Self-reported experiences of health services among female street-based prostitutes: a cross-sectional survey

Nikki Jeal and Chris Salisbury

SUMMARY

Background: *Previous studies show that women working in prostitution do not use routine health services appropriately. Little is known about the nature and frequency of service contacts or barriers to access. This information is needed if use of current services by this group is to improve.*

Aim: *To identify barriers reducing access to health services by street prostitutes, and to identify current patterns of use.*

Design of study: *Cross-sectional survey.*

Setting: *Inner-city Bristol.*

Method: *Seventy-one female street-based prostitutes were interviewed about their experiences of health services.*

Results: *The women had frequent contacts with healthcare providers. The general practitioner (GP) was the main source of all types of care. Although 83% (59/71) were registered with a GP, 62% (36/59) had not disclosed their work. Only 46% (33/71) had been screened for sexually transmitted infection in the previous year and 24% (17/71) were vaccinated against hepatitis B, a national recommendation for sex workers. Only 38% (25/65) had had cervical smears according to screening guidelines. Opportunistic screening and care was important. While pregnant with their last child, only 30% (14/47) booked in the first trimester and attended all antenatal appointments, with 13% (6/47) receiving no antenatal care until admitted in labour. Appointments, waiting times, and fear of judgement and other patients staring, were considered significant barriers to service use. The model suggested by the women was an integrated service providing basic living needs alongside health care.*

Conclusion: *Non-disclosure and poor attendance for follow-up make appropriate care difficult, and may contribute to poor health. Despite frequent service contacts, opportunities for care are being missed.*

Keywords: *cross-sectional survey; health services accessibility; interviews; prostitution; sexually transmitted diseases.*

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Introduction

COMMERCIAL sex workers are a marginalised group[1] and their social stigma is a barrier to provision of health care for them.[2,3] They have high levels of morbidity related to their lifestyle,[4-6] and they therefore need high quality care. As they have well defined 'occupational' risks[7-10] they need appropriate health care specifically targeting their needs, both for the treatment and prevention of disease.[11] Those sex workers who work on the street, rather than in premises such as massage parlours, appear to be the most at risk.[12] Previous research has shown that commercial sex workers do not access the services that are currently available. It has tended to study mixed populations of street and off-street sex workers[15] or just off-street workers,[16,17] and has concentrated on sexually transmitted infection (STI).[1,4,8,14,17] Knowledge of the patterns of use of a range of current services and their relative importance as sources of care, along with reasons for poor uptake of existing services and modifications that would improve uptake, must be known if this group are to receive care within the current framework. This is central to the implementation of the National Sexual Health Strategy[18] in order to address health inequality.[19]

The aim of this study is to describe the current use of health services by street-based sex workers, and to explore their perception of barriers to care and ways in which their health care could be improved.

Method

The research was designed as a cross-sectional survey. This was a semi-structured questionnaire survey administered during interviews of street-based sex workers in central Bristol. At the time of the interviews the local population of female street-based sex workers was approximately 120. The population was estimated through contact with One25, a charity that supports women in prostitution, and through questioning the women themselves. One25 operates an outreach van until midnight and a drop-in service during afternoons, and probably has contact with most of the street-based female sex workers in central Bristol.

Women were recruited for the study through One25, by direct approach, and by word of mouth. The inclusion criteria were women aged 16 years and over who were sex workers, with their main place of work being the streets in central Bristol. This excluded those working in off-street settings, such as massage parlours and flats, and women visiting from other cities.

Interviews were conducted over a 1-month period to minimise population changes over time. A questionnaire was

HOW THIS FITS IN

What do we know?

Commercial sex workers are recognised to be a group likely to experience poor health because of the high-risk behaviour inherent in their work. Little is known about the frequency and pattern of use of health services by sex workers.

What this piece adds

This study highlights the central role of the general practitioner in the provision of all types of care for these women, although their use of health services is suboptimal, resulting in missed opportunities for care. This information is necessary in order to implement the National Sexual Health Strategy and may allow innovative approaches to addressing the health inequalities experienced by this group.

used that contained both validated and previously unused questions and was piloted on women who had previously worked as street-based sex workers. The questionnaire included a combination of closed and open questions; for example, 'are you registered with a [general practitioner] GP?' was a closed question, but 'what things would make it easier for you to go to a GP?' was an open question for which all responses were recorded longhand and coded at the end of the study. Women were paid £20 each for child-care and travelling expenses, and the interviews lasted 1 hour and took place in premises near their place of work. Interviews took place between 09.00 and 23.00 hours. Coding was carried out after questionnaire completion to ensure inclusion of all possible responses. All of the interviews were included in data analysis. Ethical approval was obtained from the United Bristol Healthcare Trust Research Ethics Committee.

Results

Seventy-two women were invited to participate and all but one agreed. When asked about use of health services over the previous 12 months, the most common source of care was their GP. Table 1 below shows that, although the GP was the main provider of services, these women also used other services comparatively frequently.

Primary care

Although 83% (59/71) of the women said they were registered with a GP, 62% (36/59) of that group had not disclosed that they were sex workers. When asked the reasons for going to a GP, the commonest reason was depression or anxiety, given by 34% (24/71), with substitute prescribing for opiate addiction given by 31% (22/71), and obtaining a sick note by 20% (14/71) of women.

Attending the surgery was considered difficult by 80% (57/71). The commonest reasons given for this difficulty were: waiting for available appointments, 52% (37/71); difficulty keeping appointments made, 51% (36/71); and the perception of being judged by the staff, 45% (32/71). They also found waiting with other patients difficult, as they felt they were 'stared at', 37% (26/71). When asked to suggest how attendance at the practice might be made easier, the most common suggestion, given by 75% (53/71) of the women, was a 'no appointments' type system. Other frequent suggestions were: having a surgery close to their place of work (65% [46/71]) and open in the evenings (65% [46/71]), with a doctor who had appropriate knowledge of their work and existence or who 'knows the score' (63% [45/71]). Only 11% (8) suggested a facility solely for sex workers.

Sexual health care

Less than half of the women (46% [33/71]) had been screened for sexually transmitted infection in the previous year and 18% (13) had never been screened. A third of the women (25 [35%]) had attended the STI clinic in the previous 12 months. In those who had ever been screened, half of those checks (53% [31/58]) were in an STI clinic, with GPs and prisons together screening a further third (32% [19/58]). Only 24% (17/71) of the women had been vaccinated for hepatitis B, a recommendation for this group.

Seventy-eight per cent (55) of the women said they found it difficult to attend the STI clinic. The reasons given for this difficulty were clinic location (45% [32/71]); the appointment system (32% [23/71]); and problems waiting at the clinic, both the time, 25% (18/71) and waiting with other patients who were perceived as 'staring', 25% (18/71). Fear of judgement was given by 22% (16/71).

When asked how attendance at the STI clinic could be facilitated, 75% (53/71) of the women said that the clinic being located close to their place of work would make it easier, as would evening opening (73% [52/71]) and a system without appointments (70% [50/71]). Few wanted self-obtained swabs (11% [8/71]) or a facility specifically for sex workers (11% [8/71]).

Cervical screening

Just over one-third of women (38% [25/65]) were within local authority guidelines for cervical smears, which for this health authority is 5-yearly screening (six of the group were excluded

Table 1. Reported service use in previous 12 months.

	GP	A&E	STI clinic	Inpatient clinic	Outpatient clinic
Percentage using service (*n*)	82 (58)	41 (29)	34 (24)	30 (21)	24 (17)
Mean number of contacts	8.5	2.5	2.7	2.0	4.3
Median number of contacts	6.0	0	0	0	0
Range of number of contacts	0–52	0–16	0–7	0–14	0–16
Total number of contacts	604	73	65	42	73

A&E = accident and emergency department; GP = general practitioner; STI = sexually transmitted infection.

Table 2. Comparative statistics.

Issue	Data from this survey	Comparative data	Source
Percentage admitted to hospital in previous year (*n*)	30 (21)	11	General household survey 2000[21]
Average number of inpatient stays in previous year	59/100	8/100	General household survey 2000[21]
Percentage cervical screening uptake (*n*)	38 (25/65)	77	*Tackling health inequalities* review 2002[19]
Percentage rates of abnormal smears (*n*)	18 (8/44)	8.3	Cervical screening programme 2000[22]

from the denominator as they were less than 20 years of age and therefore not eligible), although 40% (10/25) had been opportunistically screened in unplanned situations such as prison or inpatient or antenatal clinics. Of those women who had ever had a smear (*n* = 46) and knew the results (*n* = 44, 2 of the screened group did not know their results), 18% (8) had had an abnormal smear. Of the 8 with abnormal smears, all of them felt they had acted appropriately in attending for follow-up for that smear. Follow-up included repeat smears, colposcopy or inpatient cone biopsy. However, subsequent to that attendance, all failed to attend for appropriate follow-up. Only one of this group was currently up to date with cervical screening, and that smear had been opportunistically conducted while in prison.

Contraception

All the women said that they used condoms for work. Condoms were the only contraception for work for 89% (63) of the women. The One25 project, a local charity, was the most common source of condoms, with 91% (64) of the women giving this as their source of condoms. Only 11% (8) of the women used any contraception in addition to condoms while working, with their GP (4/8) being the commonest single source. Emergency contraception was used in the previous 2 years on four occasions by the group, with the GP providing three of those four prescriptions.

Antenatal services

Forty-seven women had had a pregnancy that continued beyond 24 weeks. In the women with the most recent pregnancies, nearly half (49% [23]) had received their first antenatal care in the second trimester or later. Four or more antenatal appointments were missed by at least 28% (13), with 13% (6) of the women receiving no antenatal care until admitted in labour. Two of the pregnancies ended in stillbirth (2/47 [4%]).

Police/forensic services

Of the 52 women who said they had been attacked, 60% (31) did not report the assaults to the police and only 17% (9) would report all attacks. The commonest reason given for non-reporting was a poor opinion of the legal system (54% [28/52]). This included the fear of going to court and how they would be treated, and their belief that their assailant would be acquitted. This was closely followed by the impression that the police were not as interested in their complaints, because they were selling sex, as they might be in those from other members of the public (52% [27/52]). Increased reporting would be encouraged by the opportunity for forensic sampling and storage, listed by just over half (52% [27/52]). This would allow a group of the women to bring charges subsequently against an individual. Just over a third (38% [20/52]) felt a non-judgemental attitude would encourage more women to go to the police. Just under a third (27% [14/52]) had no problems with the police. All of the women (*n* = 71) were asked about use of a rape suite if they were not required to contact the police to access the service. Seventy-two per cent (51) said they would use such a service. Four per cent (3) said they would prefer to involve the police.

Service design for the future

The final question that the women were asked was what they would include if designing a service set up for women who sell sex (Table 3). Nearly all (97% [69]) said they would include a doctor who could provide an integrated service, with condom provision included by 89% (63). Location near the ‘red light’ area (where most of the prostitution goes on), showers, food and drinks, and a needle exchange were each included by 77% (55), with evening/night opening a priority for 75% (53).

Discussion

Main findings

This study highlights that, although street-based sex workers have frequent contact with health services, their use of services is inconsistent and their use of preventive health care poor. These women have low rates of screening for sexually transmitted infections and cervical abnormalities, and low levels of hepatitis B vaccination. They experience high numbers of inpatient episodes, consistent with the high levels of morbidity seen in sex workers and poor use of services resulting in advanced pathology. First antenatal contact was late and inconsistent, identifying these women as a high risk obstetric group.

GPs were the main source of all types of care for this group of women. However, non-disclosure of work in prostitution is likely to have made the provision of appropriate care by GPs more difficult, in addition to any practical problems that may be encountered in attempting to provide care for these women. Given their inconsistent use of preventative services, opportunistic care and screening was a vital source of help.

Table 3. Service provision suggested by the women.

Facilities to include in a service provision for street-based commercial sex workers	Frequency	Percentage (n = 71)
Integrated service for primary care/reproductive health/substance abuse	69	97
Condoms	63	89
Near place of work	55	77
Showers	55	77
Food and drinks	55	77
Needle exchange	55	77
Evening/night opening	53	75
Counselling	40	56
A facility to wash clothes	33	46
No appointment	23	32
Someone to talk to	22	31
Service for sex workers only	13	18
Safe	12	17
Health education	10	14
Other	39	55

The majority of the group experienced difficulty in attending existing services, with common themes of problems including the wait to be seen, the perceived attitudes of other patients, and fear of being judged. Suggested improvements to current services included providing an evening drop-in service near their working place. However, their ideal service would be fully integrated and also address the most basic needs of cleanliness and sustenance.

Strengths and limitations

The number of women in this study is relatively small and the lack of recruitment between midnight and 09.00 hours may expose the study to bias. However, it is likely that more than half the total population of street-based sex workers in the central area of Bristol were interviewed. The study also used varied recruiting methods and interviews conducted over a short time period to obtain a sample that was representative of the study population. Those interviewed are likely to represent the women with less chaotic lives and the results may be an underestimate of the morbidity for the whole population. The fact that the data is self-reported may also make it open to bias. There has been no correction for socioeconomic class. Although this group are now considered to be in social class V, this may not be the class in which they started life.

Relationship with previous research

Where this study overlaps with previous research the findings confirm poor use of current services, low levels of disclosure, and concerns about being judged, with a lack of desire for services specifically for sex workers. However, problems with examination, and preference for self-obtained samples, were not found.[20] The problem of social marginalisation is widely accepted as negatively impacting healthcare provision, and this is confirmed by the problems with the fear of other patients in the practice waiting room staring. By highlighting the relative importance of varied sources of care, looking at patterns of service use, and exploring the reasons for attendance or non-attendance and the role or potential role of opportunistic care, this study builds on previous work. This is the first study to specifically highlight the importance of primary care as a source of health care to street-based sex workers. This new information about where and how they present is needed if these women are to receive appropriate care within the current services.

Implications

Since general practice is the main provider of all types of care for these women, attempts to maximise care provided through this route may be most productive. Non-disclosure is common, resulting in lack of appropriate care, despite frequent contacts. At the time of these contacts, when opportunistic care could be provided, they are not being used to maximum benefit. While opportunistic care is better than no care, health-seeking behaviour and prophylaxis would have benefits, particularly in such a high-risk population. These problems must be addressed if this group are to receive acceptable standards of care within current services.

Ways of encouraging disclosure should be explored, coupled with training or easy access to relevant guidelines for GPs as necessary. This may be either through initiatives with the women themselves or with practices in areas where commercial sex work is common. Alternatively, helping GPs to identify female patients at high risk of selling sex, and to sensitively raise the issue, may allow more opportunistic input.

An alternative model is to provide an integrated targeted service as outlined by the women themselves. This may involve fulfilling very basic needs, such as food and clothing, which are a survival priority, in order to raise the priority given to health issues, which may be considered less important by this group. Provision at an appropriate time and location would improve uptake. Although the general population may also experience problems with access to health care, the extremely poor health seen in this group highlights the magnitude and impact of the problems they describe.[21]

This group of women have major health needs that are currently being unmet. It is necessary to explore and compare the benefits of practice-based measures and alternative models of care, such as outreach clinics, in order to improve health provision to this extremely vulnerable group of women.

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