

Health Experiences of Women Used in Prostitution:
survey findings and recommendations

CURA RESOURCE COLLECTION

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MEMORANDUM FOR THE RECORD

On 11/14/50, the Board of Directors of the
Federal Reserve Bank of New York
voted to approve the following:

The idea for this study was initiated by WHISPER, and it is their vision of advocacy and commitment to prostituted women and children everywhere which undergird this effort. The author, a graduate student in the University of Minnesota's School of Public Health and School of Social Work, contracted to design, conduct, analyze, and report the research through an internship with WHISPER. Funding for the research was secured by the author through two sources: the John B. Hawley Award for Health Promotion Research (a mechanism of the School of Public Health's Division of Epidemiology), and the Center for Urban and Regional Affairs (CURA). There are two other agencies without whom this research could not have been conducted: the Volunteers of America Correctional Facility in Roseville, who provided access to their clients who wished to participate in the study, and PRIDE, who provided a crucial location for data collection, staff expertise for pretesting, and tireless efforts in scheduling and communication with the author. PRIDE truly acted as a partner in the data collection.

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EXECUTIVE SUMMARY

A study to explore the health experiences of a sample of adult women used in prostitution was undertaken in 1993. The study sought to identify areas of concern, provide guidance for agencies which work with the population, and encourage further research into the health risks and needs of prostituted women. A self-report survey of medical access and health variables, exposure to prostitution, and demographic data was verbally administered to local women who volunteered to participate in the study. Women were recruited through announcements at agencies which serve vulnerable women, two agencies which specifically serve prostituted women (WHISPER of St. Paul, and PRIDE of Minneapolis), and a Ramsey County women's jail. The women's identities were protected, and they received \$20.00 for their participation.

The final study sample consisted of 68 women who had been prostituted for at least six months and who had not been out of prostitution for more than five years. They were between 20 and 45 years of age, with a median time spent in prostitution of approximately six years. The median number of lifetime prostitution "dates" was almost 3000, averaging over 40 "dates" per month. The types of prostitution experienced were quite varied, including traditional "on the street," strip clubs, escort services, and crack houses. Thirty-four percent of the women were white and 66% were women of color.

The survey gathered health data in the following areas: gynecologic experiences and pregnancy, sexually transmitted diseases (STDs) and condom use, drug use and addiction, physical and sexual assault, stress-related responses, and access to medical care. The health status of the women in these areas did not significantly vary by type of prostitution, amount of exposure to prostitution, or by demographic variables, with one exception: women who reported more lifetime prostitution "dates" were statistically more likely to have had more STD episodes. Higher numbers of STD episodes were also linked with inconsistent condom use with partners outside prostitution, indicating that prostituted women are not adequately protected from the risk of STD infection through personal partners.

Although it is not known how many of the women have been tested for HIV, only one reported being HIV-positive, a rate which is consistent with the general population of Minnesota women. Other STD infections are a significant health problem for the sample women, who experienced an

average of four episodes of the STDs believed to be most injurious to health: chlamydia, gonorrhea, syphilis, genital warts, and genital herpes. Certain STD infections can lead to the complications of pelvic inflammatory disease (which the women who reported more STD episodes also experienced with significantly more frequency), and can increase the risk of cervical cancer. The women who reported more STD episodes were also significantly more likely to have had a positive pap smear result. The rate of positive pap smears in the total sample was several times greater than the rates reported by the Department of Health's cervical cancer screening program for low and middle income women.

Two major risk factors for cervical cancer are multiple sexual partners and early exposure to sexual activity, indicating the necessity of regular pap smear tests for prostituted women. However, it is not known if the women in the sample received regular pap smears or not; many relied upon public health clinics which only provide STD screening and not cancer screening. In addition, while 87% of the women had a place to go for primary health care, only 35% of these had told their provider about their prostitution status, suggesting that the women may not be receiving health care appropriate to their needs.

Over two-thirds of the women in the sample had an average of three pregnancies during their time in prostitution which they attempted to bring to term. However, 31% of these women received only third trimester or no prenatal care for the last of these pregnancies, a rate almost ten times that of the general state population. It is not surprising that almost 30% of the live births reported by the women suffered from low birth weight or prematurity, compared with less than 10% in the general Minnesota population.

As with other health problems reported in the sample, the abysmal rates of prenatal care are quite likely exacerbated by drug abuse. Almost all of the women categorized themselves as chemically-addicted. While the women reported lifetime use of a variety of drugs, crack cocaine and alcohol were the drugs with the most frequent current use. Crack cocaine is of particular concern due to its association with sex-for-drugs behavior, a phenomenon which is on the rise nationally and can greatly increase both the health hazards and the degradation of prostituted women. Unfortunately, 76% of the women reported being paid with crack.

Another health problem experienced almost universally by the sample is violence. Half of the women had been physically assaulted by a "john," and almost two-thirds had been raped by one. These attacks were often extremely violent; two women spent time in a coma as a result. Even more discouraging is the level of physical assault the women experienced in their private lives. Ninety percent had been assaulted by someone other than a "john," over half of these reported being beaten once a month or more often. Previous research which has linked prior sexual abuse to entrance into prostitution was also confirmed in this sample: 62% of the women reported a sexual assault prior to being prostituted, and over half of these named a family member as a perpetrator.

Finally, the women reported an average of six stress-related difficulties, including sleep disorders, flashbacks, and depression. Most disturbing was the high rate of self-destructive behavior. Forty-six percent of the women had attempted suicide, and 19% had tried to physically harm themselves in other ways, such as cutting. The expectation that prostituted women will eventually make a transition to a "normal" lifestyle is greatly hampered by such chronic emotional troubles. In particular, three-fourths of the women mentioned difficulty establishing an intimate relationship outside prostitution, due to the inability to separate the fear, disgust, and emotionally-distanced attitude developed in prostitution from the dynamics of a loving relationship.

The study results demonstrate the complex problems threatening the health of prostituted women. There are definitive health recommendations suggested by the study. Prostituted women should consistently use condoms, even with their personal partners, to protect themselves from STD infections and complications. Prostituted women should receive regular pap smears due to their increased risk of cervical cancer, and they should find a trusted health care provider with whom they can be honest about their experience in prostitution. In addition, the study suggests that the health challenges of prostituted women are inextricably intertwined with the ravages of drug abuse and violence. Women advocates and service providers need recognize the pervasive nature of prostitution in the lives of vulnerable women, learn to sensitively screen for it in their clients, and develop methods to address prostitution in conjunction with its corresponding social and health issues.

INTRODUCTION

Common sense suggests that prostitution experiences present unique challenges to the health and well-being of women. Anecdotal evidence from prostitution survivors confirms this suggestion, although data on the general health of prostituted women are not available. Prostituted women in the United States have been studied in relation to several specific health problems: illicit drug use, sexually transmitted diseases (STDs), and violence. In countries with legalized prostitution, the health status of prostituted women is more routinely tracked, although these efforts consist mainly of gynecologic and STD screening. A more complete picture of the health status and needs of prostituted women has not been pursued.

It is often assumed, and argued by proponents of prostitution, that prostitution is a viable career choice for women and that their bodies and minds are naturally prepared to sustain the requisite sexual activities and corresponding lifestyle. Women advocates and survivors of prostitution who recognize prostitution as a form of exploitation and violence against women have long felt that more directed research into the health of prostituted women may well dispute these arguments.

To begin to fill the void of information in this area, and to encourage appropriate intervention and further research, a study to assess the general health status of women used in prostitution was initiated by WHISPER (Women Used in Systems of Prostitution Engaged in Revolt) and conducted by the author. The purpose of the study is exploratory; it seeks to gain an initial understanding of the unique health needs of prostituted women through a composite view of the health experiences and access to health care of a sample of local women who have been used in prostitution.

An important qualitative difference of the study is that it focuses on the health status of women used in prostitution *as it affects the women involved*, not merely as it contributes to the epidemiology of a specific disease problem. While some research is conducted to simply contribute to a pool of knowledge, the driving force behind this study is action-oriented advocacy: a commitment to help prostituted women and to minimize the harm which may befall them. Therefore, following an explanation of the study design and presentation of the study results, the report will list recommendations for advocates and service providers working with this population.

THE STUDY

The study was designed as a survey of a volunteer sample of adult women living in the Twin Cities who had been exposed to prostitution for at least six months and who had not been out of prostitution for more than five years. The survey gathered self-reports of health-related issues, information on amount of exposure to prostitution, and demographic data. The questions were primarily close-ended, and were developed through a literature review and discussions with WHISPER staff. A draft of the survey was reviewed by professors in the School of Public Health's Division of Epidemiology (U of M) and a physician at Hennepin County Medical Center. A final draft was pretested with women advocates who are survivors of prostitution.

In order to recruit volunteer participants for the research, announcements were distributed to half-way houses, women's treatment programs, battered women's shelters, and public health clinics. Members of PRIDE (From Prostitution to Independence, Dignity and Equality) and WHISPER, and women participating in WHISPER's support group at a Ramsey County Correctional Facility, were offered participation in the study. A key component of study recruitment was assuring strict confidentiality for the participants. Although the survey was verbally-administered by the author in a face-to-face interview, women made interview appointments using only a first name. Neither this name nor any identifying information was recorded on the interview, so that the data remained anonymous. Interviews took place in a private office at either WHISPER, PRIDE, or the correctional facility. Each interview took approximately thirty minutes to complete, and the women received a twenty dollar honorarium for their participation.

Three important points must be made about the study design and the ways in which it guides the interpretation of the survey results. First, the study is exploratory. It gathers broad measures of many issues to look for "red flags," areas which warrant further attention and research. The self-report nature of the data relies upon the recollection of each subject; future studies would ideally use medical records for verification. Second, data gathered at only one point in time cannot provide "cause and effect" information. As such, the study does not describe health problems "caused" by prostitution; it does describe health experiences common to this sample of prostituted women.

Third, it is not possible to gather a statistically representative sample of prostituted women; there is no master list from which to randomly select participants. Any convenience sample of respondents is open to criticism regarding the generalizability of the study results, and this volunteer sample is no exception. Whether involuntarily serving time in the correctional system, voluntarily attending advocacy support groups, or trying to kick a drug habit, each of the respondents was involved in social service systems in some way. As such, the results of this study cannot be generalized to the entire population of women used in prostitution in the Twin Cities. However, the study does provide a sample of prostituted women who are connected with some of the formal systems designed to serve them. In other words, the study provides data on the needs of prostituted women who we are in a position to help; women who have already been reached in some way; women who our community has the opportunity to better serve through channels which already exist.

THE SAMPLE

An initial minimum goal of fifty completed interviews was easily surpassed. A total of 73 women were interviewed for the study in August and September of 1993. Five of these did not meet the study qualifications (e.g. minimum six months exposure, not more than five years since being prostituted), leaving a final sample of 68 women.

The sample was categorized by the subjects' exposure to prostitution on several levels. It is not unusual for women to float in and out of active involvement in prostitution over a period of years. A pregnancy, a move, incarceration, or another source of income can all interrupt a woman's exposure to prostitution. In order to distinguish between those women who were currently exposed from those who were not, women whose last prostitution "date" occurred within six months of the interview were categorized as "current" (71%), while those whose last exposure occurred longer than six months before were categorized as "former" (29%).

A breakdown of women's times in and out of prostitution also yielded a total time of exposure, expressed in months. For some women this time was concurrent, and for some women it stretched over a much longer period of life. An analysis of average days per week in which the women had "dates" combined with an average number of "dates" per day yielded an approximation of total lifetime prostitution sexual exposures. For some women, the amount of exposure was fairly consistent over the time in prostitution, and for other women, exposure varied greatly depending upon life circumstances. Finally, the density of each woman's exposure was approximated by dividing the total sexual exposures by the total months. The aggregate sample results for these exposure variables are listed in Table A.

TABLE A

Exposure to prostitution variables for the entire sample

<u>variable</u>	<u>average</u>	<u>range</u>	<u>median</u>
total months prostituted	103 (8.6 yrs)	9 - 335	70 (5.8 yrs)
lifetime sexual exposures	10,292	60 - 81,270	2,827
average number of sexual exposures per month	104	4 - 752	43

The extremely high end of the exposure variables is due to several women who have been regularly prostituted in crack houses where it is not unusual to have a sexual exposure every hour in exchange for crack to stay high. Similar experiences have been documented in nationwide studies (see footnote, page 16), and it is important for the numbers representing this tragedy to be included in the overall data. However, the median figures provided may offer a more practical estimation of the "typical" experience of the women in the sample.

The types of prostitution to which the women had been exposed varied greatly, with most women having been prostituted in several different venues, including saunas/massage parlors, escort services, strip clubs, bars, and "the street." No differences were found in reported health problems across the various types of prostitution, but the percentage of women who had been prostituted in crack houses (37%) is alarming considering the accelerated rates of exposure and the additional risks associated with that setting.

The women's current ages ranged from 20 to 45, with an average age of twenty-nine. The average age the women reported for their first prostitution exposure was nineteen. This is quite a bit older than other profiles of prostituted women which generally put the age of initiation between fourteen and sixteen. The fact that the sample was limited to adult women could account for this discrepancy, especially since the average age of initiation for the younger women in the sample (20-29) was significantly* lower than for the older women in the sample (30+). Several of the differences between the two age groups are listed in Table B.

TABLE B

Exposure variables by age group

<u>age group</u>	<u>% "current" / % "former"</u>	<u>average months of exposure</u>	<u>average age of initiation</u>
20-29	75%/25%	75	16.8
30-45	66%/34%	102	21.6

* Whenever the word "significant" or "significantly" is used in this report, it refers to a statistically significant difference between groups ($p \leq .05$).

The median age of initiation for the sample was eighteen, which means that half the women were juveniles when they were first prostituted. The women in the sample who became prostituted as juveniles were significantly more likely to have higher levels of each of the exposure variables: total months prostituted, total lifetime sexual exposures, and average exposures per month.

The racial composition of the sample is listed in Table C. Analysis of key variables and health findings in the study did not find any significant differences between white women and women of color. Other demographic variables of interest are also listed in Table C. The phrase "now or during prostitution" indicates that "current" women were asked about their status now, and "former" women were asked about their status during the time they were prostituted.

TABLE C

General status and demographic variables

<u>Race:</u>	African American	59%	(40)
	Caucasian	34%	(23)
	Native American	7%	(5)
<u>Education:</u> (at time entered prostitution)	less than 8th grade	13%	(9)
	8th -11th grade	31%	(21)
	H.S. graduate or GED	40%	(27)
	more than 12 years	16%	(11)
<u>Income:</u> (now or during prostitution)	very poor	41%	(28)
	just making it	32%	(22)
	average	16%	(11)
	comfortable	10%	(7)
<u>Receive public aid:</u> (now during prostitution)	yes	73.5%	(50)
	no	26.5%	(18)
<u>Have a regular place to live:</u> (now or during prostitution)	yes	59%	(40)
	no	41%	(28)
<u>Have enough food to eat:</u> (now or during prostitution)	less than half the time	22%	(15)
	half the time	9%	(6)
	more than half the time	69%	(47)
<u>Have enough money to provide for basic necessities:</u> (now or during prostitution)	less than half the time	34%	(23)
	half the time	29%	(20)
	more than half the time	37%	(25)

THE FINDINGS

Gynecologic

One of the most effective measures of preventive medicine for sexually active women, particularly those with multiple partners, is a yearly pap smear to test for signs of cervical cancer. Ninety-seven percent (65) of the women in the sample had a pelvic exam during their time in prostitution, although only 45% (29) of these had an exam on a yearly basis. This last figure would compare favorably to general population rates -- if a pap smear test were included in the pelvic exam. Among women age 15 and over insured by the six largest HMOs in Minnesota, 46% received a pap smear in 1992 (Minnesota Department of Health, 1993).

However, it is not known if the pelvic exams received by the women in the sample included pap smears. Due to the self-report nature of the survey, it was difficult to determine reliably whether or not the women had received a pap smear during each pelvic exam. If the women only requested STD checks, chances are good they did not receive a pap smear. Of particular concern are women who rely primarily upon clinics which do not offer a full range of gynecological services. For example, of the 36 women who usually received pelvic exams in public clinics, 30% (or 16% of the total sample) specified either the Red Door or Room 111, clinics which do not offer pap smears as part of their services.

Twenty-four percent (16) of the women reported having received a positive pap smear result which required further testing. Half of these women, or 12% of the total sample, specifically mentioned having a colposcopy and/or cone biopsy. This is an particularly high figure for so young a population. According to figures from the Minnesota Breast and Cervical Cancer Screening Project (1994), which provides screening to low and middle income women and has data from over 25,000 pap smears since 1992, only 4% of the tests have found abnormalities which would routinely be referred for colposcopy and/or biopsy. Thus, regular pap smear screening is particularly important for this population. The main reasons given by the women for not obtaining yearly pelvic exams were "no need to" (53%), and "didn't care/chemically dependent" (42%).

Seventy-five percent (51) of the women have experienced a pregnancy during or since being prostituted. In total, 254 pregnancies were reported; the aggregate outcomes are listed in Table B. Sixty-six percent (45) of the women began pregnancies during their involvement in prostitution which they attempted to bring to term; they averaged three of these pregnancies each. Each of these women was asked about prenatal care for the most recent of these pregnancies: 31% received no prenatal care or only third trimester care. This rate is almost ten times that of the general state population. The Minnesota Department of Health (1992) reports that only 3.7% of all births in 1991 were preceded by a similar lack of prenatal care.

The total number of live births experienced in the sample either during or since involvement in prostitution is 123. The women reported that 29% of these births suffered complications from either prematurity or low birth weight. By comparison, 8.8% of all 1991 Minnesota births were premature, and 5.4% were low birth weight (Minnesota Department of Health, 1992).

TABLE D

Outcomes of the 254 total sample pregnancies reported during or since being prostituted

live birth	48% (123)
elective abortion	25% (64)
miscarriage	24% (61)
stillbirth	2% (5)
ectopic/tubal	<1% (1)

Percentage of the live births which suffered
low birth weight/prematurity = 29% (36)

Sexually transmitted diseases

Sexually transmitted diseases (STDs) are a significant health risk for women. Complications from STD infections can include adverse pregnancy outcomes, pelvic inflammatory disease, and infertility. Exposure to certain sexually transmitted viruses is believed to increase the risk of cervical cancer. In addition, exposure to other STDs is considered one of the best predictors of HIV infection. Although it is not known how many of the women have been tested for HIV, one subject (1.5%) had been diagnosed HIV-positive, a rate which is fairly consistent with the general population of Minnesota women. However, the overall rates of STDs were alarmingly high. Only 15% (10) of the women in this sample had **never** contracted one of the STDs believed to be most injurious to health: chlamydia, syphilis, gonorrhea, genital warts, genital herpes. By comparison, a recent National Institutes of Health study estimates that approximately 60% of the general population of sexually active Minnesota women has never contracted one of these diseases (Slovut, 1993).

The average number of STD episodes experienced by the sample women during their time in prostitution was four.* The most commonly experienced STDs were chlamydia and gonorrhea, infections which can lead to pelvic inflammatory disease (PID). PID accounts for most of the serious illness associated with STD infection. A Minnesota Department of Health Disease Control Newsletter (1994) states:

... approximately 17% of women treated for PID will be infertile; an equal proportion will experience chronic pelvic pain as a result of infection; and 10% who do conceive will have an ectopic pregnancy (pp.1-2).

It is not surprising that 31% (21) of the women had experienced at least one episode of PID, and three of the women (4%) reported having been told by a physician that they are infertile due to tubal scarring. The women in this sample who reported four or more episodes of STD infection were significantly more likely to have also had a bout with PID, and significantly more likely to have received a positive pap smear test result.

*This figure includes only the five STDs linked with significant health risks: chlamydia, syphilis, gonorrhea, genital warts, genital herpes. Other sexually transmitted diseases, such as trichomonas, are not included.

Significantly higher numbers of STD episodes were linked with the group of women who reported higher numbers of prostitution dates, and the link with a greater density of prostitution dates also approached significance. One protection from STD infection in the face of such large numbers of sexual contacts is the consistent use of latex condoms. According to research with prostituted women, condom use with johns is improving in the wake of AIDS, yet condom use with personal partners remains infrequent. The disparity can create a false sense of security for prostituted women who are still at risk from partners who are frequently injection drug users and/or non-monogamous.

This study confirmed those findings. While 68% (46) of the women reported using a condom "all the time" or "more than half the time" with johns, only 10% reported this frequency of use with men in their personal lives. The risk of STD infection outside the context of prostitution is further exemplified by another finding of the study: women who used condoms infrequently in their private lives experienced significantly higher numbers of STD episodes than did women who used condoms at least half the time with private partners or who did not engage in sex outside prostitution.

TABLE E

Percentage of women diagnosed with the following STDs at least once during time prostituted

gonorrhea	69% (47)
chlamydia	60% (41)
syphilis	18% (12)
genital warts	15% (10)
genital herpes	7% (5)
HIV	1.5% (1)

Average number of these type of STD episodes experienced per women = 4

Drug Use/Addiction

Chemical abuse compromises both physical and mental health in myriad ways, and it is a severe problem in this population. Ninety-four percent (64) of the women in the sample consider themselves to be chemically addicted. Most of the women reported using a variety of drugs over time, although the only drugs mentioned with frequency for use in the past six months were alcohol, crack cocaine, and marijuana. Women classified as "former" prostitutes reported significantly lower use of these three drugs in the past six months than did women classified as "current," although it is not possible to know whether this difference stems from an absence of prostitution, being in a treatment program or incarcerated, or other factors.

Despite the availability of treatment for the sample -- 93% of the women have been in a treatment program, an average of three times each -- the use of drugs appeared unabated in the context of prostitution. Half of the subjects reported that they were high "all the time" while soliciting and turning tricks, and another 34% described themselves as high at least half of the time. Anecdotally, while one woman insisted that "it's too dangerous to not have your wits about you," other women felt it necessary to be high before they could face the experience of being prostituted.

TABLE F

Percentage of women who reported use of the following drugs

	<u>total sample</u>	<u>those who ever used the drug</u>	
	ever	past 6 months	began use during time of prostitution
alcohol	98% (67)	72% (48)	19% (13)
marijuana	97% (66)	42% (28)	15% (10)
crack cocaine	96% (65)	71% (46)	78% (51)
powder cocaine	88% (60)	8% (5)	57% (34)
amphetamines	78% (53)	2% (1)	45% (24)
barbituates	46% (31)	19% (6)	52% (16)
hallucinogens	46% (31)	-- (0)	45% (14)
PCP	40% (27)	4% (1)	30% (8)
heroin	38% (26)	12% (3)	69% (18)

Next to alcohol, crack cocaine was the most frequently used drug (in the past six months) in the sample. The ravaging effects of crack cocaine in general and for prostituted women in particular have already been well documented by researchers.* The low price and relatively short high of crack has encouraged a tremendous increase in sex-for-drugs exchanges. Sex-for-drugs exchanges (compared to sex-for-money exchanges) increase the health risks of prostituted women by increasing the frequency of both drug use and sexual contact, and by reducing an already tenuous monetary income. In this sample, 76% (52) of the women had exchanged sex for crack. One woman summed up her opinion on the interplay between prostitution and crack by offering some advice to the author: "If somebody on crack tells you they ain't ho'n [whoring], they lyin'."

Injection drug use offers additional health threats; in particular, increased risk of HIV and hepatitis B infection through needle sharing. Thirty-seven percent (25) of the women reported injection drug use, although many anecdotally described their use as rare, stating, "I only tried it once or twice." However, 72% of the women who reported injecting drugs during their time in prostitution had used a borrowed, shared, or rented needle, and only half of these women reported ever bleaching shared needles before use.

In the wake of the AIDS epidemic, the epidemic of hepatitis B is often overlooked, yet it is a significant health risk also spread through bodily fluids. A recent serilogic study among incarcerated Minnesota women (42% of whom reported being prostituted) found the prevalence of positive hepatitis B markers to be 9% -- at least ten times the general U.S. population rate. The most significant risk factor associated with a positive test for hepatitis B markers in that sample was injection drug use. However, only 22% of the women who tested positive were aware of a history of hepatitis (Novak, 1994). Carriers of hepatitis B who can go on to infect others are frequently not aware of their infection.

This study of prostituted women found that seven (10%) recalled a history of hepatitis B, and six of these also reported injection drug use. Considering the self-report nature of the data, it is entirely possible that the true number of hepatitis B carriers could be much higher.

*For an excellent ethnographic study of crack cocaine in the lives of prostituted women, see Mitchell Ratner's Crack Pipe as Pimp, Lexington Books, 1993.

Stress Response

Emotional responses to traumatic events can have numerous health effects, ranging from sleep disorders and flashbacks to clinical depression and suicide. Eleven potential responses were tracked in the survey, and the women in the sample reported an average of six. Some of the most frequently experienced problems were depression, insomnia, flashbacks, and sexual dysfunction. The level of stress responses did not significantly vary across types of prostitution, levels of exposure to prostitution, or age of initiation, although the level was significantly higher for women who had also experienced sexual violence prior to being prostituted.

The most disturbingly frequent stress response was self-destructive behavior. Nineteen percent (13) of the women reported self-mutilation behavior, such as cutting, and 46% (31) had attempted suicide.* While there are no reliable estimates of suicide attempt rates in the general population, researchers believe that 10-15% of those who make an attempt will eventually succeed; a previous suicide attempt is the best single predictor of suicide death (Fremouw, de Perczel, & Ellis, 1990). In addition, the rate of repeat suicide attempts in this sample is alarming; 65% of those reporting at least one attempt reported multiple attempts. Comparatively, a general population study of persons who had attempted suicide revealed that only 33% made subsequent attempts (Fremouw, de Perczel, & Ellis, 1990).

Suicidal behavior in this sample also did not vary according to type of prostitution, level of exposure, or age of initiation, but women who had been sexually abused or assaulted prior to being prostituted were significantly more likely to have attempted suicide.

One of the expectations of society towards prostituted women is that they eventually leave "the life" and transition into a "normal" family and vocational lifestyle. Yet the emotional scars described by these women make a normal working or intimate relationship with men difficult at best. Half of the women reported feelings of loathing, disdain, and/or distrust for all men after being prostituted. The phrase "they're all dogs" was not uncommon, nor was the view that men are "either pimps or tricks."

* This figure only includes specific episodes of suicide attempts; reports of general behavior such as "I almost killed myself with the way I used drugs" were not included.

Seventy-six percent (52) of the women reported difficulty establishing normal intimate relationships outside prostitution. They described their inability to mentally separate a loving relationship from a trick, and the fear, avoidance, and lack of enjoyment which results from this confusion. "I'm numb," said one woman, while another explained the fear she associates with sex, even with her trusted partner, "I don't want him touching me in certain places...I keep my shirt on and stuff." One woman summed up the frequently expressed feelings: "Every time I have sex, I feel like somebody should give me something for it. I don't know about a normal relationship."

Rape

The number of rapes reported by the women in the study dwarfs even the most progressive estimates in the general population. While current research estimates that 1 in 4 women will be raped in her lifetime (Parrot & Bechhofer, 1991), 85% (58) of the women in the study have been raped since first being prostituted. The rapes occurred with equal frequency inside and outside the context of prostitution dates. Sixty-two percent (42) of the women have been raped by a john, and 65% (44) have been raped by someone else. With both types of perpetrators, a third of the women reported being raped at least several times a year.

It can be difficult for a prostituted woman to be taken seriously as a rape victim. Only a third of the women who had been raped ever sought medical attention afterwards, and several mentioned resistance by the police or medical staff to classify their assault as rape or to report it as a crime.

Incest or other previous sexual violence is often cited as a key factor in women's vulnerability to being prostituted. This study supports the conclusion. Sixty-two percent (42) of the women reported being sexually assaulted or abused prior to their initiation in prostitution. Over half these women named a family member as a perpetrator.

Physical Assault

Injury from physical assault poses a serious health threat to prostituted women. Half of the women have been physically assaulted by a john, and a third of these experienced assaults at least several times a year. Twenty-three percent of those assaulted by a john were beaten severely enough to have suffered a broken bone. The apparent randomness of violence by johns is frightening. Two of the women told horrendous stories of assaults so vicious that they spent time in a coma. In both cases, there was no prior argument with the john to warn the women of danger. One woman displayed a picture of herself on a ventilator in the hospital as she noted wonderingly that the john had already paid her twenty dollars and, "he never even took it back." He did, however, drag her behind his car before leaving her for dead.

The most commonly experienced violence for women in this sample, however, was not perpetrated by johns. While research estimates that 25-37% of all women experience battering in their lifetime (Minnesota Coalition for Battered Women, 1993), 90% (61) of the women in this sample had been assaulted by someone other than a john during their time in prostitution. Over half of these women (and 50% of the total sample) reported being beaten at least once a month. Higher rates of severe injury were also associated with violence in personal relationships versus assaults by johns. In particular, miscarriage, stabbing, loss of consciousness, and internal injury were more frequently mentioned in connection with assaults by others.

Anecdotally, there was often a marked difference in the demeanor of the women during the physical assault section of the interview. The survey covered many extremely personal and potentially painful subjects areas, yet, by maintaining a private and respectful interview environment, the women were generally quite forthcoming and unhesitant in their answers. During the physical assault questions, however, women would become more quiet and distant, often lowering their voice and averting their eyes. It was the only section of the interview which would incite tears in the respondents. As one woman explained as she struggled to gather her thoughts and continue with the interview, "I'm sorry, I'm just remembering now...it's hard for me to think about this part."

Access to Health Care

One of the few good signs reported by the women in the study is their access to health care. Seventy-nine percent (54) felt they had a place to go for primary care during their time in prostitution, and 84% (57) had some type of medical insurance coverage, at least part of the time (primarily provided by the government). Approximately two-thirds of the women who had a place for primary care used public clinics, and only 4% cited the emergency room as their usual place to receive health care.

It is doubtful, however, that these women are getting care appropriate to their vulnerable circumstances and high risk status. Health care providers consider sexual experience as a crucial part of a complete health history, particularly in regard to reproductive care. Yet, only 35% of the women who had a place to go for primary health care had told their provider about their experience in prostitution. Some of the women even described taking extra precautions to keep this information from their family doctor by going anonymously to a public clinic for care (such as STD screening) which they felt may reveal their true circumstances.

The illegality and social stigma of prostitution makes the women's concern real. In addition, illicit drug involvement, threats from pimps and abusive partners, and responsibility for children who may be lost to the social welfare system add to the fear of exposure in the lives of prostituted women. However, sensitive health care providers should provide a safe and confidential environment in which women can truthfully share their health risks and history so that appropriate care can be provided. This study indicates that women may be excellent judges of such safe environments. Of the women who told their provider about a history of prostitution, none reported being treated negatively after sharing the information and 90% said they would choose to tell again.

DISCUSSION & RECOMMENDATIONS

The overall health status of this sample of prostituted women is not encouraging. The study suggests that these women are regularly exposed to serious health risk factors. Factors such as violence, drug abuse, and severe depression put them at risk for acute illness, injury, or even death. Extreme numbers of sexual exposures, sexually transmitted viruses, and PID infections increases their long-term risk of cervical cancer and infertility. Their tenuous social and financial circumstances and brutal everyday experiences encourage chronic emotional problems. Each of these factors simultaneously threatens the children they carry, bear, and raise.

Most notably, drug abuse and violence were virtually universally present in all the women's lives, regardless of age, race, or type/amount of prostitution. The study suggests that these two factors are closely tied to the experience of prostitution and therefore, that the presence of each puts women at risk of being prostituted and vice versa. The three issues are so closely intertwined that it is impossible to separate their potential effects upon the health problems experienced by the women in the sample. The most basic recommendation for improving the health status of vulnerable women is a course of action advocates and services providers have been following for years: trying to prevent women and girls from exposure to prostitution, violence, and drug abuse, and trying to help women and girls escape the cycle of prostitution, violence, and drug abuse.

In other words, the study confirms common sense assumptions. Nonetheless, interventions designed to target certain problem areas and to recognize the complex set of factors threatening the health of prostituted women may help reduce illness and promote better long-term health among this population. Following are suggestions for such interventions, beginning with specific recommendations and moving to more general approaches.

1.) Agencies working with prostituted women should offer concrete advice to their clients for preventive health care.

-- Women must be encouraged to receive yearly pap smear screening to check for signs of cervical cancer. They must further be taught to specifically ask for the test and not rely upon STD screenings to provide them with the full range of primary gynecological care necessary for sexually active women. The inflated rate of positive pap smears reported in the sample is a clear warning sign of potentially inflated cervical cancer rates in the future.

-- Women must be encouraged to tell their primary health care provider, particularly reproductive health care providers, about their exposure to prostitution. This information is essential to receiving care appropriate to their risks. If women do not feel safe sharing this information with their current provider, they should be encouraged to trust their feelings and to seek a provider with whom they can feel safe. They should know there are providers out there who can be trusted to treat this information confidentially and respectfully.

-- Women must be encouraged to use condoms with sexual partners in their personal life as well as with johns. They must be informed that the risk of contracting STDs is present in all sexual encounters, and that the serious risks go beyond AIDS. Even though other STDs infections can be treated, they can cause long-term problems such as infertility and chronic pelvic pain, and can increase their risk of cervical cancer.

-- Women must be encouraged to seek regular prenatal care.

-- Women must be encouraged to be vaccinated for hepatitis B.

2.) Agencies working with prostituted women should be attuned to the health problems common to this population and factors which may signal increased risk for illness.

-- Pregnant women are likely to not receive appropriate prenatal care, and their children are likely to suffer disproportionately from low birth weight and prematurity.

-- The greater the lifetime exposure to prostitution (i.e. more "dates") the more likely to have contracted health-threatening STDs.

-- The greater the number of STD episodes, the greater the risk of PID and its potentially chronic health effects.

-- Injection drug users are at greater risk of HIV and hepatitis B.

-- Women who experience sexual abuse prior to prostitution are at even greater risk of severe stress responses, especially suicide attempts.

-- The younger women are when first prostituted, the more exposure to prostitution they are likely to suffer, in terms of lifetime partners, density of contacts, and total time used in prostitution.

-- The two risk factors most commonly associated with cervical cancer, multiple sexual partners and early initiation to sexual activity, are exaggerated in the population, making regular pap smears essential.

3.) Social service systems which serve women should be redesigned to better address the complex of problems which further threaten prostituted women's health, keep women mired in prostitution, and make all women vulnerable to being prostituted.

-- Programs designed to treat substance abuse, criminal justice systems, and programs for prostituted women should work in close concert with one another. If combination programs can not be developed, women in each type of program should have open and unstigmatized access to aid for correlating problems. The intertwined effects of chemical abuse, battering, and prostitution combine to keep women in such a vulnerable state that it is difficult to escape from any one of them without addressing the others. For example, substance abuse treatment may be ineffective unless a woman has dealt with the psychological debilitation of being prostituted and has an alternative means of surviving economically and socially. Conversely, a woman will not likely escape prostitution unless she has the resources to deal with a substance abuse problem and a refuge from physical and mental harm.

-- Social service systems working with women -- including domestic abuse shelters, teen runaway groups, homeless shelters, chemical dependency treatment facilities, correctional facilities, child welfare agencies, and mental and physical health care providers -- need to recognize the pervasiveness of prostitution in vulnerable female populations, learn to sensitively screen for it in their clients, and develop methods to address it in conjunction with the other functions of their agency. The health problems experienced by the women in this sample are not easily traced to a single influence, such as prostitution. Multiple factors in these women's lives create a complex web of risks, and those risks can act synergistically to create even greater health problems.

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