Sex Work and Health: A Question of Safety in the Workplace

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Sex work is an occupation or trade involving exchange of sexual services for economic compensation. Although health problems associated with prostitution, such as sexually transmitted diseases and violence, are commonly assumed to be "risks of the trade," the illegality and stigma of prostitution have prevented the medical establishment from viewing it through the lens of occupational safety and health. They have also resulted in a failure to look at such day-to-day conditions and illnesses as repetitive stress injuries and other musculoskeletal problems, bladder infections, and work-related stress that may be of more immediate concern to sex workers. This paper reviews what is known about the safety and health hazards associated with prostitution through some formal research, but primarily through informal discussions with sex workers over two decades. The overarching factor affecting the health of sex workers is the legal context, thus that is reviewed first; then I look at occupational hazards and conclude with some suggestions for immediate action and further research.

Sex work is an occupation or trade involving exchange of sexual services for economic compensation. A Medline search for January 1994 to October 1997 using the terms "prostitution" and "occupational health" produced a null set, while a search using only "prostitution" pulled more than 375 citations. And yet, health problems associated with prostitution, such as sexually transmitted diseases (STDs) and violence, are commonly assumed to be "risks of the trade." In the first instance, this can and has led many people—ranging from public health practitioners to the ordinary person in the street—to assume that prostitutes bear the primary responsibility for the propagation of STDs in the general population. In the second case, it has led some, particularly police, themselves at increased risk of violence, to think that violence is just something prostitutes should expect and the police can ignore.

A second issue that affects the way many people—including medical and public health practitioners—look at sex workers' health is a tendency to view prostitution in isolation, as though it had no common points with any other aspect of human life and work. Thus if prostitutes experience stress at work, it is because that work is prostitution, not because working under conditions set by an employer is often stressful. Or, as one informant recently said to me, "I'm tired of having [non-sex worker] friends assume that if I don't feel like going to work one day, it is because 'prostitution is so awful,' and not because I just don't feel like going to work." Finally, a related issue is an assumption about what aspects of prostitution affect how a sex worker feels about herself or himself, either positively or negatively.[1]

This paper reviews what is known, through some formal research but primarily through informal discussions I have had with sex workers over the past 22 years, about the safety and health hazards associated with prostitution. The overarching factor that affects the health of individuals involved in sex work and sex barter is the legal context in which such exchanges occur. Thus, I will first review the legal context of prostitution and other sex work before turning to occupational hazards and conclude with some suggestions for immediate action and further research.

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The Legal Context of Sex Work

Prostitution is defined legally as the provision of sexual services or performances by one person, the "prostitute" or "sex worker," for which a second person, a "client" or "observer," provides money or other markers of economic value. Sex trading or barter and "survival sex," while part of the prostitution continuum, represent sexual activity performed in exchange for a place to sleep, food, or drugs. However prostitution is defined, for as long as there have been written records, states have promulgated rules and regulations governing prostitution, or related activity. For example, some of the earliest laws in Sumer dealt with the division of prostitutes and concubines from chaste wives.[2]

With the exception of Nevada, all of the US states prohibit prostitution through city ordinances and state and federal laws. Prohibitions include soliciting, engaging in, or, in many states, agreeing to engage in prostitution; loitering for the purposes of, or with intent to commit, prostitution; crossing state lines for the purposes of prostitution; living off the earnings of a prostitute; encouraging anyone to work as a prostitute or promoting prostitution; and operating or managing a prostitution business or renting a premises to be used for prostitution. Nevada offers counties with populations of less than 400,000 the option of permitting closed brothels. Women who wish to work in the legal brothels (there are no male brothels), and approximately 300 women do so within the course of a year, are required to register with the local authorities and to submit to weekly tests for gonorrhea and chlamydia and monthly tests for syphilis and human immunodeficiency virus (HIV). All other prostitutes in Nevada and the rest of the United States work illegally.

Beginning in the mid-18th century, even before it was possible to accurately diagnose any STDs, and before syphilis and gonorrhea were recognized as sepa-

rate diseases, many countries enacted health-related laws regulating the prostitute and requiring those so identified to submit to regular examinations. Countries that did this in the 19th and early 20th centuries include France,[3] England,[4] Italy,[5] Russia,[6] India,[7] and Argentina,[8] among others. In some cases, if the examiner claimed to recognize signs of an STD, the prostitute was quarantined, in others she was simply barred from working in what were often called "zones of toleration."

As of December 1994, 22 US states had mandated HIV tests for anyone convicted, or in some cases merely arrested, on prostitution charges, and 11 had increased the basic soliciting charge to a felony for anyone arrested subsequent to testing positive (Lisa Bowleg, AIDS Policy Center, written communication, December 1994). Most prostitutes work outside of any registration and/or testing systems, with the proportion covered by mandatory health schemes ranging from about 2% in Senegal, according to Edwige Bienvenue, coordinator of a sex worker's HIV/AIDS prevention intervention in Dakar, to around 50% in Singapore (Roy Chan, MD, National Skin Centre, Singapore, verbal communication, October 1992).

Enforcement in the United States. To give a sense of what these laws mean in the United States, nationwide there were 97,700 arrests on prostitution-related charges in 1995.[9] Of those arrested, 61.1% were female, 38.9% were male, 36.6% were black, 60.5% were white, 0.5% were Native American, and 1.7% were Asian/Pacific Islander. Arrests of Hispanics were included in either black or white arrests and were not counted separately. People with a history of prostitution arrests are also arrested on other charges, such as substance use, disorderly conduct, vagrancy, curfew and loitering, and running away from home; the total number of arrests of sex workers on these other charges may be as high as 500,000 per year.[10] This kind of arrest is not reflected in the national statistics as a prostitution arrest.

Impact of Law Enforcement on Sex Workers' Health. Individuals arrested on prostitution charges often modify their work behavior in an attempt to reduce their visibility to the police. For example, street prostitutes reduce the amount of time they negotiate before getting into a client's car, and they may agree to acts carrying higher risks if it means more money, in order to reduce the time on the street, and thus the likelihood of being arrested. In the words of "Joellen Feinberg," who I interviewed in 1995, "I had to get into cars quicker, and I had to be less noticeable, so I lost money. After I got busted a few times, it affected the kind of sex I was willing to do. I wanted to get off the stroll quickly, to avoid being arrested, so I did what I could to get more money quickly. Like anal sex. It's because I became a 'known quantity' on the street." As a result, sex workers become more vulnerable to pressure to not use condoms, thereby increasing their risk of contracting STDs, including HIV. The need to make a quick decision also makes it harder to screen out potentially violent clients, increasing their risks. In addition, repeated arrests undermine the stability of the sex worker's living situation, and the likelihood of homelessness increases. Although the risk of arrest is lower for off-street workers, the impact of an arrest can still be extremely traumatic.

Police may confiscate condoms during street arrests, sometimes to use as evidence but often more as a form of harassment. Sex workers have told FROST'D (From Our Streets with Dignity, an HIV prevention project that works with low-income street prostitutes in New York City) outreach workers of police taking their condoms and throwing them in empty lots, for example. In off-street establishments, fear of arrest on felony charges can cause management to discourage the use of condoms, which could be used as evidence that the establishment is in the business of prostitution. One informant told me that her employer kept all the condoms loose in a large plastic bag so she could toss it out the window if the police came. After all, the crimes that fall under the rubric of "promoting prostitution" or "running a disorderly house" are generally felonies.

Intense law enforcement on the street (ie, crackdowns, sweeps) has a number of effects. The first is that prostitutes and/or clients migrate to other areas in order to avoid arrest.[11] Second, there is a synergistic relationship between increases in law enforcement activity and violence against sex workers, including violence by clients, drug dealers, neighborhood vigilantes, lovers, and police.[12] In New York City in 1996 and 1997, as Mayor Rudolph Giuliani organized a campaign to "improve quality of life" by increasing the number of arrests of street people, FROST'D outreach workers observed an increase in the number of rapes and murders reported by sex workers from one to two per month to five to eight per month. In those two years, a number of street workers began working out of vans and/or using beepers to reduce their risk of arrest. Others migrated to work in other neighborhoods or in New Jersey. The Committee Against Anti-Asian Violence found that as law enforcement also increased against massage parlors, Korean sex workers began to work outcall—going to the client's home, office, or hotel room—where they faced a sharply increased risk of assault. Even prior to the current crackdown, Prostitutes of New York (PONY) received sporadic reports of police entering brothels and raping some or all of the women.

A number of factors contribute to this increased vulnerability to violence. For example, as prostitutes and/or clients migrate in response to a crackdown, the sex workers lose regular clients, with whom they have established routine, safer work practices. The process of identifying and training new clients always carries some risk of violence because of interpersonal struggles over who, ultimately, controls the prostitution transaction.[13] One reason for the increased violence among massage workers in outcall is that the women had been trained to work in a communal setting and did not know how to handle a potentially violent customer without recourse to help from others. Another source of violence is neighborhood vigilantes (and sometimes the police themselves) who take governmental promises to rid the city of prostitutes as license to be brutal. In addition, the increasing instability of the sex worker's living situation due to frequent arrests can cause tensions in personal relationships, which may escalate to domestic violence.[14,15]

Occupational Hazards Defined by Sex Workers

Most people associate sex work with STDs, and there is an extensive body of medical literature identifying prostitutes as vectors for the transmission of such infections, including HIV, or more succinctly as a "core group of high frequency transmitters."[16-18] In my recent search of Medline for references to prostitution, only 14 of 376 citations (3.7%) were *not* primarily concerned with either HIV or other STDs. However, sex work involves more than the direct acts of oral, vaginal, and anal intercourse, and the occupational safety and health hazards associated with prostitution are not limited to STDs. They include injuries, other kinds of infectious diseases, emotional stress, and alcohol and drug use. Moreover, although violence and HIV are obviously the most serious hazards to prostitutes in terms of mortality risk, they are not necessarily perceived as the most worrisome by the workers on a day-to-day basis. In the following section, I will discuss health hazards in the terms sex workers have discussed them with me, working from the routine to the exceptional.

Repetitive Stress Injuries and Trauma. In my interviews with sex workers, they have identified musculoskeletal injuries as a significant occupational hazard, including repetitive stress injuries to the wrist, arm, and shoulder due to repeated hand jobs; jaw pain as a result of performing fellatio; knee pain related to working in a crouched position for long periods of time in strip clubs; foot problems related to standing and walking in high heels; and back problems related to dancing, walking, and working on inadequate beds or massage tables.

Some sex workers have reported repeated bladder and kidney infections, particularly during their first years of sex work. As one informant explained it to me, when women begin working, they may not know how to position themselves to prevent trauma to the bladder or the importance of urinating between clients. The use of diaphragms has also been associated with increased bladder infections.[19] Although it is relatively simple to treat bladder infections, at least where antibiotics are available, some women go on to develop chronic cystitis.

As discussed above, some groups of sex workers face a significant risk of violence at work, including rape and other sexual assault, physical assault, and murder. While these risks are greatest for workers who contact clients on the street, there is some risk for off-street workers as well. A study that looked at occupational hazards among sex workers in Montreal and San Francisco found that female and transgender sex workers in both cities faced a significantly higher risk of violence than male hustlers.[20]

Psychological Stress. Prostitution has long been defined as pathological in the psychiatric literature. Although most sex workers reject this characterization, they acknowledge a significant amount of stress associated with the work, not least because of the illegality and stigma. The highest stress is experienced on the street, where risk of arrest and/or violence serves to undermine sex workers' sense of control over their lives, including their health. Two recent papers examined the presence of psychiatric symptoms among sex workers, although neither identified the specific aspects of sex work that contributed to the stress.[21,22] In one study, however,[21] women who worked on the street suffered significantly more from depression than brothel workers, and the other study[22] found a higher prevalence of "paranoid ideation" among crack users who traded sex than among crack users who did not engage in sex trading.

Another factor affecting sex workers' emotional well-being is the question of managing stigma, or the compound impact of social and legal disapproval, discrimination, and marginalization.[23-25] The consequences of being labeled a "prostitute" can be quite serious. In the United States, for example, it may be grounds for denial of a tourist or immigration visa, work permit, and/or citizenship, as well as for deportation. A woman who called the San Francisco COYOTE office in the early 1980s is a case in point. She had immigrated to the United States from Canada as a child, but had not become a citizen; as an adult she had been arrested on prostitution charges several times, and the Immigration and Naturalization Service instituted deportation proceedings. Even immigrant women who have been forced to work as prostitutes under slavery-like conditions are routinely deported in many countries, while little effort is made to prosecute those who force their labor (the Foundation Against Trafficking in Women, verbal communication, October 1986, November 1993; Global Alliance Against Trafficking in Women, verbal communication, April 1997). Current and even past work in the industry is frequently used as justification for removal of children from a sex worker's care.[26]

One way that sex workers limit the impact of the whore stigma is to use a variety of names for work, leaving their original name unconnected to sex work. For example, some workers use different names in ads to suggest different skills that they offer, while on the street workers may use different names in different neighborhoods or at different times, but also to frustrate police efforts to keep track of them. While some sex workers are open about their work with everyone, many if not most live double lives to some extent, restricting the number of people who know how they earn a living. "Coming out" to family is particularly difficult, and some sex workers create complex stories about what they do for a living in order to prevent parents, other relatives, and in some cases lovers and marriage partners from learning about the true nature of their work.

When sex workers change occupations, they face the challenge of how to explain the years they worked, and/or what they did to develop the negotiation, counseling, financial management, and other business skills that would be transferable to other kinds of work.

Alcohol and Drug Use. Work-related stress is a factor in the use of alcohol and other drugs among some groups of sex workers, with the highest use occurring on the street and estimated at from roughly 50% in Seattle in the 1970s, to more than 80% in New York City at the present time (J. James, FROST'D, unpublished data, 1975).[27-29] Significant drug use is more common among street prostitutes, who have two basically distinct patterns of drug use. Approximately 60% of street prostitutes who use drugs did so prior to becoming involved in prostitution, and indeed, turned to sex work to pay for the drugs.[27] It is in this

population that a significant association between sex work and a history of childhood sexual abuse has been found.[30] The other 40% begin to use drugs after beginning sex work, presumably because of the availability of drugs or alcohol, the pleasure that psychoactive drugs can give, and their effectiveness in controlling emotional stress.[27] Drug use among off-street workers appears to be similar to that of other occupational groups of similar economic status.

The nature of the drug use can have a significant effect on how sex workers operate. For example, some New York City sex workers make a distinction between "before crack" and "after crack" (BC v AC) prostitutes, pointing out that those who began working before they started smoking crack tend to be trained and to work professionally, insisting on condom use even in crack houses. The AC workers, however, who drift into sex trading or barter to obtain crack, are much less likely to think of what they are doing as prostitution or sex work, but rather view it as a question of survival. If they do work for money, they charge much less than sex workers who do not smoke crack ($2-3 v $20-50), and are therefore less in a position to resist offers of additional money to forego condom use (Loretta Dolphus, FROST'D Case Manager, verbal communication, January 1998). This is particularly significant in terms of HIV risk, because among women who smoke crack, which can cause cuts and burns in and around the mouth, frequent performance of fellatio is strongly associated with HIV infection.[31]

Infectious Diseases. Although a great deal of attention has been focused on STDs and sex workers in the literature, little has been said of other contagious diseases, such as pneumonia, bronchitis, and possibly tuberculosis, although as with other occupations involving extensive contact with the public, one would expect the risk to be relatively high, particularly among street-based workers. One reason some Australian sex workers give for refusing to kiss clients is, indeed, the health risk (Penelope Saunders, former director of the Sex Industry Network of South Australia, verbal communication, July 1997).

Money, police, violence, and their children often feature much more prominently than STDs in sex workers' concerns. And indeed, although some studies have documented an alarmingly high incidence of STDs and/or HIV in some sex worker populations, others have found little or none. For example, the multicenter study conducted under the auspices of the Centers for Disease Control and Prevention in the 1980s was the first to clarify this reality.[32] In that study 12.3% of 1,396 female sex workers tested positive for HIV. The prevalence, however, varied from 0.0% among brothel workers and applicants in Nevada to 47.5% among sex workers tested in methadone and STD clinics and through street outreach in Northern New Jersey. In general, the higher prevalences were found on the street and in jails, drug programs, and STD clinics. In virtually all cases, HIV infection was associated with either the sex worker's own injection drug use or that of her regular, ongoing sex partner, and the prevalence tended to parallel that among other female drug users in the same communities.[33] The data in Western Europe have been similar.[33] As discussed above, an association has also been documented in the United States between crack smoking, frequent fellatio at work, and HIV seroconversion.[32] Whether it is in the industrialized countries or the poorer countries of the southern hemisphere, the incidence and prevalence of HIV and other STDs are consistently higher among low-income sex workers and traders.[16,34-36]

Although condoms remain a very effective prophylactic against disease, a number of factors act as obstacles to condom use at work, including police practices, as discussed above, and emotional factors. Obstacles to condom use in sex workers' personal relationships include the use of the condom to distinguish work from pleasure, the desire for spontaneity, and the same power dynamics that affect condom use in other personal relationships.[37-39]

A Dutch study looking at HIV risk as an occupational, rather than a personal, hazard identified three broad classes of prostitution styles of work, which the author characterized as "consistent protectors," "selective risk takers," and "risk takers."[40] The consistent protectors tended to work in clubs and private brothels, and relative to those who took more risks, earned more money, and, if they used drugs, kept their drug use under control. They tended to have a fairly relaxed work style, to maintain a professional distance from the clients, and to consider all prostitution transactions to be work. The selective risk takers tended to be somewhat older, having begun work before the acquired immune deficiency syndrome (AIDS) epidemic and were more likely to relax demands for condoms with long-term regular clients. The women identified as risk takers tended to fall into two groups. The first consisted of new immigrants, who were less likely to speak or read Dutch, and who were less integrated into the broader sex worker community. The second group tended to be women who had experienced long-term, repeated child abuse, and/or were significantly more likely to experience violence on the job. What was particularly striking about this group was that they tended to be resourceful in terms of arguments or strategies to convince clients to use condoms, but were often unsuccessful nonetheless.

Mechanical Obstacles. Another emerging problem may be a rising incidence of latex allergies, which could seriously hamper attempts to use condoms. A number of articles have reported on the increasing problem of latex allergies among health care workers,[41] but no one appears to have looked at that issue among sex workers, although anecdotal reports of vaginal irritation associated with using latex condoms abound. When I met with a group of sex workers in Nairobi, Kenya, in 1993, they told me that one of two brands of condoms distributed by the US Agency for International Development caused vaginal irritation after three contacts in a day, while the other did not. Similarly, when I mentioned problems with latex on a private Internet mailing list of some 35 sex workers, 3 promptly replied that they had had problems. According to one informant, many sex workers who purchase their own condoms have switched to the new polyurethane condom, although I don't know of any

HIV/AIDS prevention project that distributes them.

Sex workers who use nonoxynol-9 on a regular basis often report vaginal irritation[42,43] (Ruth Morgan-Thomas, Scot-PEP, verbal communication, April 1990). Moreover, although some studies have found that nonoxynol-9 appears to reduce the risk of conventional STDs, and nonoxynol-9 kills HIV in vitro, it does not appear to offer any additional protection over that provided by the condom.[44] Although the problem of vaginal irritation has been clear since 1989, most departments of public health provide condoms with nonoxynol-9 to sex work-specific HIV/AIDS prevention projects all over the United States, as I have discovered in talking with colleagues at numerous conferences.

Meanwhile, many sex workers have told me they use nonpenetrative acts that carry little risk of infection.

Sex Worker Organization for Occupational Safety

As I have discussed at length elsewhere, a number of governments have funded projects to help sex workers protect themselves from HIV/AIDS.[45] Some have funded existing sex workers' organizations or recruited sex workers to develop health-focused projects, with an emphasis on STD and HIV prevention; others have funded more mainstream organizations, some of which have relied on sex workers' knowledge to develop their programs. In both cases, the funding has enabled sex workers' organizations to develop comprehensive services for sex workers and to work toward law reform and other policy changes to improve sex industry working conditions. Many US cities have reached street-based sex workers through HIV/AIDS prevention projects focused on drug use, and some have funded sex worker-specific projects, although only a small number of projects organized by sex workers themselves have been funded (eg, the California Prostitutes Education Project/CAL-PEP, which was formed by members of San Francisco COYOTE, and WHISPER in Minnesota). Many community-based projects that seek to work with sex workers have hired current and/or former sex workers as outreach workers, counselors, and sometimes project managers (eg, FROST'D, New York HIV Peer Educators Coalition). In addition, the "square" organizers of some HIV/AIDS prevention projects and/or studies have supported sex workers in forming their own organizations, such as PAYOKE, in Belgium, which grew out of an AIDS project started by the Institute for Tropical Medicine in Antwerp, and LILA, which grew out of a social service project, Pro-Sentret, in Oslo. What began as something called "peer education" is developing into more comprehensive community organizing. It is largely as an outgrowth of these developments that the workers in one San Francisco strip club voted to join a union and affiliated with the Service Employees International Union, and that sex workers in the State of Victoria, Australia, have formed a local in the Australian Liquor, Hospitality, and Miscellaneous Workers Union (*New York Times.* April 20, 1997:E-7).[15] Although some sex workers' organizations in the United States have referred to themselves as unions, they are not actually formalized unions engaging in collective bargaining or affiliated with the trade union movement.

Although the United States has so far only considered more repressive legislation, a number of other countries are discussing or have already enacted new, less repressive laws, largely as a result of sex workers' activism. Some laws have already been revised in Australia, the Netherlands, and Germany, and discussions are underway in New Zealand and South Africa. The first occupational safety and health regulations of sex work businesses are being developed in Australia and the Netherlands, looking at such issues as hours of work, paid sick leave and vacation, pensions, provision of condoms, showers, and ergonometrically designed beds and massage tables.[46]

Harm reduction or minimization projects, including needle exchanges, legal drug provision programs (as in Liverpool),[47] self-defense training, street/workplace organizing, credit unions, and the like, are beginning to have a positive effect on the ability of drug users and/or sex workers to take better care of themselves and to get help if they have problems.[45] As long as prostitution remains a crime, however, the ability of such programs to increase the safety of sex work will be constrained.

Research Needs

Despite Medline's failure to recognize sex work as an occupation, a few publications have looked at sex workers' risk for HIV in terms of occupational hazards.[14,20,41,48,49] Quantitative documentation of sex workers' health problems (other than STDs and HIV) and identification of effective preventative measures are badly needed. One way to do both would be to establish a sex workers' occupational safety and health clinic, including primary health care, infectious disease, urology, orthopedics or sports medicine, physical therapy, stress management, and emotional health specialists (Priscilla Alexander, unpublished data, 1995).[50,51] One factor that will have to be addressed, however, is sex workers' inability to obtain health insurance, if they are open about their work, unless they are eligible for Medicaid.

Factors affecting sex workers' health that are now known largely anecdotally, including the impact of arrest on their ability to work collaboratively and/or to protect themselves, the relationship between levels of law enforcement against prostitutes and levels of violence against them, and the impact of the law on sex workers' ability to set the terms of the sex work transaction, including the ability to use condoms, needs to be precisely documented. And researchers who observe the devastating impact of illegality and stigma on sex workers' health need to ally themselves with sex workers in the struggle for a more rational approach to sex work. I have been repeatedly surprised at the silence about this aspect of sex workers' lives in the HIV/AIDS literature that has in other ways transformed the medical discourse about prostitution.

Research needs to be rooted in the lived and worked experience of sex workers, not in traditional public health assumptions. Numerous studies have tried to document sex workers' use of condoms, but not the proportion of their work that is safe in terms of HIV and STD risk because it avoids the euphemistic "exchange of bodily fluids." And yet, my informal questioning of street prostitutes in New York City sug-

gests that about half the time, vaginal sex is simulated with the hand, and a notable proportion of prostitutes perform more hand jobs than oral or vaginal sex. However, if researchers don't ask about it, but only about condom use, they will never know. Similarly, if no one asks, physicians and other health care providers are unlikely to recognize that a painful arm or recurrent bladder infection may have to do with work practices, and therefore lose the chance to help sex workers avoid those problems in the future.

It is important to recognize the health-related problems of sex work, that they are not caused by questions of morality,[52] and that they are intensified by criminalization and widespread public antipathy to sex workers. Health care professionals are among the most respected professionals in our society. They can play a major role in improving the way society deals with sex workers.[26,53,54]

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