Barriers to Health and Social Services for Street-Based Sex Workers

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Abstract: Homelessness, poverty, drug abuse and violent victimization faced by street-based women sex workers create needs for a variety of health and social services, yet simultaneously serve as barriers to accessing these very services. The present study utilized interview (n = 586) and focus group (n = 25) data to examine the service needs and associated barriers to access among women sex workers in Miami, Florida. Women most often reported acute service needs for shelter, fresh water, transportation, crisis intervention, and drug detoxification, as well as long-term needs for mental and physical health care, drug treatment, and legal and employment services. Barriers included both structural (e.g., program target population, travel costs, office hours, and social stigma) and individual (e.g., drug use, mental stability, and fear) factors. Bridging these gaps is tremendously important from a public health perspective given the disease burden among this population. Recommendations include service staff training, outreach, and promising research directions.

Key words: Prostitution, drug use, homelessness, health services, sex work.

Street-based sex workers are embedded in a complex web of social environments that make them a very important population to reach with health and social services. Many are homeless, and drug abuse in this population is common.[1–9] Significant numbers of street-based sex workers have histories of childhood sexual and physical abuse, increasing their susceptibility to mental and emotional problems.[10–14] Violent victimization at the hands of "dates" (clients, or "johns"), boyfriends, and other predators continues to play a large role in their adult lives.[8,11,15–19] Indeed, many of these problems are self-perpetuating, in that (1) childhood sexual and physical abuse beget drug addiction, homelessness, and associated street survival strategies, including sex work; and (2) the trauma from living on the street results in attempts at self-medication and escape, increasing the need for drugs and the activities necessary to pay for them.[5,20–26]

All of these factors (childhood trauma, drug use, homelessness, poor hygiene, sex work, and street life) contribute to mental and physical health problems that

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require attention. Studies documenting the link between HIV and sexually transmitted infections, drug use, and prostitution are numerous.[3,27–33] In a rare qualitative study of the needs of women street-based sex workers, mental health care and drug treatment were cited as second only to basic food and shelter needs in importance.[34]

Despite these myriad health and social problems, studies of homeless women and of women drug users highlight numerous barriers to accessing necessary services, including the structure of care systems[35]; provider resistance[36]; prioritization by women of acute over preventive care[37]; learned helplessness, depression and low self-esteem[38]; and cost and waiting times.[39]

For the most part, these studies have been carried out with women residing in housing shelters. However, the very nature of women sex workers' income-generating activities keeps them from seeking the protections and services offered by mainstream charitable and governmental organizations. Homeless shelters generally observe strict curfews and prohibit any form of illicit drug use. Neither of these rules is conducive to sex work, which is usually most profitable in the evening hours.[7] Fear of discrimination and arrest has also been cited as a reason these women do not seek out care.[40] Thorough studies on the needs for and barriers to services among this population appear to be nonexistent. Therefore, the present study, an outgrowth of a larger HIV prevention research effort, was designed to assess the health and social service needs and the associated barriers to access among street-based women sex workers in Miami, Florida.

Methods

Quantitative data for this analysis are drawn from baseline interviews conducted as a part of a research project testing the effectiveness of two brief HIV/AIDS and hepatitis risk-reduction interventions. To be eligible, participants must be at least 18 years old and have (1) traded sex for money or drugs at least three times during the 30 days prior to recruitment; and (2) used heroin and/or cocaine three or more times per week during that same period. The 586 women described in this report entered the program between March 2001 and November 2003.

Recruitment and informed consent. Because women sex workers are a hard-to-reach population that is difficult to find through the use of traditional outreach workers,[7] this study employed active sex workers as client recruiters. Using standard multiple-starting-point snowball sampling techniques and chain referral strategies[41] in specific neighborhoods where rates of drug use and sex work are known to be high, client recruiters made contact with potential participants on the streets both day and night. These active sex workers have access to and credibility with a variety of local drug user and sex worker networks. Although the plan does not ensure a totally unbiased sample, the use of multiple starting points and numerous client recruiters eliminates the problem of drawing all respondents from only one social network.

Any client who expressed an interest in recruiting and who kept an appointment for a one-on-one orientation session with the project site director was eligible to become a recruiter. Although the financial incentive ($20 per qualifying recruit)

was an important motivator, many clients also saw the recruitment of others into the project as a way to help other women. Some were also attracted by the opportunity to be productive and to engage in paid employment that did not include sex work. Most recruiters only referred one or two acquaintances. Those who voiced a greater long-term interest and who demonstrated success in making outreach contacts in multiple neighborhoods were given more advanced individual and small group training, including training for skills in targeted sampling, finding very hard to reach populations, role playing, and trouble shooting.

The most difficult aspects of retaining productive recruiters included the following: (1) as drug-involved women sex workers, even the most dedicated recruiters had some difficulties in meeting the scheduling demands of the project; (2) the project did not generate enough consistent income for women who were interested in and capable of holding a full-time job; and (3) transience and homelessness made scheduling and rescheduling appointments with both recruiters and recruits difficult. Nevertheless, more than 95% of all project clients were referred by client recruiters. About 12 women became highly trained recruiters during the course of the project, successfully referring more than 10 clients each. (A few referred more than 30.)

All contacts in the street represented prescreening interviews. Those meeting project eligibility requirements were scheduled for appointments at the project intervention center, where they were rescreened by project staff members. After eligibility was confirmed, informed consent was obtained and urine testing was conducted for cocaine and opiates. Interviews were conducted using a standardized data collection instrument developed by the study investigators and took about 1 hour to complete. After the baseline interview was completed, the client was randomly assigned to one of two alternative HIV and hepatitis prevention interventions. Testing for HIV and hepatitis A, B, and C was provided on a voluntary basis; clients received relevant risk reduction literature and service referrals, as well as a hygiene kit containing a variety of risk reduction materials.

Site and sample characteristics. The recruitment process and eligibility requirements, as well as the location of the program headquarters, influence the characteristics of the sample to some degree. The project's intervention center is located just east of Miami's Biscayne Boulevard, a more than 15-mile long major thoroughfare extending from the Broward County line into downtown Miami. An 80-block stretch at the lower end of the Boulevard is a major sex worker "stroll." Some 90% of the women in the sample who specified a particular neighborhood for their sex work indicated areas within the boundaries of eight ZIP Codes along the main stroll. Almost half (46.3%) concentrated their work within three ZIP Codes centered on the stroll.

The social geography of the Boulevard is relevant for understanding the ethnic concentration of the sample. Although over 57% of Miami-Dade County's population is Hispanic,[42] the sex work district for most of the Hispanic populations (Little Havana) lies near and around Miami's second major stroll (*Calle Ocho,* 8th Street), which enters the city center from the west. Latina sex workers (and Latino dates) are concentrated along that strip, and are both further away from and less

likely to be comfortable in the primarily English-speaking area where the intervention program is located.

Outreach far beyond the intervention center site was impractical within the context of the present study, in which large numbers of homeless and transient clients were followed for a full 12 months from intake. Given the frequent difficulties in contacting these clients, the fixed location and hours of operation of the center enabled women to drop by to visit with staff, introduce potential recruits, provide staff with updated locator information, or reschedule appointments at their convenience. Clients also appreciated the security measures afforded by the large home and fenced yard within which the project is housed.

Data collection. Baseline interviews included extensive questions about demographics, drug use and treatment history, health and health risks, HIV-transmission knowledge, sex work practices, sexual behaviors, mental health, and social service needs using the Revised Risk Behavioral Assessment.[43] Particularly relevant to this report, homeless status was assessed by the question, "Are you currently homeless?" Women's health and social service needs were collected from responses to the open-ended question, "What kind of community service do you most need?" The Child Trauma Questionnaire—Short Form[44] was used to assess childhood physical and sexual abuse. Physical abuse is defined here as any positive response to one or more of five Likert-type items, such as, "When you were growing up, how often is it true that people in your family hit you so hard that it left you with bruises or marks?" Sexual abuse is defined as any positive response to one or more of five similar items, such as, "When you were growing up, how often is it true that someone tried to touch you in a sexual way or tried to make you touch them?" All interviews were administered by trained English–Spanish bilingual interviewers who were able to assess respondents' ability to complete the interview at the scheduled time (respondents who were high on alcohol or drugs upon arriving for a scheduled interview were asked to reschedule) as well as to clarify the meanings of questions that were not clearly understood.

In addition, this report was informed by data from six focus groups held in August and September 2003. Following informed consent using a protocol approved by the University's Institutional Review Board, focus group discussions lasting 60–90 minutes were conducted and audiotaped. Participants identified themselves on the tape using a pseudonym. The focus groups included 25 women from the larger study. Discussions were guided by an interview schedule that probed the following themes: (1) the meaning and nature of homelessness among the population; (2) how women manage their health, safety, and survival needs on the street; and (3) the availability and suitability to them of health and social services in the community. These women ranged in age from 32–54 years; 14 of them were African American, 9 non-Hispanic white/Anglo, 2 Latina, and 1 Native American. Participants were selected to attend a particular session based on whether or not they considered themselves to be homeless at the time of the focus group, because the researchers believed that homeless and housed women might have different needs and face different barriers to service. The age and ethnic distributions of the 13 homeless and the 12 housed women were quite similar.

Finally, eight focus group participants also contributed to two work group sessions that were dedicated to an agency-by-agency review of local health and social service availability, accessibility, and suitability. Participants in all groups were compensated $25 for their time.

Analyses and interpretation. Data from the interview questionnaires were analyzed using a standard statistical package (SPSS Rel. 11.5.1, Chicago: SPSS, Inc.). Focus group sessions were transcribed using pseudonyms to identify individual speakers. The transcribed texts were segmented and coded while retaining their links to the original speakers and contexts[45,46] using QSR N6 text analysis software. Although the interview schedule targeted specific aspects of homelessness and community service needs, coding categories used in the analyses were not predetermined. Because this was an exploratory study, the themes emerged from the data following a grounded theory approach.[47]

Results

Demographic characteristics. Research and popular culture indicate that sex workers are of many types, ranging from highly paid call girls who work independently with a "book" of steady "monied" customers accumulated through clients' word of mouth,[48] to the down-and-out "crack whores" and "skeezers" who populate inner city streets and crack houses "turning tricks" for as little as a few hits on a crack pipe.[49] The great majority of the women encountered in this study are situated at or close to the latter end of this continuum, with almost all reporting that they were physically and mentally exhausted from surviving on the streets for many years.

Some 78% of the participants were over 30 years of age, and over half (52.4%) had less than a high school education. For reasons already noted, the sample is largely African American and non-Hispanic white/Anglo. As evidence of the women's social isolation, fewer than 12% lived with a husband or other committed partner. Although a sizeable majority (66%) had children younger than 18, few respondents (28.4%) lived with their children. Most often, the children lived with a grandparent. A small majority (56.8%) received at least some legal income, which largely consisted of government assistance (30.2%) and/or family (37.5%) support. Almost none (5.6%) received income from legal employment (Table 1.)

Homelessness. Almost half (42%) of the study participants responded affirmatively to the question, "Are you currently homeless?" Of these, 131 women reported living on the streets, 69 in someone else's home or apartment, 32 in shelters, and 14 in a variety of other places. Because some of these circumstances did not match widely accepted ideas about homelessness, housing and homelessness were major areas of discussion during the focus groups. We found that focus group respondents' definitions of homelessness varied across both individuals and contexts. For some women, homelessness was defined strictly as living on the street, so that even if they were sleeping at temporary public shelters they considered themselves housed. Several other participants said that they were staying at the homes of friends or relatives, yet considered themselves to be homeless. Most frequently, the latter kind of homelessness involved an agreement with the owner or renter of the dwelling according to which the woman was responsible for coming up with a daily or weekly

Table 1.

DEMOGRAPHIC CHARACTERISTICS OF WOMEN SEX WORKERS (N = 586)

	N	%
Age (y)		
18–20	18	3.1
21–30	111	18.9
31–40	239	40.8
41–50	207	35.3
>50	11	1.9
Median age = 38		
Ethnicity		
African American	377	64.4
White/Anglo	111	18.9
Latina	82	14.0
Other	16	2.7
Education		
8th grade or less	52	8.9
9–12 y	255	43.5
High school diploma/GED	173	29.5
At least some college	106	18.1
Financial status		
Homeless (self-report)	246	42.0
Receive any legal income	333	56.8
Marital status		
Never married	341	58.0
Married/live-in partner	69	11.9
Separated	66	11.3
Divorced	88	15.0
Widowed	22	3.8
Have children <18	328	66.0
Place of residence		
Own house/apartment	143	24.4
Someone else's house/apartment	224	38.2
Hotel/rooming house/other	50	8.5
Shelter	35	6.0
Streets	134	22.9

rent payment, without which she would be turned out into the street. In other cases, the woman was allowed to sleep at her friend's or relative's home under only the most restrictive circumstances. In one case, this included the woman having sex with her male relatives as a condition of receiving shelter.

Contrary to our expectations, these focus group discussions showed that the terms *homeless* and *housed* were of little utility in identifying needs and barriers because none of the focus group respondents lived in stable and secure housing. Even those focus group participants who considered themselves housed were just a few days' income away from being on the streets. All of the women we spoke with had spent nights on the street at some time in their lives; most had had many such experiences, regardless of their current circumstances. This was also quite likely the case for the large majority of the women we had interviewed using the survey instruments.

Drug use. Drugs used during the month prior to the baseline interview are shown in Table 2. Crack cocaine has been the primary abused drug in the Miami area since the mid-1980s,[7] and so it is not surprising that crack was used by almost as many respondents as alcohol. Few of the women were current injection drug users, and only 19.5% reported the use of any form of heroin in the past 30 days.

Health characteristics. Current and historical measures of physical health are shown in Table 3. A large minority (38.4%) of intervention program clients reported fair or poor health at baseline. The data also showed that many women were unaware of their true health status, however. Of 120 women who showed positive results for HIV on tests administered as a part of the study, only 66 (55%) had already known they were infected. Of 284 participants who tested positive for past exposure to HBV, only 13.0% had ever been told they had had the disease. And for the 158 women who tested positive for HCV infection, only one third (34.2%) already knew their status. Few clients were covered by any sort of health insurance plan; almost all those who had coverage were under a public assistance arrangement. Signaling the likelihood of ongoing mental and emotional distress, self-reported rates of childhood physical (76.3%) and sexual (51.9%) abuse were extremely high.

Perceived health care and social service needs: Survey data. Table 4 shows the frequency of women's responses to the open-ended question, "What kind of community service do you most need?" for both the total sample and those who reported being homeless at baseline. A surprisingly large proportion (17.5%) of homeless women either said they did not know or said they needed nothing. Interviewers or staff reported that such responses most often came from women who projected an aura of self-sufficiency and bravado despite their circumstances. Shelter and employment were the other most common responses, with some form of mental or physical heath care (including drug treatment) cited next most often. Homeless women's responses did not vary greatly from those of the total sample, with the single exception of shelter, cited by 41% of self-reported homeless women. Buttressing the point made earlier regarding homelessness as a somewhat subjective and context-bound status, however, 42 self-reported housed women also said that their priority need was shelter. Food and clothing were relatively rare responses to this question (and even rarer for homeless women), suggesting that these survival needs are already being met in the community.

Table 2.

PRIOR MONTH'S DRUG USE BY WOMEN SEX WORKERS (*N* = 586)

	n	%
Alcohol	446	76.1
Crack cocaine	430	73.4
Marijuana	351	59.9
Other cocaine	251	42.8
Heroin	114	19.5
Injected any drug	79	13.5

Table 3.

HEALTH CHARACTERISTICS OF WOMEN SEX WORKERS (*N* = 586)

	n	%
Self-reported overall health status		
Excellent/very good	147	25.1
Good	214	36.5
Fair	175	29.9
Poor	50	8.5
Positive test results in this study[a]		
HIV	120	22.4
Hepatitis A (prior exposure)	205	38.5
Hepatitis B (prior exposure)	284	53.3
Hepatitis C	158	29.6
Have health insurance	161	27.5
Childhood trauma		
Physically abused	447	76.3
Sexually abused	304	51.9

[a] Percentages are based on number of women for whom test results were available.

Perceived health care and social service needs: Focus group data. As described in the Methods section, one of the major topics of the focus group discussions was the identification of health and social service needs of street-based women sex workers. A compendium of the needs cited by the focus group participants is found in Table 5. Starting with physical needs, the focus group participants affirmed that free food and clothing can be found with some dependability at local social service agencies, although it took some time to learn which days and times specific agencies

Table 4.

SOCIAL SERVICE NEEDS IDENTIFIED BY WOMEN SEX WORKERS IN MIAMI, FLORIDA ($N = 586$)

Most urgent need	Total sample ($N = 586$)	%	Homeless ($n = 246$)	%
Shelter	143	24.4	101	41.0
Employment	105	17.9	42	17.1
Medical care	51	8.7	13	5.3
Drug treatment	49	8.4	18	7.3
Mental health counseling	33	5.6	9	3.7
Food	26	4.4	4	1.6
Financial assistance	20	3.4	8	3.3
Clothing	10	1.7	2	0.8
Education	10	1.7	1	0.4
AIDS education	7	1.2	0	0.0
Furniture	5	0.9	0	0.0
Transportation	5	0.9	3	1.2
Child care	3	0.5	0	0.0
Legal assistance	2	0.3	2	0.8
Nothing/don't know	116	20.0	43	17.5

opened their doors to homeless and indigent women. Fresh water for drinking and bathing was the daily survival need in the scarcest supply. Women reported that local agencies that provide food invariably offer soda or coffee (and rarely, juice) rather than water. Neighborhood businesses and homeowners refused women's requests for a cup of water or the use of a hose. Similarly, shower facilities were very difficult to come by outside of publicly financed homeless shelters. One privately operated men's shelter opens its showers to women just one afternoon per week. Together with the lack of resources to purchase feminine sanitary products, toiletries, and condoms, the scarcity of fresh water creates conditions that present major health risks for these women.

Although the need for shelter is readily apparent for homeless women, other needs for access to specialized physical spaces are less obvious. Without storage space for possessions, women are often assaulted or otherwise robbed of the few goods they own. Without access to food preparation and storage spaces, women on the streets must often purchase expensive and non-nutritious fast food, eat from garbage cans, or depend on social service agencies for food. Without a safe place to keep money or valuables, sex workers are effectively trapped in a cycle of spending all of their income on the same day they earn it so as not to risk being robbed, thereby perpetuating their economic marginalization. Only one respondent reported finding a legitimate place of temporary employment that would hold her paycheck until she requested it; in this way, she gradually became able to save enough for a deposit on an apartment. Lack of access to telephones, laundry equipment, and

Table 5.

FOCUS GROUP DATA: SOCIAL SERVICE NEEDS OF INDIGENT WOMEN SEX WORKERS IN MIAMI

Physical needs	Mental/emotional needs	Health care needs	Longer term needs
Survival	Friendship	Drug detoxification	Legal
Food	Counseling	Drug treatment	Mailing address
Water	Crisis intervention	Pregnancy/reproductive care	Photo identification
Clothing	Domestic violence protection	HIV/hepatitis/STI care	Immigration papers
Showers		Physical trauma care	Social Security number
Sanitary products		General medical care	Social stability
Condoms		Dental and eye care	Housing
Toiletries			Physical rehabilitation
Space			Employment services
Shelter			Mental health services
Possessions storage			Child custody/child care help
Money storage			
Food storage/preparation			
Services			
Telephone			
Laundry			
Transportation			

Abbreviation: STI: sexually transmitted infection.

transportation also prevented women from obtaining health and social services, getting legitimate jobs, and even from making money doing sex work.

As noted, the vast majority of the women in the study suffered physical and/or sexual abuse as children, and many experienced continuing psychological and emotional distress. Their drug use and involvement in the sex trade also frequently contributed to distance from family and friends, further reducing sources of both instrumental and social support. Many women also suffered violence from boyfriends, family, or husbands. The women's isolation and need for caring human contact were universal.

The generally poor health of the intervention program clients, and their lack of insurance coverage and financial resources, have already been described. Although hospital emergency room services are generally available in crisis situations, many barriers to health care access exist for the women in the study.

Barriers to access

Structural barriers. The focus group discussions regarding women's health and social service needs highlighted numerous problems the participants experienced in accessing services even when they are provided by community agencies. These barriers to access can be broadly categorized as structural or as individual. *Structural barriers,* as used here, refers to those factors that make an agency's programs unavailable to or inappropriate for women street-based sex workers because of the way the service is offered or delivered. *Individual barriers,* as used here, refers to aspects of a woman's specific circumstances, characteristics, or behaviors, although they may be common among women street-based sex workers in general. Across groups, participants cited the same barriers to care, which are listed in Table 6, where they have been categorized as structural or individual barriers.

Many necessary services, such as fresh water, showers, hygiene products, and laundry facilities, are simply unavailable to this population at reasonable cost. Furthermore, these purchases compete with numerous other monetary demands (temporary shelter, food, bus fare, and drugs). Regardless of what these women spend their limited funds on, the goods must be immediately consumed or discarded because of the lack of safe storage space.

Some other important services are available in the community but are difficult or impossible to reach by public transportation, or are targeted to specific demographic groups (e.g., Haitians) of which some women are not members. Many service providers, especially those in health care, require proof of legal identity and citizenship status, which many women are unable to provide; numerous sex workers in Miami are illegal immigrants, and others have been on the streets for so long that they no longer have a legitimate mailing address, driver's license, or known social security number.

Even when a woman finds a service for which she qualifies and is able to get there during business hours, she is often the victim of stigma associated with her sex work, poor hygiene and appearance, and/or drug use. Women often attempt to hide their sex work and drug use to increase the likelihood of receiving services although, in fact, hiding the very aspects of their lives that most harm their health

Table 6.

FOCUS GROUP DATA: BARRIERS TO HEALTH AND SOCIAL SERVICES ACCESS FOR INDIGENT WOMEN SEX WORKERS IN MIAMI, FLORIDA

Structural barriers	Individual barriers
Availability	Awareness of service
Information accessibility	Drug seeking and use
Transportation	Street life distractions/sense of time
Legal status requirements	Mental/emotional stability
Social stigma	Fear of arrest
Program staff communication skills	Generalized fear
Program target population	Client communication skills
Program structure	Client dress/appearance
	Negative attitude
	Low frustration tolerance

is self-defeating because providers may well remain unaware of their greatest needs for care. In any case, focus group participants agreed that it is extremely rare to find social service staff and health providers who are understanding of their problems and truly interested in providing help.

Publicly financed homeless shelters do exist in Miami, providing meals, showers, and case management services. These facilities are not suitable for drug-involved women sex workers, however; most respondents in this study indicated that they preferred to remain unsheltered. Shelters typically require clients to be inside by 4:30 or 5:00 PM each day, and that clients vacate the buildings by 8:00 or 9:00 AM the following morning. These curfews are incompatible with sex work. Furthermore, drug use is prohibited on shelter premises, creating an additional practical barrier, particularly for heroin users. Further, couples are permitted to stay together only if they also have children with them. In sum, strict shelter regulations are impossible for most street-based sex workers to abide by.

Individual barriers. Structural and individual barriers intersect in ways that often make problems self-perpetuating for street-based sex workers (see Table 6).

1. Lack of access to water, showers, and hygiene products increases the likelihood that a woman will be refused help or employment.
2. The inability to find shelter at hours of the day compatible with their lives leaves women on the street, and at increased vulnerability to violence, heavier drug use, and loss of self-esteem. Some women said they smoked crack all night on the streets so they would not risk being raped while asleep.
3. Living on the street increases drug seeking and use, making women less able to make the decisions necessary to find help.

4. Life on the streets hardens many women, leading them to expect social disdain, discrimination, and marginalization, so that they assume no one truly cares even when social service providers do offer assistance.
5. Drug use and street life foster the loss of social and communication skills, impatience, fear of authority figures, and a loss of sense of social time. Women often arrive late or on the wrong day for appointments and/or they are not willing to wait in line for service.
6. A lack of legal identity, address, and/or status causes women to be ineligible for most employment, and also to fear arrest on loitering, solicitation, and drug possession charges when going for help. Women said the latter was especially worrisome when seeking health care.

Discussion

Although it is impossible to select a truly random sample of street-based sex workers, the quantitative data presented here are drawn from a very large number of drug-involved women who work a single city stroll in Miami. Furthermore, recruitment was accomplished through the efforts of many different recruiters, limiting the introduction of social network bias into these data. Although the focus groups were conducted among only a small subsample of the project's clients, there were broad areas of agreement across groups concerning the prioritization of needs and barriers to accessing services. Furthermore, although Miami's drug-involved, street-based sex workers may not share all of the characteristics of homeless women in other cities, our findings are generally supported by other studies of the health and social service needs, and some of the barriers to access, of highly marginalized women.

This study's main contribution is the elaboration of the needs and barriers to access that are specific to drug-involved street-based women sex workers. Importantly, the nature of street-based sex work means that women represented in this study cannot be recruited into care through traditional street outreach or during normal business hours. Their level of isolation from other people, especially non-drug users, is especially severe. Nyamathi et al.[50] found that drug-involved homeless women who had social support only from other drug users had the equivalent of no social support at all. Major effects of this isolation among the women in the focus groups were loss of self-esteem and increased levels of distrust. Indeed, during their first visits to the project field office, the women's fear was palpable even though they had been brought to the site by other sex workers who had informed them that it was safe. Many women were convinced to visit the field office only because they were completely exhausted and out of options.

On an acute care level, interview data from this study found that many women are so disoriented by drug use and life on the street that they cannot even readily identify what their needs are. Nevertheless, focus group discussions indicated that food and clothing are generally available in the community, and are best acquired using street knowledge. On the other hand, agencies that conduct outreach to this population should be made aware of the critical need for access to fresh water and showers, and they should be urged to find ways to provide these. Organizations that distribute food would do well to substitute water for all other currently offered

beverages. Agencies housed in suitable buildings might consider setting aside small outdoor areas with showers and inexpensive privacy curtains.

Although acute physical needs must be met before other concerns can be addressed, focus group discussions pointed out that higher level needs vary depending on a woman's individual circumstances. Only some women had lost their legal identities or required immigration papers. Mental health care needs were prioritized over physical care by some women but not others. For these reasons, an individualized case management approach to service provision is suggested.

The findings elaborated here also suggest that social service and health care staff members (including administrative, reception, and secretarial staff) would benefit from training designed to increase their sensitivity to the needs, fears, social disconnectedness, and secretiveness of many street-based sex workers. At the same time, there are some structural barriers to service for sex workers that would be difficult or impossible to eliminate in the context of shelter provision for a more general homeless population. Curfews, prohibition of drugs and drug use on premises, and similar rules are necessary to keep shelters running in an orderly fashion and to provide needed structure to clients' lives.

Given this reality, a fruitful area for research is the identification of mechanisms to bridge the gaps between street-based sex workers and existing front-line service providers. The goal of such research would be to find effective ways to increase women's empowerment and reduce their marginalization to the extent that they can successfully navigate the complex web of social service and health care entities that exists in every community. Such efforts might include providing an intermediate level of case management, perhaps including former drug-involved sex workers in key support roles, to keep clients engaged and on a path toward making consistent, if small, steps to getting care and treatment.

Taking this point one step further, studies from many areas of health promotion have suggested that providing factual information alone is typically insufficient to produce substantial change in risk behaviors in which people have engaged for quite some time.[51] Because many health risk behaviors occur in an interpersonal context, a successful approach to risk reduction has been the use of peer role models and educators who attempt to redefine peer group norms and reinforce risk reduction. Peer education has (1) contributed to increases in prenatal care seeking among migrant farm worker mothers[52]; (2) promoted health screening increases among low-income, older African American populations[53]; (3) provided effective HIV prevention information to homeless youth who were not served by traditional HIV education efforts[54]; and (4) reduced high-risk sexual behaviors among young gay men.[55] Peer leaders in the injection drug user community trained as AIDS educators were also found to increase needle cleaning in their social networks.[56] Finally, several studies have demonstrated that the use of peers as HIV interventionists has been more effective in reducing risky drug using behaviors than interventions by public health counselors with regard to reducing sexual risk behaviors.[57,58] Research designed to improve service provision to drug-using populations by way of the involvement of peer facilitators appears to be a useful direction for future investigation.

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Notes

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