Female sex workers as health educators with men who buy sex: 
Utilising narratives of rationalisations

Teela Sanders*

University of Leeds, Leeds, W Yorks, UK

Available online 21 November 2005

Abstract

This paper reports on findings from an ethnographic study of female sex workers who work in the indoor sex markets in a British city. An unexpected finding was the collective narratives that sex workers construct to rationalise their involvement in the sex industry. Fifty-five respondents who took part in in-depth interviews maintained that prostitution is a useful occupation and function in society. Narratives included providing emotional support to male clients; a service for men who are socially or physically disabled; preventing men having adulterous affairs; and health education, disease prevention and as therapists for sexual dysfunction. This paper evaluates how the latter narrative of sexual health promotion is an example of how sex workers are ideally placed to work as health educators with men who buy sex. Arguing against gender specific sexual health policies, men who buy sex are described as a ‘high risk’ group who are also a hidden population. Limitations posed by ideological, ethical and practical concerns relating to the specific conditions of the sex industry suggest that this proposal could be partially successful. In conclusion, I suggest the sexual health of the nation and the place of sex workers in society must be considered with regard to recent policy debates on the management of prostitution and the cultural construction of the sex worker.

Keywords: Sex workers; Prostitution; Male clients; Health promotion; Sexual health; Health education; UK

Introduction

The ‘risky’ sexual health practices that female sex workers engage in has been the focus of socio-medical studies both historically (see Walkowitz, 1980) and more recently over the past three decades (Kinnell, 1991; Morgan Thomas, Plant, Plant, & Sales, 1989; Ward, 1993). The ‘discovery’ of HIV/AIDS in the 1980s reintroduced the attitude that women who sell sex are contaminated in a way that other heterosexual women are not. As Lawless, Kippax, and Crawford (1996) in this journal suggests, women who are considered to be at risk of HIV infection are stigmatised as dirty, diseased and undeserving. The assertion that because women are involved in selling sexual services they are automatically carriers of sexual disease has been echoed by the Home Office consultation paper on prostitution, Paying the Price (2004). Statements such as ‘going to prostitutes contributes to the spread of HIV/AIDS and STIs’ (Home Office, 2004, Section 7.22) can be criticised for not taking a realistic and empirical account of the high levels of safe sex practices among sex workers (for this debate see Soothill & Sanders, 2004). Recent research (Ward, Day, Green, Cooper, & Weber, 2004) notes a decline in STIs amongst sex workers in London between 1985 and 2002.
The blurred emphasis on the relationship between prostitution and risky sexual practices results in a ‘paradox of attention’ (Scambler, 1997, p. 112) in the analysis of prostitution. The mundane and ordinary features of commercial sex remain ignored while certain elements of risk receive attention, contributing to the emphasis on sex workers as spreaders of infections rather than working at the forefront of sexual health prevention. For too long there has been an assumption in the literature that because sex workers have multiple sexual partners they are automatically a health risk rather than framing the possibility that their access to a hard to reach population of male clients could present a gateway for information transfer and behaviour change.

There is evidence that sex workers are effective as health educators with other sex workers. Campbell (1991, p. 1374) reports on the efficiency of sex workers and women who have left the industry as AIDS education trainers to other sex workers through NGOs in the USA, Australia, Ghana, Dominican Republic, the Netherlands, and Cameroon. Successful peer education programmes have been established through traditional forms of outreach in sex work projects throughout the UK (see Cooper, Kilvington, Day, Ziersch, & Ward, 2001; Matthews, 1990 for detailed descriptions). Rickard and Growney (2001) adapted verbatim recordings from sex workers as a training tool relaying information on occupational and health and safety advice. As part of their everyday routines with men who purchase sexual services, the role of sex workers in the prevention of STIs is clear: ‘Their knowledge of safe alternative non-penetrative sexual practices and their expertise in eroticizing these practices also could be valuable skills in AIDS prevention efforts’ (Campbell, 1991, p. 1374).

However, what has not been explored is the role of sex workers in other types of health promotion: ‘Both ‘self-care’ and ‘customer care’ involve other preventive health practices besides AIDS and may offer an appropriate strategy for education’ (Campbell, 1991, p. 1375).

Female sex workers are not strictly peers of male clients as they are not from the same societal group and characteristics such as gender and structural power relationships mark out the women from the men. Within the commercial sexual encounter sex workers and clients hold different roles as one is the buyer while the other the seller of sexual services. Yet, on a wider scale sex workers and male clients are of the same subculture in society because of their involvement in commercial sex networks. They share the same social and communication networks (increasingly on the Internet) that are usually restricted from health professionals and inhabit the same sexual spaces, codes of conduct and expectations of engagement. Rhodes (1994) describes one form of peer education as the ‘provider–client’ model of individual outreach that involves peer educators who share similar characteristics as the target group but are not from the specific group. The findings presented in this paper explore sex workers’ understanding of their role and practices of ‘customer care’ suggesting that there is the potential for this group of women to be effective deliverers of a sexual health education with male clients.

Aims of the paper

This paper argues that female sex workers could effectively deliver sexual health education to men who by sex by building on their informal role and the information exchange that already exists. The paper reports how sex workers maintained that prostitution is a useful occupation and function in society. First, sex workers provide counselling and emotional support services to male clients; second, some women provide a valuable service for men who are socially or physically disabled; third, respondents believed that prostitution actually promoted long term relationships and marriage as it prevented men having adulterous affairs; fourth, their interactions with male clients expands into health education, disease prevention and as therapists for sexual dysfunction. I argue that the narratives relating to providing health information to men through their commercial sexual relationships forms a informal health promotion service which could be formalised into a sexual health education strategy. The challenges and limitations of peer education are discussed alongside the unique nature of the sex worker–client relationship. Finally, this strategy is considered in relation to the management of prostitution in Britain.

Methods

Data collection

The findings presented here are a result of a ten month qualitative study of certain sex markets in...
Birmingham, UK during 2000–2001. The study relied on ethnographic methods of observation across the range of indoor markets: licensed saunas, illegal brothels, apartments rented by women who worked together, women who worked from home or escorts who visited men in hotels or at their home. The central aims of the study were to conceptualise the types of risks and hazards women experienced as a result of selling sex (the majority of findings are reported in Sanders, 2005a). Access was gained through a sexual health project that provided outreach services as well as a drop-in-service and a genitourinary clinic. I conducted over one thousand hours of observation, mainly at women’s place of work or at the drop-in-service and completed 55 formal taped interviews (see Sanders, 2005b).

Sampling and analysis

To be accepted into the sample respondents had to fulfil three criteria. First, in order to avoid issues of child sexual exploitation the women had to be 18 years and over. Second, to avoid the complex issues of migration and trafficking the women had to hold British citizenship, and third (and most problematic) the women had to describe themselves as voluntarily working in prostitution without a coercive boyfriend or pimp. Women were contacted through a snowball sampling method, although a cross section of women was obtained in order to reach a range of ages, ethnic backgrounds and length of career in prostitution as well as women who did not use the sexual health project. The interview sample included 55 participants, of which 50 were sex workers, while two worked as receptionists (maids) in saunas and a further three were sauna owners. Of the 50 sex workers, 45 women worked indoors. Table 1 indicates key socio-demographic details of the women who were interviewed. Analysis involved a fieldwork diary in addition to a personal diary reflecting on the ethnography. The interviews were transcribed verbatim and then analysed using the computer package Atlas.ti for themes and repetitive categories of evidence. In the quotations below, names have been changed but the place of work at the time of the interview remains the same.

The findings

Questions were asked about the role of prostitution in society and inquiries into how women made sense of sex work. The narratives have been divided into the following four themes: counselling clients; community care; marriage guidance; and health experts.

Counselling clients

Sex workers have already described their services as therapeutic: ‘Prostitution is not unlike being a counsellor or psychologist’ (Arlene in Delacoste & Alexander, 1988, p. 134), ‘Sex work is nurturing, healing work’ (Carol, in Delacoste & Alexander, 1988, p. 124). Participants reported similar understandings of their role. Sarah had worked in a sauna for over 13 years and had similar impressions of her role and the needs of the customers:

I see this as being a physical social worker. Ten percent of the job is sex. Ninety percent of the job is chatting, therapy. They come to talk about everything. Sexual issues. And they have to justify why they come here. Either because their wives are ill, or terminally ill, or going through the menopause, or they have gone fat, or they want to have different relationships.

Comparisons were made between their work and that of counsellors, therapists and psychiatrist: ‘You are like a mixture of a social worker, a friend and a sexy sultry siren’ (Esther, escort). Respondents explained how they act as confidantes to clients who disclose personal secrets and troubles. Several women felt that their role included a significant degree of nurturing and listening:

We have a lot of clients who talk about their problems. I had a gentleman last week who...
suffers with depression and when he came down here he said he was suicidal. So I spent time with him. I could not let him out of my sight until I was sure he was not going to do something to himself. If someone is in need of help then I will not turn them away no matter how much of a pain they are (Petra, flat).

The man I have been seeing regularly, he calls me his social worker. It is very hard to listen sometimes. His wife has just died from cancer and he has been living that for years. I have men who come and tell me all their stress about work and some of them feel suicidal (Esther, escort).

I had an Indian man who was going through a divorce and all that and finding things really hard, and he would bring me flowers all the time and didn’t want to do anything just wanted to sit and talk to somebody (Anita, sauna).

A classic example of Hochschild’s (1983) emotional labour, sex workers are amongst other feminised professions that manage the emotions of male customers. For instance, Thompson and Harred (1992) found that topless dancers believed they performed a form of therapy while Sharma and Black (2002, p. 922) note how beauty therapists likened themselves to counsellors as their skills are concerned as much with feelings as with facials. Sex workers spoke frequently of the range of skills they utilised in their job, explaining how the ability to perform sexual services was only one aspect of a complex set of strategies required to attend to the male customers:

It’s not everyone that can do this job ya’ know. It’s not about lying on your back the whole time. We have to treat them with respect. They come here for some time out, some TLC [tender loving care], to be cared for. For just a few minutes out of their week they want to feel special. This job is not just about massaging their dicks but their egos (Rachel, sauna).

The skills that sex workers utilise often relate to previous occupational training and formal mainstream employment. Krystal and Petra both explained how their qualifications and experience in the nursing profession had enabled them to interact with clients:

At the end of the day I used to be a nurse and it is no different working in this job. You do get the stories about their wife don’t understand them, or they cannot get a girlfriend, or someone has died in the family. Or with the regulars you can tell when there is something wrong and they want to chat. I am a psychiatric nurse so this job suits me very well (Krystal, flat).

With regards to talking to people in this job, you use the same skills that you would when you are with patients. They don’t just want a quickie, you know, they want the human touch, to be treated like a person (Petra, flat).

Communication skills and the ability to engage with a range of different types of men was considered to be an important part of the job and essential in gaining a good reputation and keeping regular customers:

Social skills are important as you need to converse on all different levels as you get businessmen that will come to you and younger people, students and some policemen. Men from all walks of life come to see you and they are at all intellectual levels and you need to converse with people and talk to them. If you can’t they won’t come back (Sharon, sauna).

Those women who had worked for many years (the average length of involvement was nine years) and described themselves as entrepreneurs, businesswomen or ‘working girls’, were adamant that the reasons they successfully maintained regular clientele was because they could combine both sexual skills with social and emotional skills.

Community care

Women who work from indoor establishments recalled their experiences of providing services for men with physical disabilities. They saw this as an important service for men who are unable to satisfy themselves sexually, or unable to form relationships that can provide sexual fulfilment. Ava and Krystal considered men with disabilities amongst their regulars:

Ava: I have lots of disabled punters. They are just human, they have got an urge and a need and in fact they are less demanding.
Krystal: Half of the time it is not the sex it is just another human contact. Just being with another female. Sometimes you don’t even have to get undressed.

Ava: Like in the sauna, there was this man, his carer would bring him. You had to lift him out of the wheelchair and into the jacuzzi and he was stiff. He couldn’t move, could get an erection but that was about it. He could not move, or talk or anything. We used to go to this warden controlled place to do the bed ridden ones.

Krystal: It is care in the community. I look at this as an extension of my job as a nurse. At the end of the day you have to be a special kind of person to do this. There is no amount of money that would make you do this if you did not have that something about you.

(Ava and Krystal, flat).

A quarter of the interviewees had been nurses or care assistants in homes for the elderly, so were accustomed to working with disabilities and ill health. Participants understood sex work as an extension of their caring role that provides as valuable a service as mainstream medical care. Cockington and Marlin (1995) also found amongst sex workers in Australia that women were proud to be able to offer sexual services to a disadvantaged group. Kelly had worked in a sauna for three years and explained: ‘We are not just here for able bodied people. Disabled people—they still need to be relieved. It doesn’t freak me out at all, it is because of them that I think it has to be legalised’. Women who worked from hotels or rented their own premises specifically for work often thought carefully about making their facilities accessible to men in wheelchairs or those who had difficulty walking far distances. Letisha had worked in a sauna for ten years and spoke of her regular client who was blind. He had followed her to several different saunas over the years and visits on a weekly basis as well as making regular phone calls throughout the week for an informal chat. Understanding their work as ‘helping others’ or ‘care in the community’ reframes the reality of exchanging sex for money and was part of the narrative that argued for the legalisation of prostitution as a legitimate service sector.

Marriage guidance

Reflecting the socio-demographic details that are known about men who buy sex (Hester & Westmarland, 2004), participants reported that the majority of clients are either married or in long term relationships. Sex workers surmised that if men did not buy sexual services they would have extramarital affairs that could lead to emotional attachments that threatens spousal and family relationships. It was a firmly held belief that if men were buying sex rather than having affairs then there was a reduction in the likelihood of marital breakdown and family disruption:

I always think they are coming to the right place. If there wasn’t this type of place for them to come to what would they do out there? Or another thing that I think about is that they could be having affairs on their wives and this is just a bit of extra pleasure on the side which probably that man needs. It prevents break ups and getting children involved in all that mess (Danielle, sauna).

For some of them it [prostitution] is helping saving their marriages or relationships. Some guys they don’t want to be going and picking up girls and getting a reputation. Men don’t want to leave their wives or wreck their kids’ lives. There are lots of different reasons why men go to these places and I don’t judge any of them (Rachel, sauna).

There is a strong belief that prostitution enables men to perform their sexual fantasies and fetishes in a safe commercial transaction. Sex workers felt they protected wives from the less acceptable aspects of male sexuality:

I get some gentlemen who come along and they are married and they may have been married for several years and the wives are going through the menopause or are very elderly or are ill and they still have sexual needs but their partners cannot satisfy them…..So there is a good function (Margaret, flat).

I think it is wonderful that they can come to us…..Although thirty percent of the men who come here just want normal stuff, the other seventy percent I see want domination and it is something they could not ask their wives to do. I think this means their need to dress up as a woman is met and I believe it saves a lot of marriages (Angie, flat).
Sykes and Matza (1957, p. 668) explain how a technique known as ‘denial of victim’ is useful to justify deviant acts. This tactic is applied by sex workers to block out the criticisms against prostitution causing harm to family life and other women in society. Respondents justify prostitution by claiming they prevent innocent wives becoming victims of unfaithful husbands who have extramarital affairs.

Health experts

Participants found a significant part of the job involved educating men about health, in particular, sexual health. Webb and Elms (1994) suggest education and counselling are important aspects of the service, while Bell (1994, p. 103) regards prostitutes as healers, sexual surrogates, teachers, therapists and educators. Echoing the findings from Wahab (2004, p. 149), participants across the indoor markets in my study explained that an integral part of their daily routines and interactions with male clients consisted of health education: ‘In terms of their body men don’t know much. They have no idea about how diseases spread. That is where we come in’ (Margaret, flat). Explaining how sexually transmitted infections spread and the dangers of unprotected sex was a daily feature of their job: ‘Some of the older guys they don’t like wearing condoms and you have to explain why—they have no idea they are putting themselves at risk’ (Wilma, sauna). The reluctance of men to wear condoms because of their desire for ‘flesh-to-flesh’ sexual pleasure has been reported in many studies (for instance see Campbell, 2000; Wojcicki & Malala, 2001). As a result sex workers constantly engaged in a process of explaining the reasons why condom use is essential and as a result of client resistance had developed strategies to ensure condom use.

Sex workers transmit knowledge of sexual health infections and transmission to ensure that clients comply with their own codes of conduct which aims to safeguard their own physical and mental health. Esther visited men in their own homes or in hotels and explained: ‘Men don’t really have a clue about sexual health. There was a man the other day who was touching himself without a condom and then wanted to touch me and could not understand why I asked him to wash his hands’. What I have described elsewhere as the ‘hierarchy of harms’ that sex workers experience in relation to their work (see Sanders, 2004), interviewees generally maintained that their sexual health was the least risky part of their work.

Sex workers in this study displayed a high level of knowledge about types of sexually transmitted infections, how infections were spread and preventative methods. There were two routes of information transmission. Firstly, the sexual health outreach projects that specifically targeted individual sex workers and sex establishments was a continual source of information. Common to many outreach programmes in the UK, Crosby (1997) describes the pragmatic approach taken by the Manchester Action on Street Health to provide the means for sex workers to practice safe sex and access harm reduction information and advice. The second route of information transmission was knowledge gained through previous employment, namely technical facts that women had acquired when working in the health care profession. Petra explains how her nursing training equips her with information to share with clients:

What I find is an advantage from my nursing training is that when they come in and go on about having sex unprotected I can give them the advice to stop them from doing that. There are a lot of men out there and through ignorance and stupidity they do not know how you can catch STDs. Half of the time I spend educating some of these blokes that come in as they really don’t have a clue. It surprises me as even the younger guys who were around when all the hype about AIDS has been going on and they should know better but they do not think (Petra, flat).

Although sexual health was the main health issue that sex workers dealt with, there were several examples of more general concerns that women came across: ‘You feel like a nurse as well sometimes as the things you have to tell them about their bodies. Like once I found this man had a lump in his testicles—he didn’t even know himself” (Ava, flat). Aside from sexual health education, sex workers found that often men revealed their personal anxieties about sexual performance:

Some men have sexual problems and they think that you will be able to put it right. They think that because you are a working girl you know how to fix all problems...The actual sex part of business is five minutes and the rest is done over a cup of coffee (Anita, flat).
Embarrassed by medical professionals or a female partner, men visit sex workers to see if the problem can be reversed or reduced: ‘…they think that we are doctors’ (Danielle, sauna). Men who have little sexual experience often become regular clients:

Prime example, yesterday, had a gentlemen in and he paid me £35, £10 for the room, £25 for the massage. He didn’t want a massage—he just wanted me to strip naked and he wanted to massage me and touch my body although he didn’t want to touch my genitals, he wanted to look and for me to open my bits of body up so he could look, because he has never had a girlfriend and he is 40 years old….There is another guy recently who doesn’t know how to make sex last longer for him, and he has a got a fiancée. He has got a sexual problem, some have emotional problem…..It is all about social interaction (Kelly, sauna).

Reminiscent of O’Brien’s (1994) report on how nurses form a relationship with clients as part of a set of strategic nursing skills, an implicit part of the sex worker role involves health education with regular clients.

Discussion

This discussion proposes that the narratives of rationalisation described above from a group of women who are often considered deviant and nefarious can be converted to a useful end. The first part of the discussion will argue that gender specific sexual health education strategies are detrimental to the construction of sex workers as the problem in the spread of infections and as a result removes men as the target of health information. The second part critically evaluates the realities of engaging sex workers as health educators with men who pay for sexual services and assesses the limitations of this proposal.

Scapegoating sex workers: the absence of male clients in sexual health education

Although there is nothing inherently ineffective or biased in gender specific health policies in both content or target group, policies that construct women as more problematic than men are detrimental. Sex workers have been constructed as irresponsible and risk-taking in health promotion practices, therefore justifying why sex workers and not male clients are a key target group. Campbell (1995) explains how women have been expected to take onboard sexual health prevention while the role of men in sexual decision making has been ignored. In the UK, there are approximately 120 projects specifically for women involved in prostitution (see Cooper et al., 2001), yet there is no record of any initiatives that aim to educate men who buy sex from women about the risks of unprotected commercial or private sex. Instead, the health promotion approach continues to target sex workers as traditionally they have been considered to be a ‘high risk’ group. Such a gender biased approach can only fail: ‘prevention efforts that focus singly on women have been misguided and have actually served to undermine women by making them responsible for HIV risk reduction’ (Campbell, 1995, p. 197).

The absence of targeting men who buy sex is detrimental to the overall sexual health of the nation because of the prevalence of men who buy sex. Deducting from the limited statistics available, it is highly probable that there are more men who buy sex than women who sell sex. In Birmingham, McLeod (1982) calculated that in the late 1970s, approximately 800 women worked in prostitution, and in any one week 13,690 clients bought sex. Buying sex is becoming increasingly popular: the National Survey of Sexual Attitudes and Lifestyles (Johnson & Mercer, 2001) reported that 8.9% of men in London between the ages of 16–44 had paid for sex in the last five years, with an estimate of 1 in 23 men nationwide. Observing a popular website for the sex work community, Punternet, suggests that there are significant numbers of patrons of commercial sex (Soothill & Sanders, 2005). The website hosts some 30,750 ‘field reports’ that recount sexual transactions that over a five year period (January 1999–November 2004) represent a monetary exchange of £3, 787,359—an average of £124 per visit (retrieved 12.1.05 www.punternet.co.uk).

In addition to the rising number of men who purchase sex, the high rates of sexual infection that male clients experience suggests they are a ‘high risk’ group (Gibbens & Silberman, 1960; McKeganey, 1994; McKeganey & Barnard, 1996; Plumridge, Chetwynd, Reed, & Gifford, 1996). For example, Barnard, McKeaganey, and Leyland (1993) interviewed 143 male clients, of whom 72 (50%) were married and 35 (24%) had a history of sexually transmitted infections. The typical client has been profiled at an average age of 30 years, married (suggesting they are in normative sexual relation-
ships), in full-time employment and without criminal convictions (Hester & Westmarland, 2004). Yet still intervention programmes avoid targeting men with the message that condom use is paramount: ‘It seems important to include the customer in outreach efforts since he is an important part of the sexual transaction and his cooperation in using condoms is essential’ (Campbell, 1991, p. 1374).

The potential role of sex workers as health educators must be considered in a wider framework relating to the crisis in the nation’s sexual health. Over the past decade the UK has experienced a significant rise in sexually transmitted infections with chlamydial and gonococcal bacterial infections increasing by over 70% since 1997 (BBC News 15.4.03). The targets for sexual health set out in 1992 Health of the Nation report have not been met and complacency in safe sex practices has resulted in a severe decline in the nation’s sexual health. Traditionally men have shied away from seeking medical attention, especially for emotional or sexual issues (White, 2001) and sexual health programmes have failed to address male sexual health problems (Collumbien & Hawkes, 2000).

In their review of recent health trends across Europe, White and Cash (2003) note that men’s general health is a growing concern amongst health care professionals and policymakers. They note that health consultation is specifically gendered and that men do not attend mainstream medical services in the same way as women.

The nature of some types of sex worker–client relationships is ideally framed to pass on sensitive knowledge and information. As this paper demonstrates, this is because men seek out commercial sex for a complexity of physical, social and emotional needs (also see Campbell, 1998; Jones & Pratten, 1999, p. 41; Plumridge, Chetwynd, & Reed, 1997). In their review of the international literature on the motivations for buying sex, Atchison, Fraser, and Lowman (1998, p. 186) describe how men’s explanations are often related to their personal deficiencies such as psychological problems or social ineptness. Further, anecdotal evidence from my study suggests that many clients are ‘regulars’ returning to the same sex worker over a long period of time providing ideal conditions for reinforced learning.

The challenges of health education

The case of the female sex worker as a health educator with men who buy sex fulfils several advantages highlighted from the peer education model. Turner and Shepherd (1999, p. 237) describe ten claims for the rationale for implementing peer education programmes. They are cost effective; peers are considered a credible source of information and acceptable to the target group; the model is empowering and beneficial to the peers; established lines of communication are utilised; there is the possibility of reinforced learning through repeat contact. Also, people involved in the grassroots environment are more successful than professionals in health education delivery because of their influence as well as providing positive role models to hard to reach populations. Yet despite the convincing rationale that place the indigenous population in a position to carry out education with male clients, there are inherent challenges.

Lessons can be taken from programmes that have promoted peer education in the sex industry. Ziersch, Gaffney, and Tomlinson (2000) evaluated a peer education programme with male sex workers in London and found that although the peers felt the programme and their role was successful, the role was fraught with difficulties. For instance, some of the educators working in an escort agency where the management were opposed to the programme experienced discrimination. This suggests that educators are in need of continual training, mentoring and support and although this can be facilitated by health services they are already in contact with (Jeal & Salisbury, 2004), this does not solve the negative reaction educators may receive from their colleagues, potential customers and management and the resource intensive support needs.

As Turner and Shepherd (1999, p. 238) summarise, in order for educators to gain credibility they must have a higher status than others of the group and this is often a source of tension, creating divisions within the community. Ziersch et al. (2000) found that all the educators left the escort agency after a short period of time, reflecting the potential divisive role of becoming a health educator and the problems associated with training a transitory population. Turner and Shepherd (1999, p. 238) note that these issues have been overcome by promoting ‘opinion leaders’ who already exist within a community because their status is an important factor to effective education delivery. The issue of motivation amongst peers also needs careful consideration. As testified in my study, the women who are explicit about their health education role are often speaking from a nursing background.
which could already set them apart from other sex workers because of their connections to mainstream ‘professional’ employment. The overall selection process of defining who is an educator, their motivations and the transition from a sex worker to an educator requires a sensitive selection process, as well as intense training and monitoring.

It appears misleadingly straightforward to place sex workers at the forefront of alternative sources of sexual health education and prevention. The very nature and organisation of the sex industry implies that only women who work in specific conditions in the indoor sex markets would be in the position to carry out such education. The environment of the sauna provides the privacy, safety and facilities to pass on information whereas the street environment is fraught with dangers and risk. For instance, the street market is characterised by violence to sex workers from men who pose as clients, concerns of arrest from the police or harassment from residents as well as the additional vulnerability caused by severe drug addictions and coercive pimping (see Sanders, 2004).

Kirkpatrick (2000) describes some of the weaknesses when sex workers take on the peer educator role because the process assumes some degree of collective subculture. This is one reason why the street would be inappropriate for this strategy because the dangerous nature of street prostitution reduces the potential for a collective subculture. Indoors, even with the potential for a weak occupational subculture because of the competitive and often transitory nature of the work, behavioural change could be achieved because the emphasis is on individual client–sex worker relationships. Still, sex workers may only be in a position to address sexual health issues with regular clientele and not with men who visit only once, therefore reducing the effectiveness of the role and raising questions of the actual outcome of this strategy.

There are also ethical considerations given the inherent power differences between sex workers and men who purchase sex, questioning whether this process could be empowering or beneficial for educators (see Turner & Shepherd, 1999, p. 239). Rogers and Shoemaker (1971) note that for ‘change agents’ to be influential they need to be close to their peers in terms of attributes, values, social status and education. Sex workers and male clients may not be ‘homophilious’ as often women are significantly younger than clients and unlike sex workers, clients are often from different socio-economic backgrounds. Power issues also shape the sexual transaction and cultural constraints around the use of the condom are at the fore of the negotiations. The condom has a specific set of cultural meanings in the commercial sex transaction, attaching clinical connotations as a reminder of the economic basis for the liaison (see Plumridge et al., 1997). As a result, the condom can be a trigger for hostility from male clients which could potentially place sex workers in dangerous confrontations with men who do not consider it the role of the sex worker to discuss health safety matters. Indeed, the additional role of health promoter changes the traditional role of the sex worker and does not necessarily result in educators achieving the desired outcomes. Male sex workers who were recipients of peer education still tended to prefer to consult an official health professional because of their expertise, the security provided by the formal and defined mainstream role that operated under codes of confidentiality (Ziersch et al., 2000).

Nevertheless, altering the role of the sex worker to include health education could work in favour of reducing the stereotypes surrounding the female sex worker, swapping the image from one of immorality to a positive professional function in society. Yet even if the cultural constructions of the female sex worker is shifted, placing the responsibility for sexual health education on the shoulders of sex workers means that the gender specific policy cycle is not broken. As Milburn (1995) reflects amongst young people who are peer educators, the model introduces the potential to ‘artificially reconstruct social processes’ rather than change behaviours. If sex workers are promoted as health educators they have the additional burden of ensuring men wise up to safe sex practices rather than mainstream health services and social attitudes addressing this responsibility.

Conclusion

Three conclusions can be drawn from the findings and discussion presented in this paper. First, despite the documented absence of a theoretical base or more substantive principles other than a ‘working hypothesis’ (Milburn, 1995), health education still has attractions, opportunities and the potential to reach the hidden population of male clients. A template already exists informally in some sex worker–client relationships. The working conditions amongst independent entrepreneurial sex workers
may be more conducive to an education role than for those women who work in saunas where colleagues and management may present barriers. However, there are considerable ideological and ethical problems as well as pragmatic and cultural constraints to initiating a formal sexual health programme. Second, a gender specific sexual health prevention strategy serves only to reinforce entrenched stereotypes that tarnish sex workers as carriers of disease. Ignoring men who buy sex as a legitimate target for sexual health information is at the peril of others in society who are not involved in prostitution.

Third, the informal role and knowledge transfer that some sex workers already perform could be utilised more effectively if wider changes were made to the management of prostitution in the UK. At the time of writing, the Home Office is making decisions about the effective management of street and indoor prostitution on the basis of best practice examples. The evidence of the legalised brothel system in Nevada (see Brents & Hausbeck, 2005; Campbell, 1991) highlights that sex work environments that are legitimated and bureaucratised have the effect of empowering sex workers to control their working conditions and interactions with clients. A legalised system that shared the responsibility for safe sexual practices with male clients and management as well as sex workers could facilitate the role of health education both informally and formally. Indeed, as indicated elsewhere (Sanders, 2005a) some aspects of the UK indoor sex markets are highly organised and regulated, promoting strict ‘house rules’ such as not tolerating drug use or unsafe sex practices. Third parties such as brothel managers, receptionists and security personnel are well placed to promote standards of health and hygiene in the premises and reinforce positive behaviour and expectations amongst clients. Only when the place of prostitution in society is not considered the plight of the immoral or destitute, but a fixed feature of sexual behaviour, will policy move from the tone of moral disapproval or public nuisance (Kantola & Squires, 2004) to a realistic perspective that facilitates the provision of safe sexual services as work.

References


(Eds.), *AIDS responses, interventions and care* (pp. 79–94). London: Fulmer.


