The lived experience of UK street-based sex workers and the health consequences: an exploratory study

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SUMMARY

The complex, difficult lives and subsequent health issues of street-based female sex workers are well documented. This paper explores the health needs of a group of sex workers in one geographical locality in the north-west of England. Interviews were conducted with a number of women currently engaged in sex work, with the aim of identifying factors maintaining them in this work and examining their experience of health and health-related services. A thematic analysis revealed considerable life circumstance complexity, with violence, drugs, alcohol and housing problems being prevalent factors. The combination of such factors compounds the likelihood of the women’s social exclusion. Other themes related to the casual perception the women had of their own health needs, their generally poor experience of services and the demonstrable impact of one specific service in supporting a group so reluctant to engage. The study suggests poor understanding of the complex needs of street-based sex workers by both services and professionals, particularly a failure to engage with the reality of these women’s lives and the factors that maintain them in this work.

Key words: sex work; social exclusion; drug and alcohol use; Harm Reduction Service

INTRODUCTION

Street-based sex workers are more likely than many other occupational groups to experience poor health, poverty and social exclusion (Costello, 2003). Their work often supplements low paid jobs (Elmore-Meegan et al., 2004; Harcourt and Donovan, 2005), and attracts considerable stigma (Barry and Yuill, 2008). Vulnerability to sex work is more prevalent within areas of economic deprivation and is associated with habitual drug and alcohol use, poor mental health, chaotic lifestyle, homelessness and a background of abusive relationships (Belcher and Herr, 2005; Bellis et al., 2007). Health inequalities and poor health, furthermore, are experienced disproportionately by those living within such areas (Wood et al., 2006). The main characteristics of social exclusion revolve around persistent drug use, poor access to health and welfare services, low levels of educational attainment, uncertainty of living conditions and high levels of violence (Campbell, 2002). The ways in which social exclusion, poor mental and physical health interrelate to maintain women in sex work are difficult to determine accurately (Melrose, 2007). Prostitution and addiction, furthermore, sometimes serve to mask the effects of traumatic life experiences (Belcher and Herr, 2005). This study looks at the lives of a group of women currently working as sex workers, exploring their experience of health services, particularly the barriers they encounter when trying to access...
generic health care. Little is known about the problems female sex workers face when accessing generic services. The paper contextualizes the elements of social exclusion in the lives of the women and the ways in which these factors further marginalize them from services.

LIFESTYLE AND SEX WORK

Low self-esteem, depression, emotional stress (Valera et al., 2001; Belcher and Herr, 2005), hopelessness and vulnerability (Wong et al., 2006) are all prevalent among sex workers. There may be a reciprocal relationship between intravenous drugs and sex work, the latter providing the money to pay for the first, which subsequently provides emotional relief from the expectations of the job (Campbell et al., 1996; Scambler and Paoli, 2008). The emotional risks of selling sex, particularly the possibility of being discovered, might have a greater impact than is currently recognized (Sanders, 2004b).

The issue of housing has been implicated as a cause and effect of sex work (Aidala et al., 2005), with as many as two-thirds of (female) sex workers’ homeless or under serious threat of becoming homeless (Jeal and Salisbury, 2004). Once on the streets, access to the means of earning money become limited and sex work for some younger women may be a means of avoiding detection by the authorities (Chesney-Lind, 1997). This is particularly so for those with experience of having been in local authority care or running away from home (Home Office, 2006). The need for a permanent address to access many services, both health and otherwise, can sometimes exacerbate an already difficult situation, resulting in an extended period living on the streets. The likelihood of homelessness is further increased by many sex workers’ experience of statutory services (Galatowicz et al., 2005), which suggests the need for greater flexibility and variety in the ways in which housing is provided (Kurtz et al., 2005).

Nearly, all (95%) street-based sex workers regularly use heroin and/or crack cocaine, according to the Home Office (2004), though the often concealed nature of both activities, sex work and drug use, makes substantiating this figure with robust evidence difficult. Nevertheless, there appears to be a reciprocal relationship between drugs and sex work, each characterizing the other to some extent.

Access and barriers to services

Marginalization and isolation from mainstream public health services is partly a consequence of difficulties gaining access (Rekart, 2005; Surratt et al., 2005), but is complicated by voluntary withdrawal because of fear of being judged, humiliated and discriminated against (NAT, 2003). Continuity of care constitutes a significant limitation, particularly availability of accessible, acceptable and good quality care integrated to facilitate follow-up appointments, on-going health monitoring and understanding high health risks (Mardh et al., 1999). Other barriers relate to limited health service opening hours (Meikle, 2004), the unsocial hours of sex work inducing fears of losing care and custody of children (NSWP, 2005). Rekart (Rekart, 2005) makes the point that enhanced personal empowerment might counter barriers to participation in generic health services, while simultaneously promoting the lifestyle changes required to prevent rapid health deterioration. An interesting study into pregnant teenagers’ failure to use health services accentuated poor understanding
and knowledge of what was available combined with reluctance to be subject to close scrutiny, constrained by societal views and labelled underserving (Jacono and Jacono, 2001).

RESEARCH QUESTIONS

The study set out to investigate the experience of a small group of street-based female sex workers in the north-west of England with regard to life circumstances, work, health consequences and service response. Three questions were addressed, the first relating to the ways in which participants perceived their own health, and, in particular, consequent needs from services and professionals. The second sought to assess the impact of wider determinants of health, such as substance misuse, violence, mental health and homelessness. The final question concerned the effectiveness of current services in meeting these health needs.

METHODS

Participants
Nine women participated in the study. They cannot be described as a representative of sex work; rather, their participation enables a detailed examination of a few individuals with complex histories, yet living, for the most part, ordinary lives. Background information for the research participants is provided in Table 1.

An outreach health-related service for sex workers in the area is provided by the Harm Reduction Service (HRS), and has proven vital for the women because it is underpinned by an understanding of their social background, domestic circumstances and the knowledge that they have minimal access to mainstream services. The outreach workers use a holistic approach, with interventions such as needle exchange, methadone schemes, health education, information and advice routinely offered. The practicalities of recruitment to the study necessitated close liaison with the outreach workers and adoption of a snowballing technique. This involved the opportunistic establishment of contact, emphasis being placed on the health-needs nature of the interview rather than sex work or lifestyle choices, then confirmation of informed consent. It was clearly inappropriate to advertise for participation and written correspondence was unlikely to be effective; the study’s success required a combination of sensitivity, relationship-building and opportunism. Sensitivity, because of the nature of the work and the women’s attendance at the clinic; relationship-building, which required the researcher’s presence at the clinic on several occasions, for introductory purposes, in order to gain trust, and to explain further detail, if requested; and opportunism, since the women’s lifestyles mitigated against a leisurely protracted interview.

Data collection
A semi-structured interview schedule was devised and finalized following the initial meetings with the women, and subsequently utilized according to the level of engagement. The schedule addressed mental and physical health issues, diet, working and living arrangements, experience of local services. There was a mixture of open (e.g. what would you need to

### Table 1: Background demographic information

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>32–40</td>
</tr>
<tr>
<td>Median</td>
<td>35</td>
</tr>
<tr>
<td>Mean</td>
<td>35.5</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>9/9</td>
</tr>
<tr>
<td>Homeless at the time of study</td>
<td>3/9 (33%)</td>
</tr>
<tr>
<td>Age left full-time education (years)</td>
<td></td>
</tr>
<tr>
<td>&lt;16</td>
<td>4/9 (44%)</td>
</tr>
<tr>
<td>16–18</td>
<td>2/9 (22%)</td>
</tr>
<tr>
<td>&gt;18</td>
<td>1/9 (11%)</td>
</tr>
<tr>
<td>Data not provided</td>
<td>2/9 (22%)</td>
</tr>
<tr>
<td>Qualifications from school</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2/9 (22%)</td>
</tr>
<tr>
<td>No</td>
<td>6/9 (67%)</td>
</tr>
<tr>
<td>Data not provided</td>
<td>1/9 (11%)</td>
</tr>
<tr>
<td>Qualifications in further education</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4/9 (44%)</td>
</tr>
<tr>
<td>No</td>
<td>4/9 (44%)</td>
</tr>
<tr>
<td>Data not provided</td>
<td>1/9 (11%)</td>
</tr>
<tr>
<td>Local authority care</td>
<td>3/9 (33%)</td>
</tr>
<tr>
<td>Years in sex work</td>
<td></td>
</tr>
<tr>
<td>&lt;1</td>
<td>2/9 (22%)</td>
</tr>
<tr>
<td>1–10</td>
<td>2/9 (22%)</td>
</tr>
<tr>
<td>11–15</td>
<td>4/9 (44%)</td>
</tr>
<tr>
<td>Data not provided</td>
<td>1/9 (11%)</td>
</tr>
</tbody>
</table>

The criteria for inclusion comprised: (i) females over the age of 18, (ii) English speakers, (iii) voluntary and current involvement in sex work, (iv) street-based sex workers in the local area.
make you healthier?) and closed (e.g. do you go to the dentist? Y/N) questions, a format designed to vary the interview pace and maximize opportunities for response expansion where appropriate. Questions were constructed to emphasize simplicity and clarity, employed similar structure throughout and tried to accommodate interviewer flexibility around schedule ordering. Other issues raised by the women concerned material life circumstances, relationship with drugs and alcohol, interpersonal violence, which, once initiated, were further explored. Interviews were arranged for the time of the next clinic and during the explanation of participant information, the study’s independent nature, voluntary participation, treatment and support being unaffected, were all made explicit. The interviews were conducted over 3 months, occasionally ended prematurely or abruptly, and were recorded on a small digital recorder and transcribed verbatim. Nine women participated in the interviews with a further four preferring not to be involved. The interview environment was provided by the HRS, which was relatively comfortable and relaxed, though, in retrospect, perhaps rather busy and a little cramped.

Data analysis
The qualitative data, once transcribed, were analysed thematically, following Braun and Clarke’s (Braun and Clarke, 2006) elaboration of key stages, particularly the generation of initial codes and their collation into potential themes. These were then checked and re-checked, first, against the coded extracts and then against the complete data set, in order to generate a thematic map of the analysis. This approach lends itself well to the analysis of relatively small amounts of data, the women’s frequently brief, and sometimes casually brutal, comments requiring stringent investigation to unravel ambiguities or apparent contradictions.

Ethics
Ethical approval was granted by the Integrated Research Application System (IRAS) and the University Faculty Research Ethics Committee, with subsequent negotiations with the local Primary Care Trust for access purposes.

FINDINGS
The first theme related to the ambivalence with which the women perceived their own physical and mental health. Social exclusion, the second theme, comprised alcohol and drug abuse, violence and homelessness, which contextualized the health issues and experience of services. This final area of concern, the experience of services, is discussed in relation to these elements of social exclusion. The names of the women have been changed throughout.

Table 2 provides more information relating to the women’s health and experience of services.

Ambivalence
Perception of health
Health was explored through a series of questions, such as: ‘what does healthy mean to you?’, ‘how’s your health at the moment?’ and ‘what would help you become healthier?’ The women frequently appeared contradictory, tough yet vulnerable and responses to questions were often terse. They were frequently detached from their work, reluctant to discuss private concerns, and had little in common with healthcare professionals. It transpired that the women’s immediate consideration of their own health was frequently dismissive, ‘okay’ and ‘fair’ the most usual descriptions, though more detail was occasionally forthcoming:

Mary: …I wouldn’t say I was 100%, in between I suppose… it’s not too bad, but it’s not brilliant.

Holly: I don’t think my health is very good at all if I’m honest with you (laughs); it’s kind of bad.

Claire: …I get inhalers but I think it’s from smoking the crack, I think it’s ongoing.

Charlotte’s more sophisticated thinking combines a holistic understanding with recognition of the significance of family and relationships:

Charlotte: Anyone who’s happy, your mind, your body and your soul… not doing bad things… I just didn’t care about myself, where I wouldn’t get in the bath, you know, and sometimes you’re that down you wouldn’t get up for about two days… because of the prostitution… drugs… beer… I was due for a nervous breakdown as well, I do know that… got a new lease of life now, I’ve got my boys, I’ve got a new fella, he knows my past.
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Time in sex work and background</th>
<th>Health and exercise</th>
<th>Service experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amy</td>
<td>36 years</td>
<td>I don’t work on the streets</td>
<td>I’ve just had a coloscopy … and ongoing smears</td>
<td>… and the (dental) receptionist there was very nasty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lives with partner in rented accommodation. Two children in care. Owns rescue dog (‘last owner used to beat her’)</td>
<td></td>
<td>I get (anti-depressants) off other people, I know I shouldn’t</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>I’ve never heard of half of these (services), they don’t tell you, nobody ever tells you anything</td>
</tr>
<tr>
<td>Charlotte</td>
<td>40</td>
<td>11 years</td>
<td>Diagnosed with asthma (and) given an inhaler</td>
<td>GP: … the minute they find out you’re on methadone they don’t want to know, they just want you out that surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I just work when I need to work</td>
<td>I walk every day … don’t forget when I was down on the kerb I did a heck a lot of walking … seven nights a week</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Two children, both boys, the eldest lives with his father and the youngest with her. Lives with partner in new relationship in rented accommodation</td>
<td></td>
<td>GP: … not very helpful, think it’s to do with the drugs really</td>
</tr>
<tr>
<td>Claire</td>
<td>32</td>
<td>7 years</td>
<td>… a bad chest and I’ve got a water infection. … In the morning I wheeze … having trouble sleeping</td>
<td>going to see a woman (from alcohol service) after here</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I hardly work anymore … I’m not doing it every day</td>
<td>Walk with the baby almost every day … probably half an hour to an hour</td>
<td>Housing: Crap, crap, absolute crap, I need housing and they’re crap</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lives with partner, baby and mother in rented flat</td>
<td></td>
<td>Got kicked off by my dentist cos I never went to an appointment, only missed two, don’t blame them cos it costs money</td>
</tr>
<tr>
<td>Ellie</td>
<td>32</td>
<td>I only done it (sex work) a couple of months</td>
<td>I walk everywhere</td>
<td>GP: No not helpful</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lives alone in rented accommodation. Teenage years in care. Two children in care and lost a child in road traffic accident</td>
<td></td>
<td>No I didn’t know of places for homeless people</td>
</tr>
</tbody>
</table>

Continued
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Time in sex work and background</th>
<th>Health and exercise</th>
<th>Service experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holly</td>
<td>36</td>
<td>15 years I've come off the streets... so it's just my regulars</td>
<td>I've got chest complaints... I've got a (urinary) infection... I've got emphysema as well as asthma</td>
<td>I like coming to (the Lodge), otherwise I wouldn't have got it (infection) sorted out... this is the best place to come and get seen to, don't have to see anyone else.</td>
</tr>
<tr>
<td>Holly</td>
<td></td>
<td>Lives with partner in rented accommodation ('and she supports me').</td>
<td>I walk... I won't take the bus, I'd rather walk, walk there and I'll walk back</td>
<td>... he (dentist) just treated me a like a leper.</td>
</tr>
<tr>
<td>Jane</td>
<td>42</td>
<td>2 years I'm not working no more</td>
<td>...about ten minutes walk or something like that</td>
<td>Oh I dunno where I would go, the Lodge is great.</td>
</tr>
<tr>
<td>Mary</td>
<td>37</td>
<td>15+ years Anytime, we don't have a holiday girl</td>
<td>Interview terminated early as became upset</td>
<td>... what they (the Lodge) do is brilliant, you can’t fault them.</td>
</tr>
<tr>
<td>Sue</td>
<td>32</td>
<td>12 years ... as many (evenings) as often</td>
<td>... every day, I walk from here to the north end and back again, then back up cos my kids are up there, so I do that about three times a day</td>
<td>... they (dentist) look down on you a bit cos of the drugs but you know it’s not bad.</td>
</tr>
<tr>
<td>Sue</td>
<td></td>
<td>Lodging with partner at a friend’s house. Four children (two boys and two girls) living with family</td>
<td>GUM: ... I don’t like the service there they treat you bad.</td>
<td>I’ve used (social services) and I didn’t like them... I can’t really pinpoint, it was just I didn’t like going there.</td>
</tr>
<tr>
<td>Tina</td>
<td>34</td>
<td>6 years every day... after six of a night</td>
<td>(walk for a) couple of hours a day</td>
<td>‘Great’ (referring to the Lodge)</td>
</tr>
<tr>
<td>Tina</td>
<td></td>
<td>I lived with my aunty and uncle when I was younger Two children currently in care. Lives in rented accommodation</td>
<td>Alright, yeah he was alright (response to all other services)</td>
<td></td>
</tr>
</tbody>
</table>
Several of the women defined being healthy in terms of avoiding drugs and the conditions supporting their use:

Jane: ...someone that’s not on drugs.

Mary: Give up everything, off drugs and move from here. ...I’ve got nothing left round here now.

Tina: living in a better place ...because where I live is dirty and right in the middle of everything ...drugs and stuff.

**Mental health**

Depression was a reality for all the women and considered concomitant with the lifestyle, yet arose only when prompted and was rarely directly attributed to difficult life circumstances:

Sue: ...depression, in the last twelve months.

Ellie: Depression, yeah, maybe, yeah.

Claire: Yeah I do suffer with depression, yeah ongoing. ...I’m on medication, I have good and bad periods.

Jane: yeah, depression. ...I get tablets off the doctor for it.

Ellie: I lost me kids, one got killed on a roadside, it went to court, and I tried to get on anti-depressants, because I do drugs, and I got prescribed drugs, wouldn’t look very good on me in court so I couldn’t get anything. ...I’m waiting for bereavement ...lost my daughter ten years ago, never got over it, lost two of my other children, got put in care, so I haven’t sort of dealt with it all properly.

Amy: I’ve got two kids and they were took off me, so that’s what caused me depression, through being with bad fellas that beat me up. So, and I got really down ...and I self-harm and there was a point in my life when I was going in and out of (psychiatric unit) quite a lot, and I felt no-one wanted to know.

The women often recognized, though, the link between relationships, self-awareness and improved mental health, witness the words of Holly and Charlotte:

Holly: I’m on anti-depressants, have been for a long time ...I actually had my first breakdown when I was seventeen. ...I’ve had asthma since I was a baby. ...I just get through it, my mum died of it, it’s just always been in the house, I just deal with it. ...I’m a very private person.

Charlotte: I just want to get my head together because I want to get out of it all now. ...I’ve worked all my life and I’ve come to this, it’s a joke, I know what I want now.

Amy’s mental health story reveals the contradictions and complexities involved in seeking help, dealing with rejection and addressing the issues underpinning her distress:

Amy: I just never went (MIND), I was always too nervous to go. ...I can’t go out on my own, I got attacked in Liverpool. ...and I can’t go out on my own at night due to my nervousness ...because I was always like there, and the liaison psychiatrist was there, and he was just patronising ...and said there’s nothing I can do for you. He sat there and said you’ve been in and out of (hospital) far too, far too, far too many times and I said what do you want me to do, like, go and jump off a fucking bridge, like, excuse the language.

**Social exclusion**

**Homelessness**

Relations with housing providers, whether housing associations, hostels, refuges or private landlords, were constantly being negotiated; the particular flat or house, though, was often secondary to the desire to get away from the neighbourhood or local area:

Charlotte: They (Housing Association) don’t listen to you ...don’t understand you ...don’t believe what you say. I mean, the fella next door, he’s got an ASBO (Anti-Social Behaviour Order), the one in the next street, he’s got an ASBO, the one round the corner; but it didn’t matter, they still kept me in that flaming house.

Amy: The substance misuse service sent me for an interview ...I come back in an hour and they didn’t have a bed and I goes back in an hour and he said I’ve given your bed to someone else ...then I went back to my mum’s ...then they got me into a homeless hostel ...we’ve been living there for four years ...if we’ve got any chance of getting out the drugs we need to move away from where we are.

A degree of homelessness was almost normal in the lives of the women, combining with fractious relations with housing providers, unstable personal relationships and a generally chaotic lifestyle:

Holly: ...homeless twice (living) rough on the streets, (hostels) I was all over the place (however)
that’s how I met my girlfriend, when I was homeless, so we pulled each other up... no one likes being homeless, that’s all I can say.

Tina: ... everywhere... friends’ places and that... where I live is dirty and in the middle of everything... drugs and stuff.

Claire: ... homeless now, well I’m classed as homeless, I’m staying at my mum’s... a one-bedroome... flat with three adults and the baby... they (the council) just don’t offer you anywhere.

Sue: ... well we are now (homeless) so we’re just lodging with friends.

Alcohol and drugs
Alcohol had been an issue for several women and remained one for some, though several women claimed no longer to drink. Charlotte elaborates on the consequences of regular use of alcohol, hinting at how illicit drugs, despite the consequences, might prove more attractive an alternative:

Amy: I don’t drink, used to, but haven’t drunk for a year

Charlotte: It used to be about 2–4 litres sometimes more... I’ve really cut down. From yesterday I thought I’ll go on the cans and I only had five... later on, I’ll probably have four. But I’m trying to leave it as late as I can instead of, you know, feeling depressed and just thinking Oh God I need the beer, then you’re sweating, the sweat’s comin’ through your pores and everythin’ and you’re getting the shakes. ... I just can’t go through that no more, I just can’t.

The drugs have significant health consequences, though the impact on the women’s self-esteem seems also to be related to the response of others. Their delegation to the ranks of the stigmatized, Goffman’s (Goffman, 1963) ‘less than human’, is invoked by Sue’s belief that society regards sex workers a reservoir of infection, reflecting early concerns about HIV and AIDS (Karlen, 1995). Charlotte’s call for compassion and Amy’s anger illustrate different concerns about services, though it is Charlotte’s desire to be called by her full Christian name that lingers:

Mary: I’m just rattlin (withdrawing), if that’s anything to go by.

Sue: they (dentist and reception staff) look down on you a bit cos of the drugs and everything... once they find out you’ve got a drug background, people sort of stand back from you and treat you different... they think you’ve got all kinds of diseases... you can see the difference the way they treat other people.

Charlotte: I’ve seen girls go in (chemist shop for prescription) and they’re looking skanky and people are moving away from them... they can’t help the way they look, you know, it’s the drugs. Drugs do affect your life in a big way. If only people could understand what other people are going through, but they don’t want to know, they think, we’re the good people here, they’re them junkies, whatever, let’s shove them all on an island and be done with it... they need to understand you can get good people you can get bad wherever you go, you can get drugs no matter where you go... understand people a bit more, you know, they have a service for us lot and then a different service for different people... they (her local chemist) are brilliant, very helpful, they call me by my proper name, Charlotte, whereas the last one (chemist) just want you in and out... anyone who’s on methadone or medicated drugs or anything. ...The security guard follows you round and then its not nice, before you get through that door they’re on their walkie-talkies.

Amy: I find them (chemist) very arrogant, they’re bad mannered, they’ve got no respect, they just look down their noses, cos we have to go in for methadone; we find that with other services... we don’t get the treatment that we should.

The one service to attract positive comment was the HRS, the immediacy of appointment, it is constancy over time and it is evidently different ethos served to counter the experiences of more generic services.

Jane: because they (HRS) helped me out when I needed it, I would have been in shit-street, because I had no methadone script or nothing like that, would I?

Sue: (using the HRS for) about 15 years basically.

Tina: Yeah, see them (sexual health outreach team) sometimes here, they’re okay... (whether services could be improved) nah.

Violence
The violence characterizing the women’s lives included neighbour assault, sexual and work-related incidents; it tended to have powerful personal consequences and was also pervasive. Strikingly, though, the impact of the women’s words arises less from the violence or police...
reaction, and more the failure of the housing official to respond and the casual descriptions of the assaults:

Charlotte: ...his (neighbour’s) brother beat me up, he punched me seven times in the skull. His mother was standing there, everybody denied it...I was in (hospital) and, do you know, the woman from the housing, she’s still not phoned me.

Sue: I got attacked a few years back and I didn't leave the house...they (sex workers) should have somewhere the girls can work from like rooms, someone at the door for security so it’s safe for them.

Amy: When I got attacked over in Liverpool I didn't find them very helpful (police) because I'd had a drink; they were sort of making out that it was my fault, they made me feel that big (signs with fingers).

Holly: I don’t go on the streets anymore as I was attacked once too often.

Charlotte: I've been raped twice.

Amy: I was abused as a kid, I've had a bit of a bad life really...I was in and out of care and...I wasn’t an adult in my mind...I was still pretty insecure with everything that was going on, so even though he (baby) was planned, he come too soon, and plus his father, he beat me up.

**DISCUSSION**

Participants in the study were recruited from one geographical area. There should be caution, therefore, in attempting to generalize findings to other areas where sex working behaviours, patterns of service provision and barriers to access may be different. The context of social exclusion, however, seems likely to similarly afflict street-based sex workers throughout the UK, though this may vary according to the degree of local deprivation. Additionally, participants were recruited opportunistically through one service, and the views of sex workers not accessing this service have not been elicited.

The main barriers to generic services were identified.

- The problematic nature of appointments: waiting times, too many different visits, not remembering, being too sick to attend.
- Travelling to services: all the women walked, rarely even using public transport, because of the cost and having to mix with other people.
- Stigma and negative staff views: about drug use and the expectations of behaviour and background associated with this activity, though the women were also embarrassed by their lifestyle.
- Mental ill-health: particularly depression, which most of the women experienced to some degree, and restricted the ability to attend appointments.
- Ongoing issues: money, housing requests, childcare arrangements and relations with the police.
- Concern about accessing support: particularly in relation to children being taken away and losing benefits.
- Lack of knowledge about which services were available and how they might help, compounded by literacy difficulties.

The same patterns seemed to exist across services, though it is not possible to conclude that a specific service is definitely linked with a particular barrier, or whether certain women are more likely to encounter difficulties. The effect of a potential barrier depended on a number of factors. These include the attitudes of key professionals or service personnel, even pharmacy assistants, having power during individual encounters. The women had developed a degree of apparent insensitivity through their choice of work and the effects of the drugs and alcohol, so that they could appear coarse or hardened to rejection. They were, however, extremely sensitive to the remarks of others, the looks that they received in shops, their self-awareness over looking ‘skanky’. They could judge the response of others and often learned to present themselves in ways that would minimize the impact of the insults, casual remarks and muffled comments. The women’s personal circumstances, the uncertainty of relationships, nature of family support and living arrangements, changed abruptly, regularly and with far-reaching but uncertain consequences. Empowerment, the means and opportunity for self-assertion (UNAIDS, 2002), might be a useful approach to equipping the women with some of the skills to counter these problems. The issue, according to Rekart (2005), surrounds sex worker vulnerability, whereby low self-esteem combines with poor literacy skills and difficult living circumstances (Vanwesenbeeck, 2001) to virtually eradicate contact with mainstream services. Sex workers are reluctant to seek medical attention.
even following assault (Norton-Hawk, 2001), and addressing this invisibility might prove significant in enhancing their health chances. A further complication is the desire to ‘pass’ as normal and conceal (Goffman, 1963), not just the sex work and drug use but frequently the whole life story; the process of stigma perpetuating marginalization.

This study explored the link between lifestyle, drugs and sex work, and the women spoke openly about the interdependencies and health consequences. Homelessness was a regular feature in many of their lives, several currently without a permanent address. It was difficult, however, for the women to recognize poor mental health as being associated with these extraneous factors, a tendency to individualize their experience being more likely. Low self-esteem and emotional distress are common in sex workers and findings from this study confirm both the acceptance of depression and self-treatment primarily with illegal drugs (Valera et al., 2001). The women frequently overlooked the emotional risks of their work, a consequence of which may be a downward spiral into poor mental health (Sanders, 2004b).

The already significant health consequences of street-based sex work appears exacerbated by an element of professional detachment, services knowing the women, yet, as Goffman warns us, ‘familiarity need not reduce contempt’ [(Goffman, 1970), p. 70]. They were likely to disengage quickly, failing to keep appointments around routine screening, health checks and vaccinations; they require a coordinated, sophisticated and flexible response from services. Practitioners and front-line staff, especially in non-specialist settings, appear to lack awareness, training and the requisite skills to be able to work effectively with this socially excluded group, partially because of the concomitant association with illegality and stigma (Lucas, 2005). An empathetic approach to engagement, nevertheless, might be considered a prerequisite for anyone working with any socially excluded group. These women have low health aspirations, poor expectations of services and limited opportunities to influence their care. The medical model remains influential, emphasizing treatment rather than health promotion, prevention and recovery. A more holistic approach, however, appears essential for these women, the social context, particularly the structural inequalities, so disproportionately experienced by female street-based sex workers, combining with their experience of health-related services to devastating effect.

**CONCLUSION**

One way of increasing street-based sex workers’ access to services is to invest more in provision and widen eligibility, though this is unlikely in current political and economic circumstances. There is an abundance of evidence that female street-based sex workers experience significant social exclusion, and this is confirmed by this study, perhaps even more so than expected when the details of the participating women’s lives are explored. The effects of factors like interpersonal violence, children taken into care and/or dying must be immense, though not all the women’s lives were similarly afflicted. One woman may cope better with seemingly insurmountable difficulties than someone (non sex worker) with a stable family and secure relationship. Social exclusion is a complicated concept, which recognizes that issues of substance misuse, mental health, inadequate housing, low income and poor access to services are dynamic, interrelate and frequently result in exclusion from participation (Room, 1995). These women, experiencing multiple difficulties and complicated by the normalizing of violence, are marginalized from services and the wider social community as a result of social exclusion. It helps to explain, furthermore, how barriers to service use varied between women. A new relationship, for example, renewed acquaintance with family, neighbourhood improvement or link with key professional might enhance access to services. The HRS provided an established mechanism for providing long-term support, sometimes over many years, a place of safety where the women could access a number of services without feeling stigmatized. Unfortunately, however, it also served to accentuate their ‘difference’, providing a non-judgemental service but not really addressing the issue of how to facilitate greater inclusion.

Social exclusion, however, fails to explain why some female sex workers said that some services and professionals were more difficult to access than others. The ways in which some practitioners and service workers interacted with the women was better than others, though the reasons for this might be complicated.
Individual professionals have the power, effectively, to exacerbate the feeling of already being excluded or marginalized, perceiving some who use their service as being somehow unsuitable, difficult or unworthy. Such people, furthermore, are in a position to enhance the experience of others, those they consider deserving, good mothers or conforming to social norms. The interface between service provider and sex worker, therefore, is related both to the individual’s behaviour and appearance and to the professional’s knowledge and understanding of the complexity of the lives of the people they encounter. This paper has sought to address the nature of the experience of street-based sex workers when accessing services, particularly the importance of having an awareness of social exclusion. This has required considerable emphasis on the role of drugs, alcohol, violence, mental health and housing issues, among many other factors (e.g. family complexity) in anchoring the women within a particular way of life.

**RECOMMENDATIONS FOR PRACTICE AND FURTHER RESEARCH**

- Further research is required into the nature of the barriers to health services, particularly chemist shops, health centres and dental surgeries, the ways in which such seemingly peripheral services serve to increase marginalization.
- There is a need for further investigation into the social context of female street sex workers, especially experience of homelessness, domestic circumstances over time and health issues subsequently experienced.
- The significance of the HRS as a mechanism for facilitating access to health care should not be under-estimated, and the skills and knowledge of the professionals working there might provide guidance for more mainstream services.
- A different way of increasing engagement with services is necessary, which takes into account the complex ways in which different factors interrelate, so that one woman might be prevented from seeking assistance while another, in very similar circumstances, will do so successfully.
- Research is needed to investigate how barriers to health services, whether direct providers or indirect support services, emerge and why they remain, so that ways around them can be determined.
- Further work needs to be undertaken, perhaps through an attitude study, around the relationship between sex work and stigma, particularly the stigmatizing attitudes of health workers.

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