove me out of the house, when they found out.

2-2: Fear of STIs was the second subcategory emphasized by all women. It included fear of AIDS and hepatitis B. Unfortunately the participants did not know other STIs. A woman with high risk sexual behavior (participant number 18) said, "I fear of two things, unwanted pregnancy and STIs. Something can be done for pregnancy but if you catch a disease, like AIDS, nothing can be done and you are screwed forever." Participant number 1 told "Most of the time my partners do not use condoms, I am very scared to get AIDS or sexually transmitted disease and die".

2-3: Fear of rape was the third subcategory of fear expressed by some participants, especially street women (women who find their clients in the streets). Fear of gang rape was raised by the women. The participants complained about gang rape. Participant number 11 said, "Once I went home with a client. When I reached there, five men were waiting and they all slept with me. I felt bad and had body pain for two days." Also another participant (number 5) told "when I was a child, my brother raped me. I did not know anything about it and I was afraid to say anything to my mother.

Fear of (unwanted pregnancy, sexually transmitted infections as well as rape) is an important factor in impairing satisfaction and safe sex life in the reproductive health of these women.

Main Category 3: Lack of Knowledge

Lack of knowledge about different subjects was an important issue and most of the women with high risk sexual behaviors were not aware about that. The interviews indicated that lack of or insufficient knowledge was one the main reasons for these women's problems. This main category had two subcategories, including lack of knowledge about contraceptive methods and lack of knowledge about prenatal care.

3-1: Lack of knowledge about contraceptive methods was the first subcategory raised by most participants. Not using or incorrect use of contraceptive methods was among the issues mentioned by the women. Participant number 1 said, "I only know pill and condom. We don't use a condom most times because my clients don't like it." Another participant (number 13) told "I did not use condoms for the satisfactions of my partners. But I did not know this action might put me in the danger of infection and death".

3-2: Lack of knowledge about prenatal care was the second subcategory of lack of knowledge, which could be deduced from the participants' statements. Lack of knowledge about pregnancy, unsafe abortions, lack of knowledge about antenatal care, not using supplements, inattention to screening studies and other necessary tests during pregnancy were among the points discussed by the participants. Several women stated that they were forced to perform illegal abortions. One of the women (participant number 19) said, "I became pregnant once. I didn't know what to do. I got some abortion medicine from the black market with my friend and used it but the baby was not aborted completely. I started to bleed and got into a lot of trouble."

It should be added that knowledge of modern contraceptive methods prevents unwanted pregnancies and 25% of maternal deaths (according to the World Health Organization, 2021).

Main Category 4: Stigma

Stigma was one of the concerns of women with high risk sexual behaviors. This main category had two subcategories, including a feeling of discrimination and a feeling of abandonment.

4-1: A feeling of discrimination was the first subcategory of stigma the emerged from the interviews. Some women pointed to the different behavior of healthcare providers. Participant number 2 said, "I don't like to go to health centers. Once I asked a question from a midwife, she looked to her colleagues and laughed at me; I will never go there again."

4-2: A feeling of abandonment was the second subcategory of stigma. Some participants talked about rejection from family, rejection from society, and running away from home during the interviews. Regarding rejection from family and society, participant number 1 said, "My husband was addicted and made me addicted too. My sister took my daughter away from me because I couldn't raise her. I have not seen my family in 3 years. They've all abandoned me…"

Family rejection and humiliating behavior by some health care providers lead to a sense of discrimination. Health care providers should provide health care to women without any discrimination until women can experience reproductive health according to WHO define (World Health Organization, 2021).

Main Category 5: Psychological Problems

Women with high risk sexual behaviors suffered from psychological problems. This main category included two subcategories: depression and feeling of an object only for sex.

5-1: Depression was the first subcategory of psychological problems that was perceived in the appearance and statements of the majority of the participants. Constant crying, suicidal thoughts, a feeling of hopelessness, and a vague future were raised by some women. Participant number 6 said, "Sometimes I really disgust myself, because I feel depressed, I don't know anything else to do for a living. I always cry, and look down on myself and my life". Also participant number 13 told, "I have committed suicide three times with taking sleeping pills, but I was taken to the hospital and rescued. I wish I could die".

5-2: Feeling of an object only for sex was the second subcategory of psychological problems. A feeling of worthlessness was mentioned by some women. In this regard, participant number 19 said, "I feel worthless. Sometimes I think I don't know anything else to do for living and everyone abuses me."

Mental health is one of the dimensions of reproductive health and in these women, due to humiliating behavior by others, they are exposed to depression, suicide and death. These women feel that others look at them as worthless objects.

Discussion

This study was conducted to determine and describe the reproductive health status of women with high risk sexual behavior.

The results of this study showed that women were exposed to physical, sexual and psychological violence due to many problems caused by high risk sexual behaviors, and most of these women were rejected from their families. Some health care providers, with discriminatory behaviors, intensify their psychological problems.

The results of this study are compared and discussed with other studies on the following main categories:

Violence

Violence against women is a major health concern requiring special attention (Mohammadi et al., 2011; Sanz-Barbero et al., 2019). Women with high risk sexual behavior in the present study experienced different types of violence. Several other studies also reported different types of violence. In a study in southern India in 2019, Prakash Javalkar et al found that violence against female sex workers was widespread and included several populations like intimate sexual partners, paying partners, pimps, and police (Javalkar et al., 2019). In a study of female sex workers in Ethiopia in 2019, Demissie Amogne reported that many of these women were victims of physical violence and were physicaly beaten or even murdered by their clients (Amogne et al., 2019).

The participants also reporetd several experiences of physical violence in the present study. A large body of evidence indicated that female sex workers expose themselves to adverse health outcomes like increased prevalence of HIV, STIs, suboptimal affective health, increased alcohol and drugs consumption, and decreased presentation to HIV/STI clinics. The mechanism through which violence exerts its adverse effects on women's health is complicated and ambivalent. Violence may increase HIV/STI directly through increased rate of unprotected sex or may affect the women's health indirectly through depression, reduced self-esteem, increased alcohol consumption and drug use, decreased assertiveness for condom use, resulting in increased unsafe sex. In addition, sexual inequality, which makes men dominant, increases violence (Javalkar et al., 2019). A study found that age, location of selling sex, and high alcohol consumption were important predictors of sexual violence (Amogne et al., 2019). Since prostitution is not considered a job in Islamic countries and most female sex workers are street-based and work during "red-light" hours in Iran, they are more exposed to financial, mental, and physical violence. Several studies have reported that the rate of different types of

violence is higher in street-based female sex workers (Amogne et al., 2019; Sadati et al., 2019). In the present study, female sex workers reported that they used alcohol before or during sex to overcome shyness and satisfy the clients' needs and wishes. High amounts of alcohol disturb these women's assessment of the risk of violence and increase their vulnerability. In line with the results of the present study, several studies found that female sex workers were exposed to different types of violence due to low education level, poor economic status, and unequal sexual relationships (Amogne et al., 2019; Barreto et al., 2019).

Stigma

Prostitution is considered an immoral and anti-value sexual deviation in the Iranian culture with a wide range of labelling that targets women through stigmatizing as a final stage of a social process and deprives them of the main flow of the society. This stigma overwhelms them strongly, pushing them to commit more crimes and offenses. In the present study, female sex workers were all subject to stigma and rejection, which deepened their sexual deviations and even provoked a desire for revenge. When the person is considered a convict in public, she assumes that her identity is changed and subject to the stigma. This mental image affects their behavior and facilitates criminal and offensive conducts (Rabbani Khorasgan, 2015). In the present research, female sex workers mentioned were pushed out from society, stigma, and discrimination, even in medical centers. This judgmental and immoral attitude to sex workers was seen in healthcare providers, which requires special attention. According to these women, healthcare providers and staff were not qualified with the necessary skills or knowledge needed to offer proper services. Several studies recommended that healthcare providers should be aware of the isolation and social discrimination exercised against these women to reduce the stigma attached to them (Duby et al., 2019). Recent WHO guidelines for HIV/STI prevention and treatment in female sex workers recommend that health services should be made available, accessible and acceptable to female sex workers, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health (Moore et al., 2014). In line with this research, several other studies also reported that stigmatization of sex workers by the society and healthcare providers, violence, drug abuse, and limited access to treatment and prevention centers, play major roles in the high incidence on HIV in these women (Bowring et al., 2019; Lasater et al., 2019; Treibich & Lépine, 2019).

Psychological Problems

According to psychologists, the reasons for prostitution are not merely limited to social phenomena .In addition, psychological factors like variety-seeking tendency, sexual deviance, moral identity weakness, identity disorder, low self-esteem, and age play significant roles in this regard. Some of these women have personality disorders, especially antisocial personality disorder. Lack of emotional balance, sometimes exacerbated by physical-mental breakdown, and finally, the most complete form of separation between emotional component and the physical aspect of sexual behavior are distinct psychological features in female sex workers. The most obvious factors differentiating female sex workers from other people are instability, lack of true feelings and perceptions, and as a result, lack of the capacity required for making a living through endeavor and a legitimate and regular profession. The cognitive disorders of female sex workers drive them towards justifying or rationalizing their behaviors and activities. Other sociological factors implicated in prostitution are external influencing factors like population density and haphazard immigrations, demand from men, and being deprived of the family and friends' emotional support (Fatehi et al., 2010). These factors were repeatedly quoted by the participants in the present study. According to a study by Seydi et al in 2014, prostitution is usually followed by a variety of psychosocial disorders such as addiction, crime, delinquency, and alcoholism (Seydi et al., 2014), which were all reported in the present study. Female sex workers suffer from different degrees of personality disorders and, in generally, have lower IQ (Ansari et al., 2011). The results of a study by Ansari et al in 2011 showed a prevalence of 90% for personality disorders in female sex workers, with passive-aggressive personality disorder having the highest prevalence (Ansari et al., 2011). Another study found that the prevalence of depression was 82.4% in female sex workers, which was five and six times higher in female sex workers with a history of rape or high risk sexual behavior, respectively (Larki et al., 2014).

In the present study, the participants pointed to items like constant crying, suicidal thoughts, a feeling of hopelessness, feeling of worthlessness, etc. at times, which could indicate mental disorders. Therefore, with regards to the results of this research and previous studies, it can be concluded that there is a mutual relationship between mental disorders and prostitution; in other words, the odds of mental disorders increases in sex workers and some mental disorders like depression are more prevalent in women pushed into prostitution.

Since sexual and reproductive health is a major global concern and an important factor in human development and as reproductive health problems are the second

leading cause of loss of health after infectious diseases in the world, it is considered a top priority of the health section in Iran. In addition, the statistics reveal poor health behaviors in female sex workers (Farajkhoda et al., 2013; Hadi et al., 2004).

Lack of Knowledge

In Iran, as an example of a traditional-religious society, sexual issues usually have an impression of ambiguity and talking about issues related to sexuality is associated with a feeling of shame and embarrassment due to the traits of sexual shyness and conservatism in the Iranian culture. No formal education on sexual and reproductive health is offered in Iranian high schools and universities. Due to exposing to western lifestyle and culture, socio-cultural values of Iran have changed a lot and consequently, we observe the conflict between tradition and modernity and changes in behavioral values and patterns. These conflicting values have resulted in increased abnormal sexual behaviors and divorce. These changes on the one hand and lack of education on the other hand have resulted in lack of knowledge and sometimes wrong beliefs and information about sexuality and reproductive health (Bostani et al., 2017). The results of this study also indicated the participants' lack of or incorrect information on reproductive health.

Another unmet reproductive health need of the female sex workers in this study was contraceptive methods, which is an important reason for unwanted pregnancy and different STIs. In 2015, Kumar Meena et al found low levels sexual and reproductive health knowledge was low in female sex workers and only 39% of them had heard about long-acting reversible contraception (implants, injections, and intrauterine device (IUDs)). In addition, although 98% of them stated that they did not intend to get pregnant, only 43% reported continuous use of condoms and 28% reported the use of other modern birth control methods (Meena et al., 2015).

In 2016, Corneli et al. conducted a study in Kenya and found three reasons for the restricted access of female sex workers to contraceptive services, including 1- long wait times, fees, inconvenient operating hours and compulsory HIV testing, 2- discriminatory provider-client relationships, where participants believed negative behavior and different treatment of healthcare providers compared to normal men and women affected their willingness to seek medical services; and negative partner influences, including both intimate and paying partners (Corneli et al., 2016).

The participants of this study also mentioned inconvenient work hours of health centers because they mostly needed healthcare services at night when these centers are usually closed. In addition, there were also references to the different unappropriated behavior of healthcare providers, but they did not indicate their sexual partners as a barrier. Furthermore, HIV testing is done after consultation, if the person is willing to, in Iran's drop-in centers.

In line with the results of the present study, Luchters, et al and Kats, et al reported some reasons for not using a condom like having sex in exchange for more money, client's lack of interest, sex worker's lack of interest, high age of the sex worker, and competition with young sex workers, which could contribute to the increased incidence of STIs and unwanted pregnancy (Katz et al., 2015; Luchters et al., 2016). The results of a study by Sutherland, et al in 2011, also indicated the need for improving dual contraception method in female sex workers (Sutherland et al., 2011).

In a study in 2013, Fallahi, et al reported that sufficient attention is not paid to the reproductive health needs of female sex worker like safe maternity care in triangle centers (Fallahi et al., 2013). Some of the participants also mentioned lack of or insufficient prenatal and maternity care in the present research, too.

Fear

Another reproductive health problem of the participants was fear of unwanted pregnancy, which jeopardizes the physical, mental and social aspects of their reproductive health and its consequences affects the quality of life of the women, families, and society (Duff et al., 2017; Kheiriat et al., 2014; Madeiro & Diniz, 2015)

Bostani, et al in 2018, Weldegebreal in Mumbasa in 2015, and Kilembe in Zimbabwe in 2019 reported that female sex workers were at high risk of sexual and reproductive health related mortality and morbidity, especially due to unwanted pregnancy, unsafe abortions, and STIs (Bostani et al., 2017; Kilembe et al., 2019; Weldegebreal et al., 2015). There were also several mentions of unwanted pregnancy, unsafe abortions, financial problems, stigma, and fear of unwanted pregnancy in the present research. Luchters, et al reported financial problems, social stigma, being banished from the city and dangerous abortions as some of the adverse consequences of unwanted pregnancy (Luchters et al., 2016). However, some of the participants mentioned that they sometimes became pregnant to trap their client and start a family without his knowledge.

In addition, in the present study, the participants expressed a fear or rape or reported that they were raped by different people, including the family, friends, police, municipality authorities, etc. Similarly, Katz also found that violence was a common experience for female sex workers and about one third of them were raped in the past years; furthermore, 60% of the street-based and 40% of hotel-based female sex workers were beaten or

raped (Katz et al., 2015). Since most of the sex workers work on the streets at night, the odds of rape and different sexual abuses may be higher in this population, which was also mentioned by the majority of the participants in the present research.

A study in Iran in 2008 found that 23.9% of the female sex workers were raped or sexually abused before entry into prostitution. These women were mostly raped by strangers (36.3%) or boyfriends (27.3%); however, 18.2% of these women were raped by family members, which was an interesting finding. Fatehi et al.(2010) reported that 23% of the female sex workers were raped by their stepfathers between 3-16 years of age. Some of the women who participated in the present study were also raped by their stepfathers during childhood. According to several studies, sexual abuse in childhood increases the risk of entry into prostitution and in this line, prostitution also increases the odds of rape and sexual abuse.

Limitations

It was difficult to communicate with these women because of Iran's culture, but authors tried to consult and persuade them to participate to research.

Conclusion

Prostitution is associated with humiliation, intimidation, verbal and physical harm, objectification, etc. It is a strong underground phenomenon that swallows up the women's identity like a horrifying whirlpool and leads the society to perdition, which has different facets and different levels. Higher levels of moral corruption and perdition not only blemish the women's identity and dignity, but also affect other aspect of the women's life, including reproductive health, as attested by the increasing trend of the incidence of diseases like AIDS and other STIs, unwanted pregnancy, etc. Clarifying different aspects of reproductive health and its problems in female sex workers, can assist relevant authorities to plan and intervene on reproductive health and to provide more effective solutions on this issue.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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