

The Health of Women in Prostitution

by Ruth Parriott

Marcie and the interviewer sit in a quiet room in a nondescript office building near downtown Minneapolis. A soft-spoken woman of twenty-seven, Marcie is dressed neatly in slacks and a pretty, ruffled blouse. She answers the questions precisely, sometimes pausing to collect her thoughts. Although her tone is matter-of-fact, she occasionally glances at the interviewer to gauge her response. Marcie is aware that her answers may shock, that, put together, they do not paint a pretty picture.

Yes, she has given birth; to three children, each quite underweight. Marcie had her tubes tied several years ago after her doctor told her she "had to quit having all these crack babies." She's been in treatment three times, but still hasn't been able to care for her kids on a regular basis.

Yes, she has a doctor. Marcie makes sure to get a pap smear every year, especially since that positive one, and since she landed in the hospital for a week with severe pelvic inflammatory disease. The doctors said it was probably from an untreated gonorrhea infection.

Yes, she has been to the emergency room. Once after a rape, but usually for injuries from a beating. Marcie estimates that she gets beaten up a few times a month; cuts and bruises are common, but the worst was when her kidneys were damaged. Marcie figures all men are dogs, but she "doesn't know about a real relationship."

Yes, she has been prescribed antidepressants. The doctors thought the medicine would help after her suicide attempt, and Marcie hoped they would help her sleep. She still has problems with anxiety attacks, and is sometimes afraid to leave her apartment.

When the questions are over, Marcie thanks the interviewer and starts to leave. At the door, she turns to ask if there's anything else she can do. If there are any girls who need help, Marcie would be glad to talk to them. She knows what it's like, being on the streets as a teenager. As she leaves, Marcie says thank you again.

The interviewer is left alone in the room. She takes the opportunity to make a few quick calculations on the questionnaire. Marcie had her first paid date with a john at age sixteen. With time out for months in treatment and a brief respite during a move to another state, she has spent almost a third of her life in prostitution. Marcie estimated that she did only a few tricks a week later in her pregnancies, but at least ten a

day during her times working in a crack house.

With the combination of physical and sexual abuse, drug use, and poor economic circumstances, the interviewer is not surprised by the number of health problems Marcie has experienced in her relatively young life. Unfortunately, Marcie's story is not shocking because it is so similar to that of other women who have spent their lives mired in prostitution.

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, including illicit drug use, sexually transmitted diseases, and violence. In countries with legalized prostitution, the health status of prostituted women is more routinely tracked, although these efforts consist mainly of gynecologic exams and screening for sexually transmitted diseases (STDs).

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 would dispute these arguments.

To begin to fill the void of information, and to encourage appropriate intervention and further research, a research study was initiated by WHISPER (Women Used in Systems of Prostitution Engaged in Revolt) of St. Paul and jointly supported by PRIDE (from Prostitution to Independence, Dignity and Equality) of Minneapolis. These organizations offer services to prostituted women seeking to stabilize their lives. The services, which include support groups, legal and housing referrals, and street outreach, are often provided by advocates who have survived prostitution themselves.

Design of the Study

The study was exploratory in nature, designed to assess the general health status

of prostituted women through interviews with a sample of local women who have been used in prostitution. An important feature of the study was its focus on the health of prostituted women as it affects the women themselves, not merely as it contributes to the epidemiology of a specific disease. While some research is conducted as a contribution to a pool of knowledge, the driving force behind this study was action-oriented advocacy: a commitment to help prostituted women and to minimize the harm that may befall them.

The women surveyed had been exposed to prostitution for at least six months and had not been out of prostitution for more than five years. All were adults. Prostitution was defined as experiences in which women are paid—either with money or drugs—for performing sexual acts with another person.

To recruit volunteers for the study, announcements were distributed to halfway houses, women's treatment programs, battered women's shelters, and public health clinics. Members of PRIDE and WHISPER, and women participating in WHISPER's support group at a Ramsey County correctional facility, were offered participation in the study. Strict confidentiality was assured. Although face-to-face interviews were conducted, appointments were made using only first names and no identifying information was collected. The interviews took approximately thirty minutes, and the women received twenty dollars for their participation.

Several points must be made about the study design and how it guides interpretation of the survey results. First, the study gathered self-reported data. 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 describes health experiences common to this sample of prostituted women.

In addition, it is not possible to gather a statistically representative sample of prostituted women; there is no master list from which to randomly select participants. Whether involuntarily serving time in the correctional system, voluntarily attending advocacy support groups, or trying to kick a drug habit, each of the women interviewed 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.

Women in the Sample

Over seventy women volunteered to be interviewed during August and September of 1993. Sixty-eight surveys were included in the final data base. The women ranged in age from twenty to forty-five. Two-thirds were women of color and one-third were white. Most described themselves as either "very poor" or "just making it" financially, and a little over half had completed high school. They were clearly connected with the social welfare systems; almost three-fourths had received public aid for themselves or their children while they were in prostitution.

The women were forthcoming, polite, and intrigued by the fact that someone was interested in gathering data about their health rather than the sexual details of their prostitution experience. Only a brief portion of the interview focused on their exposure to prostitution in order to provide a point of comparison for the health data. The words the women frequently used when referring to prostitution were *dating* or *dates*.

The women averaged approximately eight and a half years of active involvement in prostitution (Table 1), and 75 percent had *dated* within the past six months. Many described drifting in and out of active involvement, with a move, an incarceration, a pregnancy, a supportive relationship, or improved finances providing a temporary respite followed by an eventual return to prostitution. Published research estimates of a typical "life in prostitution" have frequently assumed a more short-lived exposure, but this sample suggests a much more entrenched vulnerability to prostitution in some women's lives.

Half of the women were first prostituted as juveniles, although the average age the women reported for their first prostitution experience was nineteen. This is considerably older than other profiles of prostituted women, which generally put the age of initi-

ation between fourteen and sixteen. The fact that the sample was limited to adult women could account for the discrepancy. The women in the sample who were first prostituted as juveniles were significantly more likely to have higher levels of each of the exposure variables.

Table 1 lists the data on exposure to prostitution for the entire sample. 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, 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.

Table 1. Exposure to Prostitution

Exposure Variables	Average	Range	Median
Total months prostituted	103 (8.6 years)	9-335	70 (5.8 years)
Lifetime number of sexual exposures	10,292	60-81,270	2,827
Number of sexual exposures per month	104	4-752	43



WHIISPER sends out street workers in the Twin Cities to distribute condoms and information on how to protect oneself from sexually transmitted diseases and AIDS.

The types of prostitution to which the women had been exposed varied greatly. Most had been prostituted in several different venues, including saunas or 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 percent) is alarming considering the accelerated rates of exposure and the additional risks associated with that setting.

Reproductive Health

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. Many of the prostituted women rely primarily upon clinics which do not offer a full range of gynecological services. For example, the Red Door and Room 111, local public health clinics that offer low cost screening and treatment for sexually transmitted diseases but no pap smears, were frequently mentioned by the women in the study.

Regular screening for cervical cancer is of particular concern for this group of women who, despite their young age, reported an alarmingly high rate of positive test results. Twelve percent of the women specifically mentioned having a colposcopy or a cone biopsy, tests designed to check for further signs of cervical cancer following a positive pap smear. This rate is three times higher than that reported by the Minnesota Breast and Cervical Cancer Control Project, which provides screening to the general population of low and middle income women.

Regular gynecological care is necessary not only for the women's health, but for the children they conceive and bear. Seventy-five percent of the women had been pregnant during or since being prostituted. In total, 254 pregnancies were reported (Table 2). The women who began pregnancies during prostitution (which they attempted to bring to term) averaged three pregnancies each. A third of these women received no prenatal care or only third trimester care for their last pregnancy, a figure almost ten times that of the general state population. Coupled with the women's other health risks, it is not surprising, then, that almost a third of their children suffered complications from either premature birth or low birth weight.

Complications from sexually transmitted disease (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 had been tested for HIV, one had been diagnosed HIV-positive.

Table 2. Outcomes for the 254 Pregnancies Reported During or Since Being Prostituted

	Percent	Number
Live birth*	48	123
Elective abortion	25	64
Miscarriage	24	61
Stillbirth	2	5
Ectopic/tubal	<1	1

* Low birth rate or premature birth = 29 percent of these or 36 births.

Table 3. Women Diagnosed With Sexually Transmitted Diseases at Least Once During Time Prostituted

	Percent	Number
gonorrhea	69	4
chlamydia	60	41
syphilis	18	12
genital warts	15	10
genital herpes	7	5
HIV	1.5	1

The overall rates of other STDs were alarmingly high (Table 3). Only 15 percent of the women in this sample had never contracted one of these infections. By comparison, a recent National Institutes of Health study estimates that approximately 60 percent of the general population of sexually active Minnesota women has never contracted one of these diseases.

The women averaged four STD infections during their time in prostitution, most commonly chlamydia and gonorrhea, infections which can lead to pelvic inflammatory disease (PID). PID accounts for most of the serious illness associated with STD infection, including infertility and chronic pelvic pain. A third of the women had experienced at least one episode of PID, and three reported having been told by a physician that they are infertile due to tubal scarring. The women who reported the median number of STD episodes or higher 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.

Higher numbers of STD episodes were linked with higher numbers of prostitution dates. One protection from STD is the consistent use of latex condoms. According to other 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 non-monogamous.

This study confirmed those research findings. While 68 percent of the women reported using a condom "all the time" or "more than half the time" with johns, only 10 percent reported this frequency of use with men in their personal lives. Further, the women who used condoms infrequently in their private lives experienced significantly higher numbers of STD episodes than those who used condoms at least half the time with private partners or who did not engage in sex outside of prostitution.

Drug Use and Addiction

Chemical abuse compromises both physical and mental health in a myriad of ways, and it is a severe problem in this population. Almost all of the women in the sample consider themselves chemically addicted. Most reported using a variety of drugs over time, although the only drugs mentioned frequently in the past six months were alcohol, crack cocaine, and marijuana (Table 4).

Despite treatment programs (93 percent of the women had been in a treatment program, an average of three times each), the use of drugs appeared unabated. Half of the women reported that they were high all the time while soliciting and turning tricks, and another third described themselves as high at least half of the time. 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.

Next to alcohol, crack cocaine was the most frequently used drug over the past six months. The ravaging effects of crack cocaine in general and among prostituted women in particular have already been well

Table 4. Percentage of Women who Reported Drug Use (actual numbers)

	Those who ever used the drug		Used in the past six months		Began using 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	(0)	45	(14)
PCP	40	(27)	4	(1)	30	(8)
heroin	38	(26)	12	(3)	69	(18)



The survey found that drug abuse and violence are universally present in the lives of women in prostitution. This reinforces the importance of preventing women and girls from being exposed to the cycle of prostitution, drugs, and violence, and of helping them to escape it if they are already involved.

documented by researchers. The low price and relatively short high of crack has encouraged a tremendous increase in sex-for-drugs exchanges. These 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 percent of the women had exchanged sex for crack. One woman summed it up: "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. Approximately a third of the women reported injection drug use, although many described it's use as rare: "I only tried it once or twice." Most who had injected drugs while in prostitution had used a borrowed, shared, or rented needle, and only half reported bleaching the shared needles before using them.

Violence

Injury from physical assault poses a serious health threat to prostituted women. Half had been physically assaulted by a john,

and a third of these had been assaulted at least several times a year. 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, in wonder, 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 common experience of violence for these women, on the other hand, was not perpetrated by johns. While research estimates that 25 to 37 percent of all women experience battering in their life-

time, 90 percent of the women in this sample had been assaulted by someone other than a john during their time in prostitution. Over half reported being beaten at least once a month. Higher rates of severe injury—specifically miscarriage, stabbing, and head injuries—were also associated with violence in personal relationships rather than from assaults by johns (Table 5).

There was often a marked difference in the demeanor of the women during the physical assault section of the interview. They would become more quiet and distant, often lowering their voice and averting their eyes. In a survey filled with many painful and private subjects, the section on violence was the only one which would incite tears. As one woman explained as she struggled to gather her thoughts and continue with

Table 5. Percentage of Women who Reported Injuries

Type of perpetrator	Type of Injury			
	Miscarriage	Cutting/stabbing	Loss of consciousness	Head injury
john (N=34)	0	6	6	12
other (N=61)	18	26	39	48

the interview. "I'm sorry, I'm just remembering now...it's hard for me to think about this part."

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, 85 percent of the women in the study have been raped since first being prostituted. The rapes occurred with equal frequency inside and outside of prostitution dates. 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 becoming vulnerable to prostitution. This study supported that connection. Sixty-two percent of the women reported being sexually assaulted or abused prior to their initiation in prostitution. Over half named a family member as a perpetrator.

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 stress responses were tracked in the survey. The women reported an average of six. Some of the most frequently experienced were depression, insomnia, flashbacks, and sexual dysfunction. The level of stress responses did not vary significantly 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.

Most disturbing of the stress responses was self-destructive behavior. Nineteen percent of the women reported self-mutilation, such as cutting, and 46 percent had attempted suicide. While there are no reliable estimates of the rate of suicide attempts in the general population, researchers believe that 10 to 15 percent of those who make an attempt will eventually succeed. Suicidal behavior in this sample 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 life or intimate relationship with men difficult at best. Half of the women reported feelings of loathing, disdain, or distrust for all men after

being prostituted. They often subscribed to the view that men are "either pimps or tricks."

Three-fourths of the women reported difficulty establishing normal intimate relationships outside of prostitution. They described their inability to separate a loving relationship from a trick, and the fear, avoidance, and lack of enjoyment that results from this confusion. "I'm numb," said one woman, explaining the dissociation she has learned to bring to sex, even with her trusted partner. One woman summed up the frequently expressed feelings: "Every time I have sex, I feel like somebody should give me something for it."

Access to Health Care

One of the few good signs reported by the women in the study was their access to health care. Three-fourths felt they had a place to go for primary care during their time in prostitution, and 84 percent had some type of medical insurance coverage, at least part of the time (primarily provided by the government).

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 a third of the women who had a primary health care provider told the provider about their prostitution history. 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 might 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 add to the fear of exposure in the lives of prostituted women. Sensitive health care providers can 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 their history of prostitution, none reported being treated negatively after sharing the information, and 90 percent said they would choose to tell again.

Conclusions and 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 risks. 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

increase 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 notable is that drug abuse and violence were universally present in all of these women's lives, regardless of age, race, or the type or amount of prostitution they had experienced. Drug abuse, violence, and prostitution are so closely intertwined that it is impossible to separate their effects on the health of the women in the sample. The most basic recommendation, therefore, must be what action advocates and services providers have been following for years: prevent women and girls from exposure to this cycle of prostitution, violence, and drug abuse, and help them escape it if they are already involved.

Beyond this, there are some interventions that may help reduce illness and promote better long-term health. Agencies working with prostituted women should offer concrete advice to their clients for preventive health care. Women can be encouraged to get yearly pap tests to check for signs of cervical cancer. They can be taught to specifically ask for the test and not rely on STD screenings alone. Women can be encouraged to tell their primary health care provider about their exposure to prostitution. This information is essential if they are to receive care appropriate to their risks. If women do not feel safe sharing the information, they should trust their feelings and seek a different provider whom they do trust. Women can be encouraged to use condoms with sexual partners in their personal life as well as with johns. They need to know that the risk of contracting STDs is present in all sexual encounters, and that the serious risks go beyond AIDS. And all prostituted women should receive vaccinations for hepatitis B.

Agencies working with prostituted women need to be attuned to the health risks these women face. For example, pregnant women are likely to not receive appropriate prenatal care, and their children are likely to suffer disproportionately from low birth weight or premature birth. The younger women are when first prostituted, the more exposure to prostitution they are likely to suffer, and thus the greater the risk of health-threatening STDs. Women who experience sexual abuse prior to prostitution are at even greater risk of severe stress responses, particularly suicide attempts.

Finally, social service systems should be designed to better address the multiple problems often present in the lives of vulnerable women. Programs designed to treat substance abuse, criminal justice systems, and programs for prostituted women should work closely with one another. If combination programs cannot be developed, women in each of these programs should have easy access to the

other programs. And there should be no stigma attached to using them.

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 one of these without addressing the others as well. For example, drug 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 is not likely to 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—places such as domestic abuse shelters, teen runaway groups, homeless shelters, chemical dependency treatment facilities, correctional facilities, child welfare agencies, and mental and physical health care clinics—need to recognize the pervasiveness of prostitution in vulnerable female populations. They need 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.

New CURA Publications

Land Use Practices: Exclusionary Zoning, De Facto or De Jure? An Examination of the Practices of Ten Suburban Communities in the Twin Cities Metropolitan Area. Barbara L. Lukermann and Michael P. Kane. 1994. CURA 94-6. 74 pp. Free.

Are the Twin Cities suburbs using planning practices and regulatory requirements that exclude low and moderate income households? This study examined ten suburban communities (Burnsville, Coon Rapids, Eden Prairie, Edina, Lakeville, Maple Grove, Minnetonka, Plymouth, Shakopee, and Woodbury). The communities were chosen partly to show what practices are being followed in the suburbs with the greatest job growth. The study found that current practices do limit opportunities for affordable housing in several of these suburbs. It is, however, unlikely that a legal suit could document exclusionary zoning in any of these communities.

Courses on the Environment: A Student Guide to University of Minnesota Courses on Environmental Issues on the Twin Cities Campus, 1994-1995. CURA 94-4. 68 pp. Free.

Courses relating to environmental studies at the University of Minnesota are listed by subject area and by department. Course

descriptions are included. This publication is intended to be a guide for faculty and students and is supplemental to official University bulletins. In addition, it includes descriptions of academic programs that offer degrees related to environmental issues and includes a section describing special centers and libraries that deal with the environment.

Courses on Aging: University of Minnesota, 1994-1995. All University Council on Aging. 1994. CURA 94-5. 34 pp. Free.

The University of Minnesota offers many courses related to aging. This is a listing of those courses in which aging is a primary focus. Courses are listed by campus (Twin Cities and coordinate campuses) and by department. Listings are complete with course name, number, quarter offered, teacher, credits granted, prerequisites, time of class, and course description. Contact persons and phone numbers are listed for each department. This edition again features a year-at-a-glance grid showing when classes on the Twin Cities campus will be offered.

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Forthcoming in January

What the 1990 Census Says About Minnesota: Income and Poverty. John Tichy and William J. Craig. 1994. CURA 94-7.

The last decade has brought many changes in the income and poverty levels of people in the Twin Cities and across the state. A detailed analysis of the 1990 Census helps shed some light on the nature of those changes. Findings include: Minnesota households are generally better off than in 1980; the poorest, however, are worse off; outstate Minnesota is falling behind the metro area; and high levels of single-parent families are making the high levels of poverty among the state's minority populations

even higher. This monograph will be the first in a series that shows what the 1990 Census has to say about Minnesota.

Photo on page 1 by Elvin Wily. Photos on pages 7 and 8 courtesy of Community Crime Prevention/SAFE. Photos on pages 11 and 13 by Nancy Conroy.