



A Review of the Literature on Sex Workers and Social Exclusion

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1. INTRODUCTION

This paper was commissioned for the Inclusion Health programme and is one of a series of reports from the programme examining health and exclusion.

Social exclusion is commonly defined as a series of linked and/or mutually reinforcing processes, such as low income, poverty, debt, unemployment, poor education, health problems, housing problems, crime, lack of social support and other adverse life events (Bradshaw et al., 2004). Experience of these can lead to vulnerability and exclusion from enjoying the rights of employment, health care, secure housing and a decent standard of living (Popay, Povall and Mathieson, 2012). As well as affecting individuals, social exclusion affects groups of people such as migrants, disabled people, homeless people, and those suffering from mental illness; often as a result of impoverishment, discrimination and lack of adequate public services. Many people who engage in sex work are subject to high levels of social exclusion – in some cases chronic exclusion, and begin sex work as a result of experiencing many of the processes leading to exclusion.

Government policies to address sex work (and its consequences) have tended to focus on the law, the criminal justice system and punitive measures to tackle and reduce sex work activities at the expense of health and safety (Cusick and Berney, 2005; Hubbard, Matthews and Scoular, 2007). This approach has been criticised for its failure to adequately address sex worker health issues, including the wider determinants of health, and promote positive physical and mental health which has the potential to reduce the numbers of people engaging in sex work through the improvement of health and life options (Sander, 2007; Jeal and Salisbury, 2013).

This paper aims to review the existing evidence on sex workers in the UK paying particular attention to health alongside wider issues of social exclusion, such as poverty, homelessness and substance misuse. There are no studies which we are aware of that focus specifically on social exclusion and sex work in England and the UK. The paper is structured around three main themes. The first theme examines the driving factors which cause vulnerability, social exclusion and involvement in sex work. The second theme looks at how processes of exclusion affect the lives of sex workers and considers the different levels of social exclusion experienced by certain groups of sex workers. Sex workers face significant risks and ill-health; in particular, on-street, off-street, migrant and trafficked sex workers. Finally, the third theme explores the barriers which prevent greater social inclusion and the stabilisation of sex workers' lives. Many of these barriers relate to broader issues of social exclusion beyond sex work itself.

SEX WORK – DEFINITIONS, DEMOGRAPHICS AND TRENDS

The term 'sex worker' refers to those engaged in prostitution and is the preferred term used throughout the literature on the subject. The term has been adopted as is it free of complicated, derogatory and sexist connotations which are more commonly associated with the term 'prostitute' (May, Harocopos and Hough, 2000).

Sex work is a term used to describe a wide range of activities relating to the exchange of money (or its equivalent) for the provision of a sexual service. Harcourt and Donovan (2005) compiled a long list of the different types of sexual services practiced by sex workers around the world. From this list, they grouped types of sexual services into two categories; direct and indirect sex work. Direct sex work refers to services, such as indoor and outdoor prostitution as well as escort services. This type of sex work typically involves the exchange of sex for a fee in which genital contact is common.

Indirect sex work refers to services, such as lap dancing, stripping and virtual sex services (over the internet or phone). Genital contact is less common in this type of sex work; however, a fee is still exchanged for the service.

The exact number of commercial sex workers in the UK is open to dispute. Estimates have tended to focus on particular types of female sex work, predominantly on-street, off-street and escort sex work. Whilst a large majority of the literature (including papers published by the Home Office (2004)) cite Kinnell's (1999) figure of 80,000, the exact number of sex workers is unknown. According to Cusick et al. (2009), calculating the number

of commercial sex workers is very difficult as sex work is mostly hidden and the population is transient, with people moving in and out of sex work constantly. Nevertheless, the general consensus suggests the population is between 50,000 and 80,000 (UK NSWP, 2008a).

According to Ward et al. (2005), trends over the period 1990 to 2000 indicate that demand by those willing to pay for sex has increased. In 1990, 5.6 per cent of men reported paying for sex in their lifetime, by 2000, this had increased to 8.8 per cent. These figures are likely to be even higher due to the reluctance of people admitting to paying for sex. Those who reported paying for sex in the past five years were likely to be aged between 25 and 34, to be divorced or never married, and to live in London. Ethnicity, socio-economic status and education had no relationship with the likelihood of purchasing sex. Additionally, Ward et al. (2005) reported a small increase in the average number of women who had paid for sex.

Sex workers are a heterogeneous group. Women make up the majority of the sex work population, with some estimates suggesting the proportion is around 85-90 per cent (Scambler, 2007). Whilst the remaining population comprises of both male and transgender sex workers, let it be stated that the numbers of male and transgender sex workers are not insubstantial. London is estimated to have the highest proportion of male sex workers (30-40 per cent of the London sex working population) (Scambler, 2007), whilst a study by Wilcox and Christmann (2006) into male sex workers in the Yorkshire area of Kirklees found a small number of male sex workers working in the area although none of them actually lived in the area.

Sex workers come from a wide range of socio-economic contexts. For example, small numbers of students engage in sex work to help fund their studies; the number of which are thought to have increased with the introduction of top-up tuition fees (Roberts et al., 2010). This goes against the general assumption that sex workers originate from lower social economic backgrounds; however, it is unlikely that this small group face high levels of social exclusion and will likely stop selling sex once they have finished studying (Scambler, 2007). There may however, be health implications, particularly in relation to sexually transmitted infections and mental health which could affect this group.

Other characteristics of the sex work population have been explored by a small number of studies. For example, a study by Dickson (2004) which looked into London based female sex workers, found 93 different ethnicities among the London population - only 19 per cent of whom said they were from the UK. On the other hand, a study looking into sex workers in Bristol found the majority of the City's sex workers to be White, with only 10 per cent describing themselves as Black, and none describing themselves as Chinese or Asian (Jeal and Salisbury, 2004).

Further work provides an interesting insight into the characteristics of migrant sex workers. A guidance document by the UK NSWP (2008a) on the UK's migrant sex work population estimates that around 37 per cent of UK commercial sex workers are migrants with as many as 52 per cent of migrants coming from Eastern Europe. This increase in the migrant population of sex workers has been documented in other works. A study by Ward et al. (2004), which looked at data collected from clinics targeting sex workers over the period 1985-2002, noted a trend in London based sex workers being more likely to originate from places outside Britain; 25 per cent in 1985, compared to 63 per cent in 2002.

These studies indicate a diverse and rapidly changing population of sex workers in England; however, there is a serious lack of data and information about sex work which makes analysis difficult.

2. FACTORS DRIVING ENTRANCE INTO SEX WORK

The literature has revealed a wide range of processes which can lead to involvement in sex work. These processes tend to differ depending on the type of sex work.

MONEY, DEBT AND LOW LEVEL WELFARE BENEFITS

Commentators, such as Brents and Sanders (2010), stress the importance of financial drivers which often push people into sex work. With the indoor parlour industry estimated to be worth around £534 million per year (latest figure, 1999) (Moffat and Peters, 2004), there are obvious financial rewards for some involved in sex

work including brothel owners, managers and sex workers. Brents and Sanders claim that with fewer well-paid jobs available, welfare benefits too low to meet the ever increasing cost of living, in particular, for single mothers and women who are often marginalised from the mainstream employment structure, the financial drive to engage in sex work is very strong.

In a separate article, McNaughton and Sanders (2007) state that welfare benefits are not generous enough to prevent poverty or marginal lifestyles. Debt plays a significant role in driving entrance into sex work. Low or insufficient income results in worse outcomes in both long-term health and life-expectancy. As the Marmot Review (2010) recommends, a minimum income for healthy living would ensure appropriate income for all stages of the life course reducing overall levels of poverty, health inequality and improve living standards.

For migrant sex workers, there are a wider range of factors which may result in engagement in sex work. The inability to find work in their home countries is one reason why migrants (especially women from Eastern Europe) have migrated to the UK and ended up working in the UK sex work industry (Scambler, 2007). In Mai's (2009) study, migrants were found to engage in sex work to fund aspirations of social mobility, better living standards, educational aspirations and greater and more rewarding working conditions. In many instances, migrants engage in sex work to earn money which they then send back to their home countries to support families, including their own children and other dependants.

Migrants are often unable to find other forms of employment which are as financially rewarding as sex work due to language barriers, a lack of qualifications, a lack of rights to work in the UK and the lack of adequately paid jobs on offer. Additionally, there are some migrants, such as asylum seekers, who lack recourse to public funds and enter sex work as their only means to make money, predominantly as a form of survival (Dibb et al., 2006). Other studies indicate that migrants are less likely than UK nationals to engage in sex work to fund drug addictions (Platt et al., 2011).

HOUSING AND ADDICTION

Homelessness and drug addiction have been identified as the two most significant factors which prompt engagement in on-street sex work and two of the main barriers to stabilising the lives of sex workers (Spice, 2007; Davis, 2004). In their study into on-street sex workers in Bristol, Jeal and Salisbury (2004) reported a high proportion of on-street sex workers who claimed they were either homeless or living in insecure/temporary accommodation (two-thirds) and all respondents admitted to problems with drug addiction. This type of engagement in sex work is often described as 'survival sex', where people engage in sex work as a last resort, to provide shelter, food, or fund severe addictions in a 'work-score-use' cycle (McNaughton and Sanders, 2007; Sanders, 2007b).

Additionally, research exploring problematic alcohol use amongst female sex workers across England and Wales, found that alcohol use, before entry into sex work, was used as a coping mechanism to help overcome or deal with experiences of loneliness and abuse during childhood and/or adolescence (Brown, 2013).

VIOLENCE AND POWER

The influence and severity of violence and power, as a driving force of sex work involvement, is important, yet, often overplayed and overemphasised by Government, activist organisations and certain segments of the sex work literature. For example, whilst sex trafficking is an extreme form of violence that must not be taken lightly, the number of sex trafficked victims in the UK is believed to be low in comparison to the rest of the sex work population. Despite the low number of trafficked victims, consecutive Government action towards sex work has been dominated with anti-trafficking rhetoric and a focus on criminalising sex work, failing to consider some of the broader issues which are more pertinent to the rest of the sex work population (Cusick and Berney, 2005).

The situations in which people fall victim to sex trafficking and pimping are rarely explored in the literature. However, the claim that victims are often young and debt-bonded, suggests there are socio-economic, financial, power and dependency factors which may drive entrance into sex work through trafficking and control (Jackson, Jeffery and Adamson, 2010).

FAMILY BREAKDOWN AND 'CUT OFF CARE'

The consequences of family breakdown have been documented by studies which consider the links between institutionalised care services, vulnerability and chronic exclusion, in relation to sex work and wider social exclusion (Berelowitz et al., 2012). For example, Jeal and Salisbury (2004) in their study looking at on-street sex workers in Bristol, found that one third of the women they interviewed had been a 'looked-after' child and/or young person as a result of family breakdown. Additionally, nearly two-thirds of women reported they had experienced physical, sexual or emotional abuse during childhood, whilst a third had left school by 14; those in care left earlier. Other research has found that leaving care, prison, hospital, education and mental healthcare systems can lead to or exacerbate social exclusion (Tonybee hall, 2007; Fitzpatrick, Bramley and Johnsen, 2012).

Furthermore, neglect by either the family and/or the care system can lead to, or exacerbate, the vulnerability of some young people (Stein et al., 2009). An example of this type of neglect has been highlighted by the recent high-profile case in England of nine men in Oxford facing trial for various crimes relating to sexual violence and exploitation.¹ In this case, British girls who were trafficked and prostituted by groups of men, tended to be young, vulnerable, in care or from chaotic households. They were coerced into sex work due to their vulnerable situations.

'Cut off care', the abrupt reduction or removal of institutional care systems and safety nets, can leave people vulnerable to exploitation from controllers and may result in engagement in sex work through necessity or habit. In many cases, those who have been discharged (cut off) from a particular care system may experience a lack of money, housing, employment, social capital and appropriate networks of support, which can drive people into greater social exclusion and may lead to engagement in sex work as a survival technique and/or as a way out (McNaughton and Sanders, 2007).

MENTAL HEALTH

Whilst to the best of our knowledge there have been no comprehensive study into the mental health of UK sex workers, we can reasonably infer that traumatic experiences, such as physical or sexual abuse during childhood, has negative implications for mental health throughout the life-course. Although the links between child abuse and engagement in sex work is unclear, in a study by Bindel et al. (2012) where 72 per cent of the sex workers interviewed reported experiences of physical, sexual and verbal violence during childhood, past experiences of abuse were said to compound feelings of worthlessness.

Furthermore, in a study by Fitzpatrick, Bramley and Johnsen (2012) which looked at pathways into multiple level exclusion and homelessness in UK cities, they found mental health problems to be prominent amongst people who experience chronic social exclusion. Mental ill-health can cause difficulties with employment, social relationships and dealing with day-to-day life, as well as poor physical health, which can lead to social exclusion (Social Exclusion Unit, 2004).

LOW EDUCATION

The literature suggests that poor education, as well as a lack of training and qualifications, impacts on vulnerability; driving entrance into sex work and reducing the chances of finding alternative forms of employment. In Jeal and Salisbury's (2004) study, they found one-third of interviewees had left education at the age of 14 years or younger. Similarly, Bindel et al. (2012) found 39 per cent of respondents had no training or formal qualifications. Poor education could affect the ability to find mainstream work meaning opportunities to earn an income are limited.

Sanders (2007a) points to educational factors which reduce the vulnerability of sex workers. She claims those who work off-street are more likely to have come from social backgrounds which are not excluded, have

¹ <http://www.guardian.co.uk/uk/2013/jan/15/oxford-gang-girls-prostitutes-bailey>

participated in mainstream work, completed full-time education, and may have a professional background. One could assume that it is both the more stable nature of off-street sex work which draws these workers to it, but also the relatively stable position of the workers which leads to greater stability in the first place.

DISCRIMINATION

Discrimination can take many forms, such as racism, stigmatisation and prejudice. It can prevent social inclusion, driving marginalisation and vulnerability. For some migrants, discrimination can exacerbate feelings of isolation and loneliness; common experiences associated with moving to a foreign country where support from family and other social networks may be lacking. Additionally, it can prevent or obstruct access to services and employment which may drive migrants to use other means of survival, such as sex work (UK NSWP, 2008a).

The literature also indicates that people with a criminal record, especially those who have recently left prison, see above section on 'Cut Off Care', are at risk of vulnerability due to difficulties in finding employment (Fitzpatrick, Bramley and Johnson, 2012). Again, sex work engagement may occur as a means to find alternative forms of income and survival. Criminalisation and sex work is discussed in more detail below.

3. HEALTH AND SEX WORK

Different types of sex work are associated with different levels of risk and thus have different implications for health. Low risk sex work activities, such as stripping and non-contact sex work, are less likely to be associated with adverse health problems (Harcourt and Donovan, 2005). The lower risk activities are not discussed in any great length within the sex work literature, likely because the vast majority of literature on sex work focuses on activities which involve higher levels of risk to both sex workers and the wider public; by and large, commercial sex work.

SOCIAL AND ECONOMIC FACTORS WHICH IMPACT ON HEALTH

There are very few studies which look at the general health of commercial sex workers and the implications of sex work on workers' health. The large majority of services targeted at sex workers provide essential support and assistance with sexual health and drug addiction, but may not meet the wider needs of sex workers, including more acute physical and mental health needs, financial needs, housing needs and educational needs. Poor or lack of necessary healthcare, high morbidity, homelessness, lack of qualifications, poverty, stigmatisation, addiction and the sale of sex for financial recompense can be detrimental to participation in societal 'norms and services' and result in adverse consequences, such as poor health (Jeal and Salisbury, 2004).

The socio-economic conditions, in which people are born, grow, live and work, have a significant influence on health. People from the poorest neighbourhoods can expect to live, on average, seven years less than those from the richest neighbourhoods (Marmot Review Team, 2010). The range of factors listed in the paragraph above, in which issues like poverty, housing and poor education play a major role, interact to shape the health and well-being of sex workers. Many sex workers, like other vulnerable people, experience a syndemic, where social problems, such as poverty, violence and homelessness, combine to negatively impact on health in a way that is more severe than if they were afflicted by just a single social problem. Whilst there has been no comprehensive research into the impact of these conditions on sex worker health, the poor socio-economic conditions of many sex workers, detailed in the literature, suggest that health and life expectancy among this group is likely to be extremely poor, even without consideration of the adverse health consequences of sex work.

SEXUALLY TRANSMITTED INFECTIONS

Due to the nature of the work, sexually transmitted infections are another inevitable risk which a number of outreach programmes aim to combat (Jeal, Salisbury and Turner, 2008). Whilst it is widely acknowledged that many sex workers still engage in risky behaviour, such as having sex without a condom, research suggests

condom use amongst sex workers has increased over the last 30 years and incidents of HIV have decreased over the same period (Scambler and Paoli, 2008). The numbers of other sexually transmitted infections also remains low; however, the potential for transmission is high. Sex workers must continue to get the sexual health support they require to enable them to play their role in preventing sexual health epidemics (Cusick and Berney, 2005).

VIOLENCE

Physical, sexual and verbal violence are common experiences for many sex workers. The large majority of studies looked at in this report indicate that violence is a prominent feature in the lives of sex workers in almost all sex work settings. Some, such as Spice (2007), argue that physical violence is the single greatest threat facing sex workers. A study by Harding (2005), which examined the experiences of female sex workers in Nottingham, found that all of the women interviewed had experienced some form of violence, whether physical, emotional or sexual.

More recent studies also reveal high levels of violence. A study by Bindel et al. (2012), found that two-thirds of the sex workers they interviewed experienced violence, whilst another study by Sanders-McDonagh and Neville (2012) claims that many sex workers have experienced increasing levels of violence and complained of harassment by police. Reporting of violent crime is low among sex workers (for more detail, see below).

The consequences of physical violence can often lead to poor physical health, as well as poor mental health due to trauma (Rossler et al., 2004). At its most extreme, violence against sex workers leads to death. An example of this is the high profile case of Steve Wright who murdered five sex workers in the area of Ipswich around 2006.² In addition, a study by Ward and Day (2006) which examined the lives of 130 sex workers over a 15 year period discovered that two of their cohort had been murdered over the 15 year period.

Furthermore, the recording of violence against sex workers is problematic. As is discussed below, relationships between the police and sex workers is often poor and lacks trust and understanding on both sides. Additionally, whilst it is possible that victims of violence may visit A&E and other health services to receive treatment for injuries, it is unlikely that these incidents will be recorded in such a way that would identify the patient as a sex worker. There is no procedure amongst hospital staff for identifying sex workers and in most cases, sex workers would be reluctant to reveal their occupation to health staff for fear of stigmatisation (UK NSWP, 2009).

ADDICTION

Drug addiction amongst sex workers is typified by a 'work-score-use' cycle (Jeal, Salisbury and Turner, 2008). In a study by Jeal and Salisbury (2004) which explored the health of on-street sex workers in Bristol, all interviewees admitted to having a history of alcohol and/or drug use. Over half of respondents stated they entered sex work specifically to fund drug addictions and many continued to use drugs whilst pregnant. It is claimed that alcohol use amongst sex workers is used for self-medication; to help mask some of the negative feelings associated with sex work, including distress, anxiety and experiences of selling sex (Brown, 2013). However, as mentioned above, this is likely to be lower for migrant groups.

Drug and alcohol addiction can cause serious damage to people's health. Many drug addicts are undernourished and homeless. Some of the most prominent health concerns facing sex workers as a group are communicable diseases, such as HIV and other Blood borne Viruses. In addition, common health complaints by this group have included abscesses, as a result of intravenous drug, poor dental care and premature death through overdose (Ward and Day, 2006).

MENTAL HEALTH

² <http://www.guardian.co.uk/uk/2008/feb/22/wright.sentenced>

As mentioned in the previous section, research into sex work and mental health is scarce. However, research by Rossler et al. (2010), assessed 193 female on-street and off-street sex workers in Zurich (5 per cent of all registered sex workers in the city) to identify potential patterns of mental health issues. The study found high rates of anxiety, stress and post-traumatic stress disorder, predominantly due to the high levels of violence these women experienced. Other mental disorders were identified, including psychosis and schizophrenia. In addition, the study looked to establish if women with existing mental illness were more likely to engage in sex work; however, it was unclear whether any relationship existed. The researchers claim that the effect of a single year of engagement in sex work is likely to have the same impact on mental health as an entire life of experiences prior to involvement in sex work.

CRIMINALISATION AND STIGMA

Over the last decade government legislation has attempted to tackle prostitution by criminalising many aspects of sex work (Home Office, 2004). However, these policies have been criticised by commentators for failing to address a wide range of issues, including the health and poverty of sex workers; and contributing to the difficulties experienced when trying to find pathways out of sex work. Factors which lead to sex work, such as poverty, unemployment, inequality, debt and vulnerability (and how to tackle them), have largely been overlooked by policies (Cusick and Berney, 2005).

Government policies have neglected the complex needs of sex workers, criminalising sex work and thus forcing sex workers into even more marginalised and vulnerable positions. This subjects them to increased likelihood of violence, poor health, addiction and an inability to escape their situation (Boynton and Cusick, 2006). Finally, the behaviour of both the police and criminal justice system discourage sex workers from reporting violence and other crimes. Often, investigations tend to focus on the crimes relating to sex work instead of the crimes originally being reported. As a result, sex workers feel they cannot safely report crimes as they fear being treated like criminals and not as a victim (Boff, 2012).

Furthermore, sex work is associated with high levels of social stigma which is said to arise from an attribution of shame – particularly applying to women (Scambler, 2007). From this view point, sex work is problematic, indecent and a violation of women's rights which undermines the formal economy (Ward and Day, 2006). Stigmatisation occurs in all aspects of their life: from clients, general public, healthcare and other service providers, and police (Sanders, 2007b). This can result in reduced contact with health services and other providers of support, increased stress leading to mental health problems, and feelings of isolation; contributing to social exclusion (Cusick and Berney, 2005; UK NSWP, 2009).

4. TYPES OF SEX WORK AND LEVELS OF EXCLUSION

The literature revealed several different types of sex work which are caused by, and can result in, varying states of vulnerability. Social exclusion is the leading cause of entrance into sex work and exclusion is often deepened as a result of engaging in sex work. The severity of the exclusion tends to differ depending on the sex workers situation. Those who are most excluded are those who have been sex trafficked and enslaved in sex work. At the other end of the spectrum, there are those who become involved in sex work through non-coercive means making a particular lifestyle choice, such as the student sex workers described above (Scambler, 2007). The differences between the types of sex work and the severity of vulnerability will be examined below.

SEX WORKERS AS VICTIMS OF TRAFFICKING

Trafficking of people is the recruitment, transportation, transfer, harbouring or receipt of people, by means of force, coercion, threat of violence, fraud or deception. Trafficking takes many forms, ranging from labour exploitation to sexual exploitation. Sex trafficking is the most severe and exploitative form of sex work. It is a serious violation of human rights and at its worst is a form of slavery (Zimmerman et al., 2006).

Globally, hundreds of thousands of people are estimated to be victims of trafficking each year, with the UK being one of many destinations for trafficked people. A conservative estimate suggests the number of people

trafficked in the UK is around 5,000 (House of Commons, 2009). The specific numbers of sex workers who have been trafficked in the UK are unknown. However, some estimate that there are around 2,600 trafficked sex workers operating in England and Wales (Jackson, Jeffery and Adamson, 2010).

In 2006, Operation Pentameter was launched. This involved a public campaign to raise awareness about sex trafficking, and coincided with 525 police raids on establishments where sex was being sold; raiding approximately 10 per cent of the UK sex work establishments. From these raids, the police found 72 women and 12 girls who were described as 'victims of trafficking'. However, there are questions overhanging the operation around the methodology used to identify these women as 'victims of trafficking' and how they were dealt once they were picked up by the authorities (UK NSWP, 2008a).

In a study which interviewed 100 migrant sex workers, 67 women, 24 men, 9 transgender, on their experiences of the UK sex work industry, only a minority of interviewees, amounting to six per cent of female respondents, expressed that they had been victims of deceit and forced into sex work (Mai, 2009). The report also claims its findings indicate that vulnerability, trafficking and exploitation in particular, often resulted from migrant's socio-economic status, lack of social networks, and lack of knowledge about their rights and protection in the UK.

Whilst we cannot be certain on the exact scale of trafficking, researchers and commentators have been more specific about the damage and harm caused to the victims. Those trafficked in the UK for sexual exploitation, predominantly women, are the most vulnerable and socially excluded of all sex workers. There is little quantitative data on the physical and mental health of victims of sex trafficking. The literature indicates that most victims of trafficking will operate in off-street settings and are less likely to have drug-use problems than non-migrant sex workers; however, victims of trafficking have still been found to use drugs and small numbers are known to operate on UK streets (Dibb et al., 2006; Jackson, Jeffery and Adamson, 2010).

A study by Zimmerman et al. (2006) provides a good insight into experiences of trafficked women across Europe. 207 women were interviewed for the study originating from 14 different countries, both inside and outside the EU. The women interviewed were asked about many aspects of trafficked life revealing some alarming results.

Around 95 per cent of the women in the study reported experiencing physical and sexual violence by their controllers, while 77 per cent reported they had no freedom of movement. Not only were these women fearful of their own safety, but also of the safety of their families; threats of violence against victims' families are used as a common form of control. In addition to these conditions, the women experienced many adverse health problems. The majority of women experienced fatigue, weight loss and loss of appetite, and were forced to work long hours. These symptoms are associated with stress and depression, a result of their trafficked situation.

The women also had other health complaints. 81 per cent of the women complained of headaches and dizziness over prolonged periods of time, whilst 63 per cent said they experienced abdominal pains and around half of respondents complained of cardiovascular problems. Back pain and dental problems were mentioned by 69 and 58 per cent respectively, in addition to this, 60 per cent complained of pelvic pain. It was noted that the women also displayed many other symptoms that were unspecified.

Other studies have played down the degree to which trafficked women are themselves subject to violence. They claim trafficked women who are often debt-bonded are controlled by the threat of violence to their families (Jackson, Jeffery and Adamson, 2010). However, it is the fear and control which appear to be most damaging to trafficked women's lives. Access to health services and the ability to leave sex work for trafficked women is very difficult. Women who are under strict control are often refused access to healthcare, for fear that they may use contact with public services as an escape route. Furthermore, the women themselves may be fearful or unwilling to access services due to a lack of knowledge of their rights, language barriers and a fear of deportation due to uncertain immigration status (UK NSWP, 2008a; Mai, 2009; Platt et al. 2011).

ON-STREET SEX WORKERS

A lack of economic opportunities and debt are key reasons for the entrance of (predominantly) women into

on-street sex work (UK NSWP, 2008b). On-street sex workers tend to be British born, with high rates of drug addiction, homelessness, mental health problems, and likelihood of having been in care following family breakdown, (Jeal and Salisbury, 2004 and 2007). These factors are both a cause of street sex work engagement and a consequence of street sex work, leaving women subject to violent attacks from men, including clients, and harassment from police (Sanders-McDonagh and Neville, 2012).

On-street sex workers have tended to be the targets of Government policies and the criminal justice system aimed to curb on-street sex work activities. The effects of such targeting has increased their isolation and vulnerability overlooking more pressing issues, such as poverty or help with drug and alcohol addiction, and made finding alternative forms of employment more difficult (Cusick and Berney, 2005; Boynton and Cusick, 2006).

Throughout the literature, strong links are made between sex work, homelessness and drug addiction, particularly in relation to on-street sex work. In a study by Jeal and Salisbury (2004) which analysed the health needs of 72 on-street sex workers in Bristol, two-thirds of the women claimed they were homeless or under threat of being made homeless; staying in temporary accommodation such as hostels, bed and breakfasts, and crack houses. Additionally, a report by Davis (2004) which looks into homeless women, stated that specialist agencies were reporting regular contact with high numbers of homeless women who were engaged in on-street sex work (between 200-300). It was also discovered that these women were likely to be excluded from hostels and other temporary forms of accommodation due to substance misuse and other complex needs.

Another key issue which emerged from Jeal and Salisbury's (2004) study is in relation to drug addiction. All of those interviewed for the study reported current or recent drug and/or alcohol dependency; many of whom referred to the use of intravenous drugs. According to the Home Office (2004), 80-95 per cent of on-street workers use heroin or crack, based on information from Church et al. (2001) study into sex work settings and violence.

Jeal and Salisbury's study also highlighted other issues concerning health. All respondents reported some kind of chronic illness with 54 per cent of respondents reporting poor health, whilst very few reported receiving treatment for their illnesses. STIs, vein abscesses, tuberculosis and other respiratory diseases, fatigue, acute pain and stress related issues, are commonly cited in the literature on sex work to affect this group (Jeal and Salisbury, 2004; Zimmerman et al., 2006; Spice, 2007).

Jeal and Salisbury also discovered that 59 respondents had been pregnant (beyond 24 weeks) a total of 97 times, with five pregnancies resulting in still births giving a birth rate of 50 per 1000 live and still births. According to figures from the Office for National Statistics (2012), in 2011 the average still born rate in England and Wales was 5.2 per 1000 live and still births. Over half of the women in Jeal and Salisbury's study who had children were engaged in sex work prior to carrying their last child and were more likely to use drugs when pregnant than women who had never sold sex. As a result, it was common for children to experience postnatal problems, such as drug withdrawal, with a quarter needing to visit special baby care units.

Additionally, despite around two-thirds of the women in the study having children only 21 per cent of women with children aged 16 and under had children living with them. Of the children who did not live with their mothers', two-thirds lived with other relatives, including fathers, whilst the remainder of children had been taken into care.

OFF-STREET BRITISH BORN SEX WORKERS

It is widely assumed that the off-street sex work setting, in brothels, flats, saunas and escort services, is a more secure and less vulnerable setting than on-street sex work (Home Office, 2004; Jeal and Salisbury, 2004). They are often run like a business; with an interview process, rules, such as no drug taking or drinking allowed on brothel premises, and some may even pay taxes (Sanders, 2007b). However, while this group of sex workers may be less vulnerable to poor health, violence and police harassment, they are still vulnerable.

In a study by Jeal and Salisbury (2007) which compared the health needs of on-street and off-street sex workers, they found off-street sex workers report fewer chronic health problems (often related to drug use among on-street sex workers) and were less likely to use injecting drugs and share injecting equipment,

spending less of their income on drugs. Although off-street sex workers are less likely to use drugs, drug use is still a problem. Off-street sex workers are more likely to be registered with a GP (94 per cent to 83 per cent), be more likely to attend cervical screening programmes and report more consistent attendance at antenatal services. Overall, off-street sex workers were found to display less risk taking behaviour and lived healthier lifestyles than on-street sex workers; however, they are still at greater risk to poor physical and mental health than the general public.

As off-street sex workers fear being stigmatised, many prefer to keep their occupations hidden from service providers which can often prevent them from accessing the necessary services they need (Jeal and Salisbury 2007). Furthermore, fear of judgement and discriminatory attitudes from health professionals and other service providers can result in reluctance to disclose drug use and other risky behaviours (in addition to sex work), and prevent access to necessary services. An example of such an incident occurred in one of the main GUM clinics in a large northern city. The clinic reported having seen only 23 people who had identified themselves as being a sex worker over a ten year period. Such low figures do not reflect the estimated levels of the sex work population (UK NSWSP, 2009).

MIGRANT SEX WORKERS

The term 'migrant sex worker' is used to describe a person who is not a UK national but who freely enters the UK, for whatever means, and engages in sex work (UK NSWSP, 2008a). As previously mentioned, the migrant sex work population has increased over the past decade with particular concentrations in London. This trend has been noted by studies, such as Platt et al. (2011), which examined the experiences of Eastern European migrant sex workers and their UK-born counterparts in London. They found a rise in the number of migrant sex workers operating in London over the last decade. With information gathered from sex worker service providers, they estimate that as many as 76 per cent of sex workers are migrants – the majority of whom are from Eastern Europe. They go on to claim that this increase in Eastern European migration coincided with the expansion of the European Union. Scambler (2007) associates Eastern European sex work migration with changes that occurred in the migrants' home countries. The collapse of Communism and the Soviet Union resulted in the closure of state institutions and the reduction of welfare provision, leading to a decline in the rates of formal female employment and girls attending school during the late 1980s and 1990s. Scambler states this lack of opportunity for Eastern European women has resulted in migration to the UK and engagement in sex work.

Other studies have identified migrant sex workers from elsewhere in the world, such as Africa, South-East Asia, South America, the Caribbean, Asia and other parts of Europe; though it is believed that these workers make up less of the migrant sex work population in England than those from Eastern Europe (Dibb et al., 2006; Jackson, Jeffery and Adamson, 2010; Mai, 2009).

The large majority of migrant sex workers are involved in off-street sex work (Dibb et al., 2006). Some studies estimate that around 14,000 migrants are selling sex in brothels, flats, saunas and as escorts (Jackson, Jeffery and Adamson, 2010). The literature suggests that for the most part, the migrant experience of vulnerability and exclusion differs from other forms of sex work (trafficking, on-street and off-street sex work by British born sex workers), yet there are many barriers which prevent them from sex working in a safe environment, should they choose to do so, and finding other forms of employment.

According to a guidance paper by UK NSWSP (2008a), discrimination, both in the workplace and from service providers often places migrants in extremely vulnerable situations. For example, migrant workers with insecure immigration status may be manipulated by sex work managers into working longer hours, partake in more risky behaviour (not using condoms), feel reluctant to contact health services especially primary care services, due to fear of arrest or deportation, and be unable to access services because of language barriers. These factors all contribute to and worsen exclusion and potential poor health, in addition to the isolation they may feel from being a migrant in a foreign country.

In Mai's (2009) study of UK migrant sex workers, he claims that immigration status and knowledge of migrant rights, "is the single most important factor restricting migrant sex workers' ability to exercise their rights" in both their professional and private lives. He goes on to state that stigmatisation and confusion around immigration status increases their vulnerability to violence and other forms of crime.

Whilst the on-street selling of sex and drug use is more commonly associated with British born sex workers, migrants have been known to work in on-street settings and have drug and alcohol problems (Dibbs, 2006; Jackson, Jeffery and Adamson, 2010). For this small proportion of migrants, the combination of migrant status, the on-street selling of sex and drug addiction will heighten their exclusion and increase vulnerability.

More recently, a study published by the Eaves Project and commissioned by the Mayor's Office for Policing and Crime (MOPAC) (2013) exploring prostitution and trafficking in London, documented new developments in the demography of London's on-street sex working population. A number of sex work outreach services in several different London boroughs reported contact with new groups of women who broke the British-born trend.

It is believed that these women migrated to London from Romania for the specific purpose of selling sex, and whilst they do not appear to display the work-score-use behaviour of more stereotypical on-street sex workers, there is a concern that these women may be being organised and/or controlled by men (Bindel, Breslin and Brown, 2013).

MALE AND TRANSGENDER SEX WORKERS

There are few studies into the lives and experiences of male and transgender sex workers and there is little written evidence about this group. According to a guidance document by UK NSWP (2008c), male sex workers often enter sex work for different reasons to female sex workers. It is claimed that male sex work is often linked with the commercial gay scene in which drug use and alcohol is common among workers and clients. Additionally, a small proportion of male sex workers have female clients.

A study by Wilcox and Christmann (2006), which interviewed male sex workers in Yorkshire, found no forms of coercion among their sample population. However, while the majority of male sex workers are not subject to the same level of vulnerability and exploitation, young and particularly homeless men are susceptible to exploitative behaviour. In addition, few services and outreach programmes target male sex workers or are equipped to deal with their needs (UK NSWP, 2008c).

Information on the lives of transgender sex workers is also scarce. Many are said to suffer from the double stigmatisation of being a sex worker and transgender. It is claimed that in some cases, sex work is one of the only viable options for transgender people, turning to sex work to fund their treatments and experiencing difficulty in finding other forms of employment (UK NSWP, 2008c). Again, the services available to this group are very limited. Moreover, government policy has on the whole excluded male and transgender sex workers from policy discussions and tended to focus all of its attention on female sex work (Whowell, 2010).

5. STABILISING THE LIVES OF SEX WORKERS

Successive Government approaches have focused on pressuring those involved in sex work to exit it, fundamentally viewing sex work as a problem which should be abolished (Home Office, 2006; Sanders, 2007a). Whilst, some studies found the majority of sex workers they interviewed were happy with the profession they had chosen and enjoyed the freedoms and control they had over their working conditions (Mai, 2009), other studies found sex workers unhappy with their situation and wanting to change it, particularly on-street sex workers, and victims of trafficking (Bindel et al., 2012).

According to Sanders (2007b), at the forefront of Government action to deal with (predominantly street) sex work is the criminal justice system which is used to control and pressurise sex workers into exit. Compulsory rehabilitation measures such as arrest referral programmes, compliance agreements to work with outreach programmes, criminal and behaviour orders, curfews and imprisonment, are the preferred measures used to encourage exit from sex work. However, the majority of these measures often fail to address the complex needs of sex workers and can negatively impact on the chances of reducing social exclusion due to criminalisation.

There are serious practical issues with measuring the effectiveness of exiting strategies. Unlike other treatment services, such as drug addiction programmes where it is possible to determine whether a person

has stopped using drugs through tests, it is impossible to fully determine whether somebody has stopped selling sex. However, it is possible to stabilise the lives of sex workers by addressing their complex needs. Addressing their needs can improve health, wellbeing and reduce negative and damaging behaviour, such as drug taking. Meeting these needs may even result in reducing the selling of sex or stopping it altogether.

Therefore, whilst the review may draw on some of the literature which focuses on exiting, the approach that shall be taken in this section of the report will examine issues which inhibit the stabilisation of sex workers lives and prevent those who wish to cease selling sex from doing so, in the hope of highlighting key issues which need addressing.

Open Doors Case Study

Homerton Hospital's Open Doors Sexual Health Service is a specialised clinical and complex case management service which primarily works with female street sex workers. Funded by the City and Hackney Primary Care Trust, Open Doors has been operating in the London Borough of Hackney since 2006 and has since expanded its reach to other London boroughs, including Tower Hamlets and Newham.

The Open Doors service has a number of objectives, including:

- Managing and minimising harm amongst the client group, ensuring that options and strategies are understood by the women reducing morbidity and mortality amongst the cohort.
- Motivating the women towards a change in lifestyle that ultimately reduces street sex work and drug use, enabling them to consider and develop broader personal options and lifestyle choices.
- Facilitating fast track access to a range of health and social services that will help clients in achieving the first two goals.

In its first year of operation, Open Doors worked with 180 women. Since then, the number of women they engage with has increased to around 250 women per year. However, these numbers reflect a changing and transient population, with women leaving the streets as their needs are addressed by the Open Doors service and new women moving onto the streets as their personal and drug related lives become too chaotic and unmanageable.

Whilst being equipped to address its clients clinical needs and engage with women on the street, Open Doors provides safe and welcoming environments for the women, where they can eat a hot meal, wash, socialise, pick up clean clothes, get advice, and escape the chaotic environment of the street; even if only momentarily. Open Doors caters for other forms of sex work, such as providing sexual health screening services for brothel and parlour sex workers, and information and support services for migrant sex workers. It also provides specialised support services for sex workers who have experienced violence and rape, assisting women through the prosecution process. The service works closely with other public services, including the police and Homerton's Tuberculosis Outreach Team.

Additionally, since 2008, Open Doors provide a unique service which engages with the male partners of female street sex workers. Through the use of a Male Partners Coordinator, Open Doors has been able to address and treat the needs of male partners, who often experience severe addiction problems, homelessness and poor health, much like their female partners. They too are fast tracked into clinical treatment and social services. Since working with male partners, Open Doors has increased the retention and engagement with their female street sex work clientele by working with both the sex worker and her their partner as a joint case.

In a study of 114 women involved in all types of sex work, Bindel et al. (2012) identified a number of barriers which prevented improving and stabilising the lives of sex workers. Addiction and problematic drug use was mentioned by 83 per cent of the women in the Bindel et al. study. Many respondents stated a desire to change the situations they were in and address their addiction problems, but found themselves unable to do so through drug treatment programmes alone, requiring additional support around housing, benefits and employment. Additionally, as mentioned previously, drug addiction is often treated as a criminal justice matter with addicts either sent to prison or forced to attend mandatory drug treatment programmes, with little attention paid to other needs, such as housing (Sanders, 2007b).

Similarly, alcohol may pose specific challenges to people seeking to lead a life outside of sex work. As has been mentioned previously, alcohol is often used by sex workers as a coping mechanism and a form of self-medication. Some sex workers may be reluctant to access support and treatment for their alcohol use for fear of losing this mechanism for coping (Brown, 2013).

POOR PHYSICAL AND MENTAL HEALTH

Sex workers suffer from a wide range of health and wellbeing issues. In the Bindel et al. study, 79 per cent of the women complained of physical and/or mental health problems, whilst it is possible that others may suffer from physical and/or mental health problems that have yet to be diagnosed or reported. Sex workers represent a high-risk group where communicable yet preventable diseases, including TB, HIV, other Blood borne Viruses and STIs, are common (Collinson, Straub and Perry, 2011). Furthermore, research into the mental health of sex workers in Switzerland found sex workers often suffered from mental health problems, including depression, anxiety and Post-Traumatic Stress Disorder (Rossler et al., 2010); which can also negatively impact on physical health.

Additionally, within the Bindel et al (2012) study, many claimed they were unable to envisage a life outside of sex work, particularly those who had begun selling sex before the age of 18. The combination of an inability to conceive of a life outside of sex work and other destructive behaviours, such as drug abuse, poses a particular challenge to hopes of stabilisation. Likewise, poor physical and mental health would make maintaining more formal forms of employment very difficult or in some cases, due to the severity of the problem, impossible.

HOUSING

According to McNaughton and Sanders (2007), the issue of housing is very important. Whilst housing can provide an opportunity for transitions out of sex work through safety and security, it can also trap people in situations of vulnerability. Basic needs, such as housing, frequently go unmet by Government and local authorities which has a serious impact on the lives of sex workers, particularly those involved in on-street sex work. In the Bindel et al. study, 77 per cent stated they had problems with homelessness and housing. Warm, safe and secure accommodation is a basic need for any human being.

A lack of appropriate accommodation makes addressing sex workers' more complex needs very difficult and any hope of stabilisation near impossible. Homelessness can force some women into seeking accommodation in places which compound their vulnerability, exclusion and destructive behaviours, such as staying with abusive partners, partners with drug addictions, sleeping in crack houses or sleeping rough. Others stated they sold sex in order to meet high rent and mortgage demands, whilst others found the accommodation they were given by local authorities tended to be located in areas where the selling of sex and drugs is frequent.

MONEY, DEBT AND FINANCE

Financial issues have an overwhelming impact on the lives of sex workers. In the Bindel et al. study, 52 per cent of the women reported struggling to pay off debts. Whilst the details of these debts were not described in the report, information from other sources may provide some explanation. For example, it is well known that on-street sex workers suffer from problems with drug addiction. In some cases, sex workers may accrue debts with drug dealers to feed their addiction (Davis, 2004). In other cases, trafficked sex workers may be debt-bonded and have debts amounting to large sums of money which they are required to pay off before

they are released by their controllers (UK NSWP, 2008a).

Alternatively, some sex workers reported difficulty in giving up the amounts of disposable cash they were used to earning through sex work and the lifestyle that came with it. However, some felt that sex work was not worth the money and was damaging to their self-esteem, but depended on the income it provided (Bindel et al., 2012). Additionally, many felt they would be unable to earn similar amounts of money through more formal types of work due to a lack of employability and a lack of well-paying jobs in the labour market. And, as mentioned previously, state benefits are often insufficient in addressing financial need. Therefore, it is common for people to sell to sex where neither current levels of state support and current jobs available in the labour market are able to meet people's financial needs (McNaughton and Sanders, 2007)..

COERCION AND VIOLENCE

50 per cent of respondents in the Bindel et al. study reported experiencing some form of coercion, including pimping and trafficking. Restrictions on movement and behaviour by controlling individuals can deprive sex workers access to essential resources, freedoms and hopes of stabilisation.

CRIMINALISATION

In the same study, 49 per cent of respondents had a criminal record relating to prostitution offences, while 67 per cent had a criminal record for other offences not directly related to sex work. As mentioned previously in the review, criminalisation stigmatises sex workers, seriously reducing access to alternative forms of employment and other public services. This further impedes stabilisation (Peate, 2006; Sanders, 2007a).

LACK OF EDUCATION

In the Bindel et al. study, 39 per cent of respondents reported a lack of formal education with no qualifications, skills or training. Education and training is very important if vulnerable people are to find alternative forms of employment and cease selling sex. Other sources have highlighted the lack of alternative employment options, especially forms of well-paid employment available in the labour market which contributes to their marginalisation and reduces their chances of achieving stability (UK NSWP, 2008c; Sander, 2007).

MALE PARTNERS

It is important when addressing the needs of vulnerable and excluded people, particularly those who suffer from addiction issues, to look beyond the context of the individual and to consider the wider social context in which they exist (Bury, 2011). As Collinson, Straub and Perry (2011) have documented, specialised sex work services like Homerton Hospital's Open Doors began to encounter specific problems when trying to address the needs of on-street female sex workers. It was clear that some users of Open Doors were unable to fully engage with the support services. Open Doors discovered that service engagement was limited by complex relationships with male partners, whom they were often married to and had children with.

The couples' relationship to drugs exists co-dependently, with the woman selling sex to feed both drug habits. From the outside, this can appear to some as a form of pimping, but a closer examination of this type of relationship suggests that the woman's engagement in sex work to provide drugs is more through altruism than coercion. As a result of this co-dependency and long standing relationships with male partners, the women were often reluctant to take up welfare support and other services, such as drug treatment, as it would mean leaving behind their male partner, which they did not want to do. The women would usually withdraw from the service after a short period of time as a result (Collinson, Straub and Perry, 2011).

Like on-street sex workers, male partners are often a vulnerable, excluded and a particularly hard to reach group, sharing similar health needs, drug problems and housing issues as their female partners. The majority of these men have criminal pasts and are unlikely to engage with any services outside the criminal justice

system. In addition, these men face social stigma due to misunderstandings around their relationships with female partners and do not fall under the remit of any targeted services.

However, Open Doors began to engage with the male partners seeking to address their needs as well as those of the on-street female sex workers. In so doing, they were able address both party's needs getting them listed on drug treatment programmes, into more secure accommodation and claiming the necessary benefits; fundamentally, on the path to stabilisation. This saw a significant improvement in engagement and retention amongst on-street sex workers with the women much more likely to utilise social support services and complete drug treatment programmes (Bury, 2011).

SERVICE PROVISION AND SERVICE ACCESS

A key message to emerge from the literature stresses the importance and effectiveness of holistic approaches to addressing exclusion and need if stabilisation is to be achieved. Effective service provision for this group is achieved through holistic, fast-track support, as well as a clear understanding of how to deal with vulnerable people (Bury, 2011). As has been highlighted above, sex workers face high levels of exclusion and have a complex array of needs, including no recourse to public funds, a lack of rights to work, assistance with drug and alcohol addiction, homelessness, debt, poverty, poor mental and physical health, poor education, uncertain immigration status, lack of social support from family or other social networks, escaping controllers, and breaking cycles of destructive behaviour (Tonybee Hall, 2007; UK NSWP, 2008c; Bindel et al., 2012).

Due to the nature of the sex work industry, many sex workers lead nocturnal lifestyles meaning that attending regular appointments within normal working hours can be particularly challenging. In many ways, conventional public and support services are completely inadequate to meet the complex needs of sex workers. Fragmentation of services, inappropriate locations, difficulty accessing services, a lack of knowledge on behalf of service providers and the social stigma attached to sex work, result in inadequate and inappropriate service provision.

Furthermore, help and support services are often disjointed and often result in sex workers being treated for a single need, for example drug addiction, but not treated for other needs, such as homelessness (Tonybee hall, 2007). They are usually discharged from a particular programme of treatment and soon return to sex work, as their other needs remain unmet.

6. CONCLUSION

A review of the sex work literature revealed there are multiple social exclusions which:

- Drive entrance into sex work
- Result in negative consequences, such as poor physical and mental health, homelessness and stigmatisation, as a result of sex work
- Act as a barrier for those wanting to stabilise their lives and cease selling sex

In many cases, there is an overlap between sex work, homelessness and other forms of social exclusion, such as impoverishment, violence, family breakdown and untreated mental health problems. The interaction of different forms of social exclusion is best described as a syndemic whereby people often suffer from multiple processes of exclusion which exacerbate negative health impacts. The literature also indicates that different types of sex work result in different levels of further exclusion. Those trafficked into sex work are the most excluded, forced to live in fear with almost no control over their lives. Unstable housing, drug addiction and violence are issues which affect sex workers of all types.

The literature described a wide variety of factors (often forms of exclusion) which drive people into sex work:

- Violence
- Power
- Family Breakdown
- 'Cut Off

- Money, Debt and low level Welfare
- Addiction
- Housing
- Mental Health
- Low education
- Discrimination

Additionally, sex work results in further exclusion through:

- Stigmatisation
- Socio-economic factors – poverty
- Mental illness
- Addiction
- Poor health
- Homelessness
- Coercion
- Violence
- Criminalisation

Finally, many of the factors listed above which drive sex work engagement trap people in vulnerable situations and have been identified by the literature as barriers which prevent sex workers from stabilising their lives and ceasing to sell sex:

- Addiction
- Poor physical and mental health
- Housing
- Money, debt and finance
- Coercion and violence
- Criminalisation
- Lack of education
- Male partners
- Service provision and service access

The lack of support in areas such as housing, finance (benefits system), mental health and drug addiction, and the abrupt withdrawal of formal care systems can lead those in positions of vulnerability down various pathways of chronic exclusion, such as sex work, as well as homelessness. Thus for many, entrance into sex work is a means to survival; funding severe addictions, a place to sleep for the night or to top-up benefit payments.

Additionally, the lack of adequate support systems fails to address the needs of current sex workers attempting to stabilise their lives and cease selling sex. In particular, the literature states that sex workers would benefit most from a holistic approach to addressing their needs. However, indications suggest that the majority of ordinary support services are disjointed and tend to address needs in isolation from one another. This does not adequately meet the needs of sex workers.

Furthermore, the driving factors of chronic exclusion can have a detrimental effect on health. Although research into the impact of sex work on general health (not sexual health) is lacking, the literature (including a few studies with health as a specific focus) suggests that the processes of exclusion experienced by many sex workers negatively impacts on health. Higher rates of chronic illness – particularly symptoms relating to intravenous drug use and preventable respiratory diseases – and child mortality, combined with lower rates of GP registration and attendance of secondary care services, such as antenatal care, are just some of the negative health related issues identified in the sex work literature.

Finally, there are many gaps in the existing literature. The current figures being used to estimate the sex work population are outdated and the literature on male and transgender sex workers is very small. Research into issues, such as mental health and the complex interrelated factors which lead and trap people in sex work, is

also lacking. Additionally, there are only a few studies which monitor and evaluate outreach and intervention programmes.

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