Editorials

Women involved in prostitution:

hidden in plain sight?

INTRODUCTION

The 'sex industry' in the UK generates billions of pounds of revenue every year. Most of this money ends up with those who are controlling the women involved and a small fraction is given to the women themselves. The majority of those buying sex are men and the majority of those providing are women. The term 'sex industry' relates to activities including: online webcamming and selling images and videos; pornography; lapdancing; stripping; indoor and outdoor prostitution; and sex trafficking. Women often start with activities that do not involve contact but then progress to having intercourse due to the increased income it provides.

The discussion and debate around whether prostitution is legitimate work or exploitation rages both academically and also among groups who aim to support women.[1] There are stark divisions in the feminist debate. The more radical feminist lobby indicate that since society is inherently patriarchal then men purchasing women for the purposes of their own sexual gratification is exploitative and reinforces entitlement and male privilege. This view and the focus on who takes responsibility for male behaviours has come to the forefront again in the aftermath of the murders of women going about their routine day-to-day activities.

The sex positive feminist argument is that women should be able to make free choices as to who they have sex with and whether or not it is transactional. These arguments rage passionately, with many of the sex positive arguments originating from women involved in prostitution. In Scotland, the government's strategy for tackling violence against women and girls cites prostitution as one of the forms of violence against women.[2] There is a clear commitment by the Scottish government to challenge men's demands for prostitution as part of the Programme for Government.[3]

SEXUAL VIOLENCE

Of all women attending a sexual health service for those with complex and high need in Edinburgh, only 3% identified prostitution as being a free and positive choice. From the same group, 40% reported experience of sexual violence, and 75% gave a history of childhood abuse (including neglect, and physical and/or sexual abuse) (unpublished audit of women attending WISHES [Woman Inclusive Sexual Health Extended Service] in Lothian, 2019). This is in line with previous statistics.[4]

Statistics around how many women are involved are very difficult to find since most women are hidden, under the radar, or hide their involvement. Undoubtedly a proportion are trafficked or coerced into involvement. The main driver for the remainder is money.[5] The COVID-19 pandemic has highlighted the issue of poverty and rising numbers of women are now involved in transactional sex because they feel they have no option. How do we as healthcare professionals provide care to women who are often riddled with shame and guilt, traumatised, and who struggle to disclose involvement?

HEALTH INEQUALITIES

One of the authors of this editorial is a gynaecologist who set up a sexual health service for socially excluded women many years ago. She is able to provide holistic care in conjunction with third sector agencies. Her service advertises itself as being for those affected by homelessness, substance or alcohol use, criminal justice, and/or prostitution (Supplementary Information S1 shows the WISHES flyer; see online version of this editorial). Women therefore do not have to make a disclosure nor do they fear judgement/reaction. The words are already out there. Simply by attending, women identify themselves.

The other author is a GP with >30 years' experience of working in an inner-city, high demand practice. Despite the deprivation and financial need, and undoubted involvement in transactional sex of some of the women living in that part of Glasgow, her practice has had few disclosures from women of their involvement in prostitution.

This does not reflect on the ability of primary care to create a safe environment for disclosure. Nor does it reflect poor relationships between patients and their GPs. It does however demonstrate the complex psychological frameworks which women involved in prostitution build in order to survive. All women have multiple roles in society — for example, partner, wife, mother, daughter, sister, friend, colleague. Compartmentalisation of women's lives is inherent. Those involved in prostitution create an additional persona for this. Most will use a different name to advertise their services and will use that name with clients. They dress differently, put on different make-up and participate in different sexual practices (often high risk) in order to attract clients. Some women describe putting on a mask and playing out a role when selling sex.[6] Women therefore may preferentially attend sexual health services, using their work name, rather than seeing their GP, for issues relating to sexual health. The shame and stigma around prostitution can make disclosure to those who have known them for a long time and in other roles very challenging.

Women involved in transactional sex are not a homogenous group. Some have substance or alcohol misuse issues, many have mental health problems, some use their involvement in prostitution to supplement income from a permanent job, others only receive income from transactional sex. Income generated varies from less than minimum wage, especially if pimps take significant sums for themselves. Recent times have seen a rise in student involvement. Lacking decent opportunities for paid employment and spending longer online has made it more tempting for female students to engage with webcamming, OnlyFans and so on. While their income may rise, so too may their anxiety levels and their mental health and self esteem suffer. They may present with these issues and not disclose the underlying cause. Women who are involved in physical sexual contact are also often anxious. There are high rates of sexual and physical violence and concerns about transmitting infections to partners

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and children. Women involved in prostitution should be routinely offered hepatitis A and B immunisations, with 3-monthly testing with triple swabs (oral, vulvovaginal, and rectal) for chlamydia and gonorrhea, as well as blood tests for HIV/AIDS and syphilis. However, often women's worries are not about health, but about housing, benefits, childcare, and gender-based violence. Signposting to local organisations is vital. The availability of organisations who can support women to leave prostitution is very variable nationwide. The outcome of a recent Scottish Government consultation on challenging men's demand for prostitution has emphasised the need for appropriate support for women to ensure that they have choices, including exiting prostitution. There is promised investment in organisations who are able to provide this.[7]

WHAT CAN GPs DO TO SUPPORT WOMEN INVOLVED IN PROSTITUTION?

Unlike sexual health clinics, primary care does not have the luxury of long consultation times and patients do not expect to be routinely asked about their sex lives. However, keeping in mind the possibility that a woman may be involved in transactional sex and asking about sexual partners may lead to disclosure. There is no single 'flag' for identifying such women, but questions about when she last had sex, how many partners she has had in the last 3 months may indicate to her that it is ok to talk. In sexual health clinics we ask about paying for or being paid for sex as a routine. When women do disclose, they are very wary of reactions — even if these are well meaning.

Moving away from prostitution is not easy for practical and psychological reasons. Replacing income may be extremely difficult. In addition, admitting that you have been exploited, endangered, and are in a difficult place takes courage. It also deconstructs ideas that may have built up over a long time about the reasons why involvement in prostitution is a positive choice. Harm reduction principles are paramount for creating safety and looking at health and social priorities. Primary care cannot provide all of this, but can signpost to organisations who can help further.

To quote our colleague and friend, Dr David McCartney (Clinical Lead for Lothian and Edinburgh Abstinence Project and GP): *'As doctors, often all we can do is try to ease suffering'*. As doctors, we frequently underestimate the importance of the consistent messages we give to patients. We treat them with respect, we value and care for them, and want to help. This is immeasurably important for people who may have no other reliable support in their lives. We may not be told the whole story but we are always there and offer a safe and respectful space.

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