A STITCH IN TIME

A short study into the needs of women working in the Sex Industry in Edinburgh

Prepared for SCOT-PEP by

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The needs assessment was conducted within a very short time period in January and February 2003. It would not have been possible to even start, never mind come up with an understanding, had it not been for the generous help of women working both in the outdoor and the indoor industries. As ever, their willingness to help others understand the complex issues they manage every day, was unstinting. So thank you.

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Finally, and not least, it is never easy for an outsider to arrive in a place of work, to meet with those with whom you have to manage day to day relationships, and to interpret findings from a very different point of view. Yet the staff and volunteers of SCOT-PEP were generous in their help to pave the way to meetings and to helping make the experience for the author a joy as well as a challenge. Thank you too.

1. Executive Summary

1.1 Introduction

SCOT-PEP is required to undertake an annual needs assessment as part of its service level agreement with Lothian Health Board. Perhaps more pertinent are changes in the environment in which many women work; SCOT-PEP had identified implications of the re-location and dispersal of women working outside, particularly in terms of safety and security.

As indicated, SCOT-PEP will undertake an annual review of its service provision as well as a regular but not frequent needs assessment To achieve this, SCOT-PEP also required that a methodology that would enable the agency to undertake its own needs assessment in the future would be designed. This has been prepared and made available to the Board of SCOT-PEP.

1.2 Methodology

The Study, funded from SCOT-PEP's own reserves, was undertaken at the end of January/beginning of February. The fieldwork took place over eight days and face to face interviews were undertaken with internal and external stakeholders as well as with women working in both the outdoor and indoor parts of the sex industry.

The first draft of the Report was circulated to the Lothian Primary Care Trust, Lothian NHS Board, City of Edinburgh Council Social Work Department and Department of GU Medicine in Edinburgh as well as SCOT-PEP itself for comment.

1.3 Overview

The change in the culture of sex work, particularly in the outdoor industry, is such that there is a palpable sense of fragmentation and profound isolation. This appears to be as a result of a combination of factors, including the dispersal of women to an area which covers about 2 or 3 square miles where there is limited contact between women while working; the rise in drug use amongst women working outdoors; and an emerging culture of 'drug pimping'.

The level of violence towards women has increased five fold over the last couple of years. The reports from women are now all about aggression and violence towards them as contrasted with previous years when most reports concerned clients who refused to pay or refused to use condoms.

Women in all parts of the industry appear to find it difficult to access primary care services, and thus access to specialist provision. Within the industry itself, women appear to pay scant regard to their general health and well-being, although they are concerned about STI management. This focus appears to be mirrored in those medical services with which they do come into contact, specifically GU and the medical outreach team which focuses on STI's rather than 'on the whole woman'. Whilst this is understandable, there is a cause of concern in that, critical issues for example and specifically drug use and its impact on choices that women make about how much they work, and how they work are not being taken into account.

The casework offered by SCOT-PEP is, as always, resource dependent. We noted that it is difficult to provide case work at early stages of problems as women find it difficult to keep appointments until there is a crisis that cannot be ignored or put aside against other identified priorities.

The particular issues for young people are difficult to identify as when at work, they appear to want to be 'invisible' within their working peer group. However, once there is a possibility to explore issues with them, while away from immediate colleagues, they appear to search for information about their work, including how to encourage clients to use condoms, as well as information about STI's. In addition, the Study noted that young people are less likely to have information and knowledge about how to manage finances generally and within this particular community, this is likely to have a more than usual negative effect on their ability to develop independence and confidence, with all that means in terms of health and well-being.

1.4 Fieldwork Findings: A Summary

Women do not appear to perceive themselves 'in the round' when considering their own health and well-being and this appears to be mirrored by health care provision

There is a problem in accessing and considering primary health care. There are different issues for those women working outdoors than inside. However, there appear to be some core issues:

Physical access to primary care: Women reported that finding a G.P. especially if a woman is a (problematic) drug user is difficult. They reported that GPs will not make house calls if the woman is known to be a drug user. They did not know how to find a GP if they had recently moved or were in short term accommodation e.g. bed and breakfast as significant numbers of women working outside appear to be. For those who did know of a GP, some reported that they had difficulty attending surgery as the times they were open invariably clashed with working times.

Psychological access to primary care: There is a need to accept that many women find it difficult to disclose the nature of their work to those working in primary care. However, women reported a range of experiences and indeed concerns that may be borne out of that experience, or their own anxiety; or the views of others that contribute to them either not using primary care or, more particularly, not feeling able to speak frankly with their GP. Such experiences, etc. included fear that confidentiality would be broken; lack of understanding of the potential physiological impact of sex work; and discrimination. Unless primary care services can take positive action to let it be known that they would welcome women who work in the industry and have a willingness to 'hear' their concerns which impact on their use of services, women will continue not to see primary care as a crucial way in which they can consider their 'whole health and well-being'

Agencies not working as part of service networks: Perhaps as a consequence of the difficulties in accessing primary care women appear not to access service networks. Referral to specialist agencies (health and other) tends to take place by evoking personal contacts, rather than acknowledged service referral pathways.

Case work undertaken by SCOT-PEP does have contacts within agencies. However, it was noted that when the medical outreach team was involved, that any referral was undertaken in the medics non-outreach team time and from their other place of work.

GU Clinic at Royal Edinburgh Infirmary physical access issues: Some women reported difficulty in accessing the GU clinic and identified opening times; location; and waiting times as their main source of difficulty.

GU Clinic at Royal Edinburgh Infirmary psychological access issues: There did not appear to be confidence in the service provided by the GU clinic across the community. Women reported experiences of discriminatory practice towards sex workers and those who have been in prison. Further, they experienced delays in receiving test results; and incomplete HBV vaccination programmes. Whilst this was reported as a problem by women, the nature of the vaccination programme does make it difficult to remember appointments. In addition, there appears to be a difficulty concerning the provision of cervical smear tests for sex workers. We understand that the GU clinic does not provide smear tests for anyone. However, if the clinic is the only type of provision that women use, this leaves a gap in provision.

Medical Outreach Team: Again, there are physical access problems due to staffing arrangements, that it is only available one night a week; and its location in a busy street and opposite a busy Kentucky Fried Chicken shop. Further, the service appears to be misunderstood. It is suggested that advice about primary care can be found at the clinic; women believe they can use the clinic as a primary care service. The subtlety in the language is we believe a cause for some confusion. That women feel confident in the service because it is a specialist service is important and maybe leads to consideration of the establishment of a specialist primary care facility for women.

Medical Outreach Team: Psychological Access: Whilst not the responsibility of medics or other health professionals, it was noted that there is overt and discriminatory practice on the part of Allander House. Some toilet facilities are closed to women and inappropriate requirements are placed on SCOT-PEP as part of running a clinic from the site.

There is no consistency of medical staff, and since December when the ‘core’ health adviser resigned, no consistency of health adviser staff. In addition to the value to the women in knowing and to some extent relying on at least one member of the team being in attendance consistently, the health adviser who has now left was able to facilitate links with SCOT-PEP staff and volunteers attending the clinic, and thus provide an opportunity to explore non-medical issues during the clinic time. In addition, at the time of the Study GU had not been successful in identifying health advisers who were willing to undertake a role with the Medical Outreach team due, in part, we understand to the impact of that on their other responsibilities within the clinic.

At the time of writing, the service has been suspended as a result of not finding health advisers willing to undertake this role.

Medical Outreach Team: Management and Service Network Participation: We understand that those working on behalf of the team, do so on a specific contractual basis. They do not attend as an outreach function of GUM, nor as a formal part of any network. The soft intelligence they gain, therefore, from providing this service, is lost to other agencies looking to identify emerging issues. In addition, as indicated elsewhere, any need to refer a woman to another agency is limited to what the particular doctor is willing and able to do from other parts of their work.

Housing: It seems that emergency housing provision works well, certainly well enough. However, the difference between surviving and thriving is an important distinction in terms of the choices people can and do make. It was noted, however, that once emergency accommodation had been identified problems could occur e.g. re. housing harassment which were not managed with the same rigor and sex workers are not considered as 'vulnerable' and thus a priority in the same way as other 'risk communities' e.g. gay men and lesbians.

Drug services: Women and agencies reported long waiting lists to drug treatment programmes. Women sex workers are not given priority for drug treatment programmes. This, despite the correlation between drug use and women working in the outdoor industry. A report in a recent SDF Bulletin seems to suggest that there are GPs who will work with drug users. However, the Study only identified one GP of whom the women were aware who could offer methadone treatment.

Case work: The level of casework that can be offered by SCOT-PEP is limited by its resources. That combined with day to day pressures on women not to avail themselves of casework services, means that when women do respond to an offer to help, they are likely to be at crisis point. At the present time, casework is one of the few ways that women consider themselves and they are considered 'in the round'.

Sex workers: Not a homogeneous community: Difference between women is most noticeable and reflected most clearly between those working indoors and those outside. However, this does not reflect the movement between the indoor and outdoor industries; neither does it take into account the diversity within each 'community of interest'. Services therefore need to be more flexible and able to reflect diversity of interest, vulnerability; and actual ability to consider health related and other options.

Nature of sex work: As indicated elsewhere, women do look after STI control. That focus appears to be re-enforced by service providers when not addressing 'a whole health aspect'. There is a sense in which women manage their work, by in some way 'splitting' their activity while in role from other aspects of their humanity. In some cases, this has psychological implications; in others different services respond to whatever aspects a woman presents. The implications of such provision on those who may anyway not be able to integrate all aspects of their lives may contribute to chronic difficulties becoming acute. Reference to 'Mae Lifes Worth Mair Than That' report commissioned by Lothian Health in 1996 which highlighted the need for a space where the whole person could come together as the women felt able and confident in doing so.

Peer Support and Education: The high turnover for those working in flats and saunas; the negative attitude, we believe, of the majority of owners and managers towards access to information and support; and the pressures on women not to seek help from each other for fear that would have a negative impact on their ability to operate fully, combine to inhibit peer support and education. Yet, when women are outside of their immediate work environment, they are keen to both seek and offer advice to each other. For those working outside, the dispersal and isolation of the women contribute to them not working in close proximity with each other and thus inhibits their ability to give and receive help and advice from each other. Again, when there is the opportunity so to do e.g. on the mobile unit, peer support and education/information does occur.

Younger Women*:* As indicated there are difficulties for even those who are experienced to ask questions of each other. This appears to be more so for younger women who lack knowledge and skill about their work and information about STI's and other health matters. However, once again when out of the immediate work environment younger women have involved SCOT-PEP staff and volunteers in discussion about e.g. the impact of their work and how they might find other courses of action. Other issues most relevant to young people include managing finance, pregnancy, and child care.

1.6 Conclusions and Recommendations

It is difficult to come to clear set of recommendations arising from what was an essentially short term needs assessment. Those will need to be considered by SCOT-PEP itself and developed with the Health Board and other commissioners.

Having said that, however, there are clear and urgent needs which need to be addressed, and which we have set down here as recommendations.

- We recommend that urgent attention is paid to the meeting of primary care needs of women working both in the indoor and outdoor industries. Consideration should be given to the viability of a specialist primary care service. Or, if that is not possible to the establishment of a 'list' of primary care providers willing to develop their interest and competence in working with women in the industry.

- We recommend that provision of primary care within establishments be considered, albeit on a limited basis in the first instance.

- We recommend that an exploration take place with the Department of Genito-Urinary Medicine to develop training for GPs in Edinburgh and to offering a fast track referral facility for women working in the industry.

- We recommend further study of the emerging culture of 'drug pimping' and its impact on the outdoor industry and the resources required to meet need is undertaken.

- We recommend that exploration take place with appropriate partner agencies to meet wound treatment needs with women working in the outdoor industry.

- We recommend that exploration take place to establish diversion schemes for women who are drug users and in the criminal justice system.

- We recommend that exploration take place with drug treatment facilities to provide fast track referrals for women.

- We recommend that exploration take place with Housing so that experience of violence or harassment can be addressed quickly.

- In addition, the provision of supported accommodation should be considered.

- We recommend that information concerning finance should be developed and mechanisms found whereby women, especially those who are younger and may have no previous experience on which to draw, can learn ways in which they might be better able to manage their financial situation.

SCOT-PEP: Needs Assessment of Women Working in the Sex Industry in Edinburgh January to March, 2003

2. Background

SCOT-PEP is required to undertake an annual needs assessment as part of its service level agreement with Lothian Health Board. Perhaps more pertinent are changes in the environment in which many women work; SCOT-PEP had identified implications of the change of the beat for women working outside, particularly in terms of safety and security. The last independent assessment of need was undertaken as part of a strategic review commissioned by SCOT-PEP in 1998. As a result of these various and diverse reasons, it was felt that an independent needs assessment should be undertaken to inform SCOT-PEP itself, wider service development and configuration, and the debate in Edinburgh and beyond.

It should be said, at the outset, that it is unlikely that anything would have been discovered in this short Study that is not known already. Similarly, the length of the commission and therefore the depth and subtlety it could explore was limited and only provides a snap shot of need at a particular moment of time.

That having been said, the array of needs identified are 'the top voices' of a range of women, in different settings, and of different ages (from 18 to 40) and different types of experience. Their voices, we would contend, need to be heard, and considered.

No-one asked for the stars. All, whatever their experience, sought only a basic level of services and approach to the provision of that service, that all of us would want. We have sought to contribute to the visibility of women who work in the sex industry – to challenge the assumption that just because women may not make comment about services does not mean that services are psychologically as well as physically accessible, and will therefore be used by women with confidence both in the competence of any service and in the integrity of service providers.

3. Methodology

As the study was commissioned by SCOT-PEP from within its own reserves, budgetary constraints made it necessarily short. The fieldwork took place over a period of 8 days and included face to face interviews with women working in saunas, flats, and using the mobile in Salamander Street. In addition, we were able to meet with a range of internal and external stakeholders including representatives of Lothian Health Board, Edinburgh City Social Work Department bodies as well GU medicine and other relevant provider agencies in Edinburgh.
Whilst it is necessary to accept, therefore, that the study provides only a snap shot of activity and thus cannot explore women's needs with much subtlety, we believe that the key issues have been identified and should therefore be considered fully.

4. Findings and Commentary Arising from the Fieldwork

4.1 Introduction

The 'outdoor industry' is often focused upon not least because of its visibility, and the particular vulnerability of its membership. In Edinburgh, there has been an enhanced focus because of the removal of the 'tolerance zone', the change of the location of the working areas and a high profile level of activity within the Scottish Parliament. Such focus, while important and probably necessary, can serve to de-prioritise the needs of women working indoors, be that in saunas or flats. The intention is, no doubt, to focus on known and multiple need. However, the study did serve to 'flag up' many needs which, unless addressed, could develop into the indoor industry's own particular health needs not being understood or addressed.

Some issues are common to both working environments, although they may be differently expressed, and we have sought to explain them in the two main sections below concerning the Indoor Industry and the Outdoor Industry.

4.2 The Indoor Industry

The indoor industry comprises unlicensed flats and licensed establishments e.g. saunas and escort agencies. The study noted that women may not work exclusively in one sector, although they may not let it be known that they work across sectors.

SCOT-PEP has contact with 17 licensed establishments; and 11 unlicensed establishments and has recently begun work with escort agencies.

There appears to be at least a notional hierarchy between parts of the indoor industry as well as between different saunas and even within individual saunas. Such hierarchy was expressed in a number of ways: some, who work from flats, said that they thought 'saunas are like meat markets – picking and choosing the "prettiest girls/younger". It's more comfortable in flats and women do help each other'; some talked about the potential within saunas of cliques being established making it difficult for one or two women to act as information conduits between services e.g. SCOT-PEP and other women working in the sauna; and others identified the pressures on 'older', more experienced women not to act as mentors and thus equip younger women to deal with demands from clients, for example having unprotected sex.

4.2.1 There appears to be a lack of clear and consistent information for women working in the indoor industry.

In the case of flats in which fewer women work, perhaps only one or two work at a time, and in which it appears that the culture is conducive to information exchange, the difficulty appears to refer to women not necessarily being aware about what services are available, where. For example, when interviewed, 'flat based women' mentioned that they were not aware of the up-coming training event SCOT-PEP was running about managing aggression.

In addition, there was a lack of a clear understanding about the medical outreach service. Women had misunderstood the nature of the medical outreach service, believing it to be a primary care service, as well as a specialist GU service, and one which could facilitate referral to other appropriate specialists.

Finally, there appeared to be no coherent way of informing all the women who work about more immediate issues, for example concerning whether the medical outreach was actually running at a certain time. In this instance although SCOT-PEP had passed a message to the flat that the clinic would not be running at its usual time, that had not permeated through the flat, leaving some women waiting outside Allander House when there was no service.

Those working in saunas reported a slightly different difficulty, which related to 'gate-keepers' not necessarily passing information on. For example, an information leaflet providing information about services and forthcoming events is delivered with every delivery of condoms to establishments. However, those leaflets are usually separated from the condoms, and are not usually displayed. Those working in saunas identified that gate-keepers may be sauna bosses and may have a vested interest in not passing information on. This clearly a complex issue, but is interpreted as some 'bosses' not wanting women to develop or maintain their confidence and consequently making 'demands of the owners'.

In addition, there is a greater movement of women with saunas. There are up to 30 women working for some establishments. It is harder, therefore, to ensure that information is passed on. When exploring the possibility of one of the women acting as a conduit for information to services, concern was raised that such a process could translate into one woman being perceived as top dog'; cliques could form; and a potentially already uneasy set of relationships be further undermined.

Various examples were given about information that was not known throughout flats or saunas. Women noted that the system of '*ugly mugs' was a useful thing* for women working indoors as well as outside. They noted, 'it would be useful to be passed round the girls in flats, but we understand that that sort of information probably needs to be kept in the office and there's a danger than men might sue'… That having been said, it should be noted that SCOT-PEP does send out the Ugly Mugs on the Inside reports to establishments requesting them. Once gain, however, there appears to be an issue about gatekeepers allowing them in and disseminating them to the women and then preventing known Ugly Mugs from accessing the establishment

Another example given concerned the recent home testing for Chlamydia study being undertaken by Healthy Respect. Whilst some women were aware of the availability of the kits, not all were and none understood that it was a part of a study.

4.2.2 Access to healthcare and approach to well-being

'No one's getting ordinary things like colds/chest infections sorted out', licensed premises manager. Most women, be that in licensed or unlicensed premises, noted that they either did not access primary care services or, if they did, did not disclose the nature of t heir work. The general approach to general health and well-being was

that: it wasn't a priority; women were concerned that their confidentiality would not be protected if the G.P. also took care of their families; and 'you don't want to waste their time'

At the same time, women identified 'We need regular 'MOT's' including Chlamydia tests and cervical smears'. A number of women talked about some form of certification of good (sexual) health. 'But they need to understand how sex work might affect you like "your womb may move" because of the nature of the work.

'I work here (in a flat) now. I used to work in a sauna but lasted about six weeks because it was bitchy and unsupportive. I went to a GU clinic after a condom burst, for advice; they suggested that I could wait for three months before an HIV test (or I could have one there, but I would need to have another) which is what I decided to do. I'm going to the GU clinic, but I'm very nervous. I did go to SCOT-PEP but found it a bit intimidating'.

This person has G.P. with whom she has been open about her work 'well, how can they help you properly if they don't know the whole picture?' She described a very positive experience in which during the initial consultation, the G.P. asked open questions, allowing the woman to give ambiguous answers, and then the G.P. gently, checked out her own understanding/interpretation of those answers. This approach, the woman said, allowed her to take her own time, decide how much she was prepared to say on the basis of how the G.P. related to her answers and to her.

Such experiences, however, appeared to be in the minority with most women separating their own health into sexual health (for GU) and not using primary care facilities unless for their families. 'I can't tell my G.P (what I do); he's the G.P. to my family', Allander House service user who works in a sauna. 'G.P.'s practice beyond their competence; I don't trust them to be competent, so wouldn't encourage women to use primary care services', professional drugs worker. Such a view clearly reflects individual experience. However, if workers have such beliefs, that can only serve to re-enforce women's concerns and inhibit uptake of services.

Concern about how the women might be perceived and how physicians and other health care workers might relate to them did not only relate to primary care but to the GUM service. 'I went to the GU clinic because I had an infection. The Doctor was a man which I didn't want, but I dealt with that. But when I said what I did, he started sneering. I won't feel comfortable about going back'. I took a friend with me, she asked if they could do her third HBV jag because she'd been released before she had it; he sneered at her as well when she said she'd been in prison'.

Women spoke about the length of waiting times at the clinic as well as what is experienced as a long delay when getting test results.

Women valued a specific service for them, provided at the time of the Study at Allander House, 'I'm only 18, and I don't want to get a disease' Allander House service user who works in a sauna. However, as indicated earlier, there appeared to be a perception that the medical outreach service provided a primary care as well as GU facility, 'What if you don't have a G.P.? I don't and wouldn't know where to go except Allander House'.

In addition to the general misunderstanding of the role of Allander House, and the difficulties when using GUM services, there appears to be a difficulty concerning communication of test results. There appear to be a number of options, but no consistent approach to the giving of test results. Women can telephone the clinic for results. However, that requires them to remember and for the clinic to be able to respond. Other options including leaving letters to be picked up at the SCOT-PEP office, which is an option, that has been used in the past. It should be noted that the only occasion on which this occurred was in February at the time of the suspension of the clinic. However, whilst there is a clear protocol, which states that SCOT-PEP staff do not open the letter and pass on the information by phone or in person, even with the direct wishes of the woman, this can be difficult to manage. The alternative of sending a letter direct to the woman requires that she is willing to give her address which we understand rarely is the case and that she could cope with a the information that such a letter would give, be that a positive or negative result being given in this way. Women in the Study reported that they did not want to be informed by letter, but that there was no apparent other way.

All in all, women expressed disquiet about the approach by both primary care and specialist health professionals' view of them, about the potential for discriminatory practice, and a lack of confidence in maintaining confidentiality, particularly in a primary care setting.

There are perceptions that sex work will affect movement of the womb. Whether or not it actually does is not known as we believe that research has not been undertaken in this area. However, the key issue has to be about perception and how physicians and other health care staff respond to such perceptions and how they might engage with sex workers around broader sexual health issues.

The women who had come across the Healthy Respect Study and provision of home testing kits for Chlamydia welcomed it. They noted the value of being able to test in their own time and at their own convenience; and the ability to find out without going to clinic. They welcomed the opportunity to be reminded about Chlamydia and the need to test for this 'silent' infection.
We understand that there has not been a big uptake of kits. However, we believe that this is likely to reflect the problems about communication about their availability rather than their perceived value.

Further, we understand that the Study itself is about to come to an end. SCOT-PEP will be able to make kits available until their stocks are exhausted.

Although the study itself may not have had many returns, it is perhaps worthy of note that women valued and welcomed the availability of kits and thus the extension of the services available to them.

Women working in flats and saunas use SCOT-PEP's as the main provider of condoms. We understand that some sauna workers use the Harm Reduction team to source their supplies, and it should be noted that condoms are free from them. The service is appreciated. However, some women though not the majority reported that they could find increased numbers of free condoms when working in Glasgow.

Base 75 give out 50 per visit compared to SCOT-PEP 12 at office and clinic and 4 on establishment outreach which base 75 do not do.

All the women involved in this part of the Study had taken steps to ensure that they were vaccinated for HBV[1]. Women did note the difficulty of ensuring that they attended appointments especially as there appears to be a fairly long programme of vaccination used in Edinburgh. We understand that gay men attending the Department of GU Medicine are routinely offered HBV vaccination, but women in the sex industry are not.

Unlike an understanding about HBV and the importance of vaccination, women seemed unclear that HCV[2] can be sexually transmitted as well as intravenously.

None of the women involved in the Study who worked indoors acknowledged drug use. However, it was noted in another part of the Study i.e. discussion with SCOT-PEP workers, that whilst intravenous use may be rarer than with those working outside, it is unlikely that women do not use drugs at all**.**

The particular needs of older women were raised as an issue, although it was not possible to explore it in any detail. Mental health as well as sexual and general health was identified as something, which needed to be explored at some depth.

What we were able to identify concerning older women is raised in the section below 'Developing Choices'.

While mentioning different generations working in the indoor industry, we were struck by the numbers of women who we met during the course of the Study whose date of birth was 1984 or thereabouts. We did not ask women their age, but merely noted when women offered their dates of birth to SCOT-PEP workers and volunteers; or when women as part of discussion mentioned their own age.

Again, in common with 'older women' were unable to explore particular health needs, but issues concerning choices were identified and are noted below. Having said that younger women did not specifically talk about health needs relating to their age, two broader health issues were mentioned. The first, quoted above, was to do with being younger and not wishing to contract an STI; the second concerned pregnancy and motherhood.

The role of older/more experienced women was discussed by virtually all those involved in the Study. For younger, less experienced workers, there was a real value in learning from others who could give advice about what they could request and where they could draw their own boundaries. They noted how valuable they found being mentored or 'counselled' by someone who 'had been there'; finding advice non-judgemental and practical. For those who were older/more experienced, it was felt important to advice and guide less experienced women, and often mentioned that they had been mentored in their early days and wanted to occupy that role now that they were able so to do.

[1] Hepatitis B
[2] Hepatitis C

The ability to occupy a mentoring role and to accept the guidance of those with greater experience appears to depend on how conducive the establishment is to that taking place. Some older women reported situations in which they had sought to offer advice or help e.g. about having sex without protection, to less experienced girls, only to find that a manager had in turn said to the younger girl – "don't take any notice of her; she's only jealous that she isn't as young as you".

This is fundamental to peer education and support**.** As we have indicated earlier it appears that the majority of sauna bosses do not identify the health and general well being of those working with them as a priority. There is some anecdotal evidence that some sauna 'bosses' actively work to undermine women's confidence and work to create environments in which competition and a lack of trust prevail. Such 'bosses' can encourage women not to use condoms, saying 'oh, you can get that treated, it doesn't matter'. Clearly not all do, but it is likely that most women working will have worked in that type of environment and thus not feel confident in asking for help and support from others colleagues or services.

We noted that when outside of their environment, for example in the waiting area at Allander House, those women who did not feel able to speak did so more. We understand that this is relevant for all ages, but noted that younger women were more willing to 'be more visible' in such environments – saying their age; asking for hints and tips about dealing with customers and sauna owners from peers; and in raising issues about STI prevention as well as more personal issues with both colleagues and staff and volunteers.

4.2.3 Developing Choices

When considering the issue of pregnancy and motherhood, we noted that where the women mentioned their pregnancy, they did so with a view to working in the most lucrative place they could find before they 'started to show'. In one case, the woman was enquiring of colleagues where women could work in Glasgow, the levels of risk, and the level of remuneration. Neither woman, who had raised this issue, had considered what implications, other than on a financial level, that motherhood would have for them. Those women involved in the Study who mentioned their pregnancy appeared only to be considering their ability to work after the birth. Whilst this actually was not the only issue with which they were concerned, the lack of an identifiable place to explore any of their concerns was noticeable.

We noted that some managers did encourage woman to save money and consider how childcare could be managed. However, concern was expressed about the potential and perceived increasing, difficulty when opening a bank account. There is a concern that women will not know how to describe their work to a bank and/or that the variation of the amounts deposited may alert a bank and thus an unwanted scrutiny of an account. In one instance, we found that women were encouraged to save and the manager kept money in the safe on women's behalf. Whilst the intention appears laudable, we were concerned that should the relationship sour between a woman and the manager, the 'holding of monies' may be a source of disagreement and difficulty.

We understand that women could describe themselves as self-employed therapists or in other ways. However, what appears to be important at the moment is that the fear of unwarranted scrutiny or misinformation being imparted by some managers albeit with good intention leaves women with no facility to protect their finances.

It should be noted that not all sauna managers see the current or future interests of the women as a priority or as part of their role or responsibility.

Some women thought it would be useful to consider 'tips about how to leave the sex industry'. Others identified the need to learn how to develop curriculum vitae for potential employers or training and education providers, without disclosing the nature of their work. Others wondered how it would be possible to gain references.

One establishment in particular sought to consider these issues with women, and provided opportunities to work in a number of roles, from reception, to catering, to beauty therapy, to hairdressing and other roles. This enabled women to develop their interests and the establishment manager an opportunity to provide bona fide references.

One woman had completed a degree course, but pondered on its value when set aside her work and how she could make sense of that to future employers. Women had interest in doing courses while at work. One manager noted that they intended to get a computer to aid women's learning/course work. Some women asked for information about distance learning courses as well as college based programmes the timetables of which would fit into their work schedules.

It appeared that undertaking distance learning would be more possible in unlicensed establishments as there was less 'movement' and more 'personal space'

At the same time as considering these issues, these women and others discussed the real difficulties of moving to types of work where, at least at the beginning, remuneration would be less than current earnings. Such consideration was particularly, but not exclusively, an issue for women shortly to be embarking on parenthood where they were concerned to have as much money as possible to benefit their child.

Those involved in the Study mentioned the costs of a new baby. However, others including older women and managers, identified the costs of child care which in turn raised the issue of where to find child care and how women could be accessed should there be a problem while at work when they were not permitted to have their mobile phones switched on. Whilst not of exclusive interest to those aged under 21, this is perhaps of particular interest to the younger people's work.

In addition, older women were also worried to maintain a level of earnings to avoid the 'disappointment' or 'frustration' of older children who had become used to a certain 'standard of living'.

4.2.4 Partners

Sexual health research points to most sex workers diagnosed with STIs identify their partners as the source of infection. Some women felt that it would be useful to extend the medical outreach service to their male partners as they thought it would provide a facility for men to gain advice and GU health checks in a non-judgemental environment. Women participating in the study had varying views about whether such a service should be available citing on one hand their need to maintain a confidential boundary from their partners about their work; and, on the other hand, wanting a place where there was choice for them and their partners to disclose.

When the issue was explored with one male partner (we were only able to meet with one man in this regard), he stated unequivocally that he would not wish to attend such a clinic. It may be worthy of note, that the man was unusual in that he took an active stance towards his own health care i.e. he did take an active role when considering his own health, made his own appointments with his G.P. and so on. He had no doubt that his partner was equally responsible about her own health care and he had no anxiety on health grounds.

We understand that the medical outreach service is not only not able to offer this facility to male partners, but to men in general. Whilst it was not within our brief to explore the needs of male sex workers, we are aware that such a facility could provide a useful service to clients of ROAM and Stonewall as well as a vehicle for partnership between SCOT-PEP and these agencies.

4.2.5 Concluding Thoughts

In the section below concerning the outdoor industry, we have used Maslow's hierarchy of need to highlight the fact that women in the industry have to have levels of needs met in order that they can come to a position in which they have real choices about health and life decisions.

The part of the Study that focused on women in the indoor industry caused us to reflect that whilst some establishments provide environments in which women find some of their basic needs met, not all - in fact the majority, do. As we have indicated there is movement between aspects of the indoor industry and indeed between the outdoor and indoor industries. There is a danger that unless positive action can take place to maintain and raise the level of provision, what does exist will be eroded; women will find themselves with fewer choices and harder decisions to make concerning their own health and well-being.

There are points of constructive and positive practice which leads us to believe that 'it is possible' if key players within the industry – 'bosses' and women can play a part in designing provision.

There is an absolute need to establish either some form of specialist primary care provision which can be used by women or develop a list of interested primary care practitioners who would open their lists or go into premises on an agreed basis. Both routes have pros and cons, but that there is a need cannot be in dispute.

We were concerned that the medical outreach team did not appear to be a part of a system as such. Thus operating as single practitioners offering a basic level of service, which while adequate, neither had the formal ability to make referrals, nor a route, which could be used to take forward, its learning or issues raised while it was working.

We are aware that the medical outreach service has been suspended, as it has not been possible to identify health adviser provision. That role-plays a crucial part in providing consistency and, we understand, a positive link between health and broader issues i.e. between the medical team and SCOT-PEP provision.

We were very concerned that agreement but the use of Allander House appeared to be based on there 'being nowhere else'. Other options were offered by the LHCC but Allander House was the best in terms of location and facilities.

At the time of the Study we noted that the female lavatory had to be locked by a member of staff and a 'staff only' sign put on the door. In addition, the men's lavatory had a sign put on it that made it a female lavatory. All this just for the purposes of the clinic. In addition, those attending the clinic were not permitted to use Allander House equipment i.e. mugs and spoons.

Whilst appreciating a requirement that would mean that everything was left clean for the following day, we could find no explanation other than discrimination for these requirements.

The following day, a complaint was received from Allander House concerning an aromatherapy bottle, which had been left out. The complaint appeared to be les about a bottle than as a panic to what the bottle might contain.

We understand that it had been thought that these 'problems' might be resolved in discussion with the medical outreach team leads, but this clearly has not been the case.

4.3 The Outdoor Industry

What can be said about the outdoor industry that hasn't been said before and that isn't known already? Probably very little! However, the author wanted to note that there appears to be an enormous difference in the culture and therefore the approach of women to their own physical and sexual health safety since the last time we were involved. Whilst we appreciate that the loss of the zone is a political issue and which this Study could not examine with any real sense of making a difference or reversing decisions (for that will be made elsewhere and in other ways), we believe that the implications of the loss of the zone need to be managed by all providers and commissioners of primary health services, specialist sexual health services, drug services, housing providers, social work services as well as SCOT-PEP itself.

We have sought to explore the implications of the change of culture resulting from the loss of the 'zone' and the move to what appeared to this outsider as a desolate spot in the section below about information.

The experience of working is quite different to that around Coburg Street. Women work in an area of about 2-3 square miles. There are usually only about 12 to 14 women out a night working from side roads, or hiding in door ways not least to keep out of sight of the police. It is not uncommon for women to walk a 3 or 4 mile circuit during the course of their 'shift'. Women are not able to see each other and thus provide a sense 'of someone being around'. During the time of the Study, it was cold and wet. Women were reporting men circling around in their cars and it was believed that this was done, so that as the women became colder and wetter, that they may reduce their prices. It is an isolated place and an isolating experience.

At this juncture, we would like to make a note of an issue raised during the course of the Study concerning the role of 'pimps' in introducing girls to heroin and then to crack cocaine use; and to the notion of 'selling girls on/ or 'drug pimping' as part of what appears to be some form of trade. The Study did not examine this issue and thus we have little to say, other than to raise the issue for agencies in Edinburgh. However, such activity was reported and concern was expressed that the girls involved in this way would have no access to information or services. In addition, this clearly raises issues about the level of autonomy that such women have. The way this issue was raised was to prompt some action bearing in mind that those involved are likely to be young and clearly very vulnerable.

It was noted that one licensed establishment saw it as part of their role to provide succour to young women working outdoors and vulnerable. This was enabled by the values held by the manager and the willingness of women working in the establishment to support in many ways, including financial, young women in this type of difficulty.

If this is a significant feature in Edinburgh at this part of the decade, and taking account of what appears to be a more widespread need of women working outdoors (see the sections below), then consideration should be given to the development of some form of supported living for those working outdoors.
In order to provide some internal coherence to this Report, we have used the same headings where possible.

4.3.1 There appears to be a lack of clear and consistent information for women working in the outdoor industry.

More than with the indoor industry, understanding about how to access services was identified as the key information gap. Women believed as a result of their experience that G.P.'s had a rule that did not require them to make home visits if it were known that a woman was a drug user. In similar vein, women were unaware of what services were available, for example the Well Woman Clinic or how to access them.

The mobile unit was valued not only as an opportunity to pick up supplies of condoms and needles, but as a means to meet other women and ask staff and volunteers about what they could do about pressing problems, for example to meet housing need.

It was thought, by both staff and women, that the existence of the zone, the availability of the drop-in at Coburg Street, as well as the outreach and mobile service all contributed to the creation of a culture in which there was co-operation between women, the opportunity to share tips and hints concerning work and safety, a common approach towards pricing, and a constructive approach towards a whole variety of information sharing. Since the loss of the zone, the focus has moved away from the women themselves directly to the mobile unit as, probably, the only place in which such issues may be explored. 'It has become quite cruel'. 'There used to be pride in mentoring each other. Now that only happens on the bus.'

There is something about the fact that they can't do that as the dispersal means the mobile unit is often the only time they see one another 'Only if the bus is out will anyone say that there is a new girl out.' Similarly, women only appear to inform each other about a possible 'ugly mug' if the bus is out.

Posters, advertising programmes and service provision, are placed on the mobile unit. However, it was noted that they are not looked at by women using the unit, and perhaps a re-positioning of them e.g. a 'news section' would be useful. In addition, at the time of the Study a managing aggression course was being advertised through posters on the unit. We noted that it was difficult to find an opportunity to do anything other than mention the course, and even this was rare. Opportunities to discuss the course's value, what it would comprise, and how women could access it, did not appear to occur. We appreciate that it is difficult for women in such extremis to remember all they hear and we note that the trainers for this particular course had spent 4 nights on the mobile unit seeking to engage with the women on this and developing the safety handbook being produced as part of this project funded by the council.

4.3.2 Access to healthcare and approach to well-being

'I'm just starting a programme. I'm going to get on a methadone programme, and you get counselling as well. That will be great as it will mean that I wont have to come out every night', a woman attending the mobile. The woman seemed delighted that she had found a G.P. who was sensitive to her needs as a drug user, and who could not only offer a methadone programme, but counselling as well. She had been able to talk about her work, and her need to support her drug use and her interest in stopping use and perhaps re-considering how and when and perhaps, even, whether she worked.

The worker on hearing this, identified immediately that the woman may have some time to offer via SCOT-PEP to others and suggested that the woman may like to volunteer. The sense of optimism with the woman was palpable and she appeared 'warmed' by the idea that she could offer something to others.

Another woman's story reflected quite a different experience. Having lost her home, she was living in bed and breakfast accommodation sited in a different part of the city to where she had lived before. She had no G.P., nor she thought any chance of getting one; she reported that she had not been able to attend appointments with her psychiatrist and that when she had asked him to help with letters to housing or referral to general health care he had not been able to provide that.

The woman seemed desperate about her mental health and general health in that she said that she thought she had a breast lump as well as abscesses but didn't know how she could find someone to help her. In addition, she reported that although she had a roof over her head, her accommodation was not satisfactory in that there was nowhere for her to do laundry, and she believed that the landlady was looking through her personal belongings while she was out. She had identified her own need: suitable accommodation and a package of health care to meet her urgent needs and offer a diagnostic service.

In similar vein, it was reported, when living in bed and breakfast (as many women do) that they do not necessarily have good access to showering and clothes washing facilities. It can be embarrassing to use the laundrette for working clothes, and some women have found it necessary to buy new clothes every day to manage these difficulties. A laundry facility is still operated at the SCOT-PEP offices. However, this is by appointment only and women appeared not to know about it, or to have forgotten that it was there – it was not immediately accessible when and where they needed it.

Other difficulties can arise for women not in bed and breakfast accommodation, or living 'on friends' floors concerning maintenance of tenancies. It was reported that women can experience harassment or harm from neighbours. There appears to be a difference in practice about responding to such experience for those in the sex industry in that 'if you're gay and experience harm or harassment Housing will move you quickly. That is not so if the harm or harassment relates to you as a sex worker'.

Clearly, the women attending the unit were availing themselves of condoms and using the needle exchange facility. During the course of one evening, all those who used the unit were IV drug users, and on another approximately two thirds used the needle exchange. All the women who attended the unit were provided with condoms.

Such an uptake of the resources on offer should not suggest, however, that all women working outside always engage in safer sex. Women attending the unit noted that some colleagues would engage in unprotected sex and some implied that a higher fee from customers could be sought when offering unprotected sex.
It is perhaps worthy of note that such an expression of 'someone else is the problem' is not unusual. It must be difficult to admit to engaging in unsafe sexual practice amongst peers or with SCOT-PEP staff and volunteers.

Some women identified a need to have some form of basic wound treatment on the unit. We understand that whilst some believe this could be possible, that other workers believe that the lack of privacy, particularly if there is a 'rush' on the bus make the idea of even basic wound treatment impossible.

Women valued the opportunity to explore difficulties with workers and volunteers. When possible, strategies for coping are offered. Where further work is required, e.g. identification of appropriate agencies or appointments need to be made, or where the issues may be complex, a case work approach may be offered. However, because it needs to take place during the day, and women are asked to attend a

meeting with staff at SCOT-PEP office, then such offers are not often taken up such is the difficulty in their lives. Only when the issue has reached a real 'crunch point' are women likely to avail themselves of the SCOT-PEP casework facility.

As suggested above, there appears to be a dearth of G.P.s willing to accept drug users on their lists. Women were concerned that they could not find G.P.s, and were certainly doubtful that if they disclosed the nature of their work they would be treated in a respectful manner. Such perception was mirrored by at least one drug agency worker who expressed doubts about the competence of G.P.s as well as their 'attitude' towards sex workers. It was suggested that the health staff who work with the Harm Reduction Team might provide a valuable resource as 'with them at least the battle regarding their attitude had been won'. Other agencies including Homeless Medical Practice have medics, nurses and social workers who work together to provide a holistic service. This model is one perhaps worthy of replication.

With the exception of two women who participated in the Study, none were linked with primary care services and thus to any service network. At the same time, all the women with whom discussion took place on the unit identified multiple problems, which were inter-connected; specifically relating to housing, primary care and drug services. Clearly, such issues need to be managed 'in the round' with a primary care provider.

Further, as indicated earlier, most of the women involved in the Study were drug users and, with the exception of one, wanted access to methadone and other drug programmes. All complained about the length of waiting lists as well as a lack of understanding of how to gain access. The one exception to this was the woman mentioned at the top of this section who wondered why 'everyone can't do what Dr. Robertson does'

In common with women working in the indoor industry, women were aware of the need to be vaccinated for HBV. However, they were not clear about how to get vaccination, or, if they were, noted the difficulty in accessing treatment centres at convenient times.

Most of the women attending the unit during the course of the study, identified aggression by both customers and to some level, the general public while passing in their cars, and when walking home. In addition to the violence associated with their work, some women reported incidents on their way to and from work.
Although reported elsewhere, we thought it might be useful to include statistics prepared by SCOT-PEP against sex workers in Edinburgh in 2002

1 January – 31 March 2002 – There were 11 attacks reported to SCOT-PEP

1 April – 31 May 2002 – there were only 2 attacks reported to SCOT-PEP, however the staff were aware from discussions amongst the women that the level of violence remained high but that women were not taking the time to report attacks to SCOT-PEP.

1 July – 30 September 2002 – there were 7 attacks reported to SCOT-PEP. During this period staff promoted the Ugly Mugs reporting system to women. However women remained reluctant to report attacks and our system of recording attacks was changed to a simple incident log in mid September.

1 October – 31 December 2002 – there were 11 attack incidents reported to SCOT-PEP. 6 of those attacks occurred in October 2002.

Total No of attacks reported in 2001 during 'non-harassment zone' = 11
Total No of attacks reported in 2002 after loss of 'non-harassment zone' = 31

In addition the nature of the attacks being reported are far more serious in 2002 than in the previous year, when a number of Ugly Mug Reports were about verbal abuse, arguments about not using condoms and non-payment.

Last, in this section, but not least concerns the lack of a site based drop-in facility now that SCOT-PEP has relocated and access times to the office are limited and we understand by appointment. The mobile unit provides a drop-in facility, but a limited one. Outreach provides a way of identifying women who are unfamiliar with SCOT-PEP and its services and the mobile unit. In a way the mobile embodies the ethos of SCOT-PEP and provides an invaluable facility for those who are working in an extremely isolated setting and way to meet others, give and receive information and help, as well as gain access to direct services. However, its availability is limited as is its space. And, although the centre at Coburg Street also had limited access times, such is the nature of the women's isolation and
the level of need, it is much missed.

4.3.3 Developing Choices

When considering 'choice' and women working outdoors, it is impossible not to think about Abraham Maslow and a hierarchy of need. We have taken the opportunity to set it out as it speaks, we believe, most perfectly, about both the needs of women in the outdoor industry and requires those providing and commissioning services to recognise the vastly different culture and norms which pertain in the industry now that: the zone has gone; there is an increase in drug use; that for some at least there is a notion of 'being owned by drug dealers and/or pimps', and a decrease in the level of self sustaining, peer support and education within the community itself.

Maslow identifies at the base of his hierarchy:

Body needs i.e. medical, emergency, rescue and coping
Security needs i.e. safety, planning, food and shelter
Social needs i.e. social self-help, mechanisms for escape, dealing with alienation, and having a sense of belonging
Ego needs i.e. self help, health, pride, direction and empowerment

Only then does it come to Self Actualisation which perhaps for now is actually much further away from the possible than it was even five or so years ago.

n.b. the highest level 'spiritual' is an addition which we have not considered in this Study or its analysis.

It felt almost impossible to explore women's thoughts about their choices without appearing to make a negative judgement about their current lifestyle such is the lack of even the base line for example the lack of basic treatment of wounds and abscesses, and then the lack of certainty of what Maslow refers to as security needs. However, we did identify that women need options which are real before they can consider their choices.

Without a culture in which self esteem development is encouraged and supported, and in which women believe that they will be taken seriously, choices are difficult to make.

The choices that women were looking for related to their basic needs. The choice (if that is the right word) of where to live so that they could do their washing and feel confident that their belongings would not be rifled while they were away; the choice of G.P. (or more precisely to have a G.P.); the ability to get basic treatment; the choice of services that they could use for their sexual health; the choice of attending methadone and other drug programmes which were supportive and had an understanding of the women's work and attendance at which could mean that a woman would not have to work every night and provide opportunities to do other

things with her time; and the choice to have basic treatment. And, at least in terms of health services, to have a choice about where they could attend at times that are convenient and that take into account their work and their own private and family lives.

4.3.5 Concluding Thoughts

There has been a huge change in culture in the outdoor industry in recent years. Perhaps there is a need to concentrate on basic needs and in that regard identify and train GPs who could be listed for immediate access for women without a GP and thus access not only to primary care, but referral routes to specialist health care.

There appears to be a very positive approach by Housing to emergency need. However, the difficulties, no doubt contributed to by a lack of housing stock, once emergency bed and breakfast accommodation has been found need to be addressed as a matter or urgency.

Long waiting lists for drug programmes re-enforce a whole variety of difficulties. Involvement in sex work not given a priority; not taking account of the risks women are taking when involved in sex work. 'I can go out working less if I can get into this'.

Given there is little likelihood of renewal of a tolerance zone and thus the maintenance of high police activity, at least in the short term, diversion schemes which offer women not only support but access to treatment should be considered.

Lack of access to showering and clothes washing facilities near to women's place of work contributes to lack of self esteem and thus a more assertive and self respectful approach to personal/health safety; and more pragmatically to an unnecessary use of income thereby requiring women to work more whether or not they want to.

The mobile unit appears to be the only way in which the ethos of SCOT-PEP is held and communicated. Given this ethos is equivalent to Maslow, this can exacerbate difficulties. It provides the only drop-in facility to which women relate and whilst it seeks to meet basic needs – such are the women's basic needs that it is difficult to do so without emergency treatment facilities. Certainly, women's development needs are unlikely to be met within such a setting.

There appears to be a lack of capacity to take forward case work identified on the mobile unit. Priorities have to be made. However, given the level and complexity of need against the resources available, even when including direct service provision undertaken by both the SCOT-PEP administrator and manager we believe that it will not be possible to meet the level of casework need within existing resources.

5. Conclusion and Recommendations

As always at this point in a Needs Assessment exercise, one is aware of what we have not discovered, not understood, or have failed to challenge. The accompanying document which has been prepared for SCOT-PEP to enable it to undertake needs assessments in the future seeks to suggest things to do and ways to do it, that we have not done, but had time allowed believe would have been useful.

We have provided a snap shot of the needs of those with whom SCOT-PEP is involved. However, whilst we believe that SCOT-PEP is probably in contact with approximately 50-60% of women working indoors. We note that the agency used to have contact with, in excess, of 95% of women working outdoors. However, since the loss of the zone, numbers are more difficult to estimate. There is concern that women are not accessing the mobile unit, rather than they have left the industry. In addition, we are aware that we have not considered the needs of men working in the industry. For the future, it would be useful, we believe, to engage with agencies like ROAM and Stonewall to identify those needs. This would not be with a view to undertaking services that are being met by others, but rather to try to get a whole picture.

There have been four big shocks in undertaking this Study at this time:

The profound change in the nature of the women working outdoors. In the main, women who work outside are drug users; their most basic needs are not being met in most cases; and their ability to use services and resources is limited by their almost intolerable circumstances. As ever, it has been a privilege to meet and talk with the women. As we have said in the report, they don't want the stars, just those things that we all need and want and take for granted.

As well the women working around Salamander Street, there appears to be a new culture emerging – 'drug pimping' which we did not explore, but which seems to feature women selling sex for drugs from the partners of other sex workers – leading probably to impossible relationships between the women; and drug dealers getting younger women involved in heroin and crack cocaine use, requiring them to sell sex and then in some way to 'sell them on'.

There are parts of the indoor industry where women are encouraged to take care, to get advice and information. We noted that some managers were clear that their businesses' 'bottom line' were not compromised by decency and good practice. Such owners and managers offer a model to others, probably the majority who have a negative view of the value of information and access to health services; who will not tolerate access to agencies such as SCOT-PEP, or who encourage women not to use condoms, saying that disease is easily curable. Such managers and owners undermine women who seek to offer guidance to those less experienced; and fail to provide an environment where women can thrive rather than merely survive.

The last shock was in some ways the greatest of all – the failure of the public sector – health, housing, social work etc. – to operate 'in the round' and provide a 'holistic' or 'joined up' approach to women who by their nature deal with fragmentation and splitting every day. Specialist GU facilities are important to address complex STI needs. But most women do not have such needs. There is a need for sensitive primary care provision, which can also work competently with sexual health matters, and have fast track referral pathways to specialist provision where that is required. Health advisers usually have 'their feet' in the practice of sexual health and 'their heads' as part of a wider health and well being story. We understand that GU facilities are under pressure as they are throughout the UK. However, with support in the short to medium term, we can only hope that they would be willing to train

interested GPs and other primary care health professionals to be involved in some way with this vulnerable community.

We were impressed by how SCOT-PEP is viewed by women, sauna 'bosses' who think about these things, and by other agencies. The Harm Reduction Team was very keen to maintain and develop partnership with SCOT-PEP, and had there been time we are sure that other agencies would have considered an option to work more closely of enormous value.

There is perhaps a need to formalise some of the practitioner links that SCOT-PEP has including those with Access Point, the Well Woman Clinic, Housing and others so that valuable soft intelligence can be shared and strategies developed to meet the complex needs of women.

It is important to remember that the Study was commissioned to identify the needs of women working in the Sex Industries in Edinburgh by SCOT-PEP. The recommendations concern service development and configuration 'in the round', that is by a range of statutory and voluntary sector organisations including health, social work, housing, the police and so on. As the commissioner for this Study, we have directed the recommendations towards SCOT-PEP, not as the vehicle for delivery exclusively, but as a means to inform both strategic work in Edinburgh and practical service provision.

While we are aware that any recommendations can only act as a prompt to SCOT-PEP, we have identified our key recommendations:

We recommend that urgent attention is paid to the meeting of primary care needs of women working both in the indoor and outdoor industries. Consideration should be given to the viability of a specialist primary care service. Or, if that is not possible to the establishment of a 'list' of primary care providers willing to develop their interest and competence in working with women in the industry.

We recommend that provision of primary care within establishments be considered, albeit on a limited basis in the first instance.

We recommend that an exploration take place with the Department of Genito-Urinary Medicine to develop training for GPs in Edinburgh and to offering a fast track referral facility for women working in the industry.

We recommend further study of the emerging culture of 'drug pimping' and its impact on the outdoor industry and the resources required to meet need is undertaken.

We recommend that exploration take place with appropriate partner agencies to meet wound treatment needs with women working in the outdoor industry.

We recommend that exploration take place to establish diversion schemes for women who are drug users and in the criminal justice system.

We recommend that exploration take place with drug treatment facilities to provide fast track referrals for women.

We recommend that exploration take place with Housing so that experience of violence or harassment can be addressed quickly.

In addition, the provision of supported accommodation should be considered.

We recommend that information concerning finance should be developed and mechanisms found whereby women, especially those who are younger and may have no previous experience on which to draw, can learn ways in which they might be better able to manage their financial situation.

We hope that this short needs assessment has been of value. It has certainly been a stimulating challenge.

Stephanie Sexton
April 2003