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Female street sex work in Belgrade as a risk environment for a syndemic production – A qualitative study

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SUMMARY
Introduction/Objective Although female street sex workers are contextually vulnerable to numerous health-endangering factors, they also contribute in re-producing them. This synergetic production is approached by syndemic theory developed within medical anthropology.
The objective of the study is to present an analysis of the results of a qualitative ethnographic study conducted in Belgrade, Serbia in 2015, and reflect upon social environment factors influencing syndemic development of medical conditions.
Methods The risk environment factors enhancing possibilities of developing particular medical conditions were investigated by applying qualitative anthropological methodology, emphasizing semi-structured in-depth interviews, a standard qualitative sample, and respondents' self-reporting.
Results Social environment of sex work, generally considered risky due to sexually and blood-transmitted diseases, in this study also proved as receptive for many other illnesses, whose syndemic character has been insufficiently addressed. The study confirmed the syndemic nature of street sex work.
Conclusion The social science perspective should be used in health policy conceptualization and implementation not only during latter stages, i.e. in the interpretation of the social conditions influencing medical related issues, but during early stages of understanding how those conditions and issues circularly constitute each other.
Keywords: medical anthropology; qualitative research; street sex work; risk environment; syndemics: health policy

INTRODUCTION

Street sex work in Belgrade is identified by previous research as an environment capable of generating various epidemiological risks, most notably those related to HIV/AIDS and sexually transmitted infections (STI) [1]. The population of female street workers (FSWs), highly vulnerable to such risks in itself, makes altogether with their male clients the so-called "bridge population," which holds the potential for transmitting diseases to a wider population, otherwise at not so high HIV- or STI-related risk [2]. Both working and living conditions of street FSWs make them susceptible to some other diseases, the infectious ones, like hepatitis C virus (HCV) or tuberculosis (TBC), or the non-contagious ones caused by alcohol or drug abuse. FSWs are also prone to be the victims of physical and non-physical violence, as well as of stress caused by social stigma and poverty [3, 4]. As street sex work contextually perpetuates numerous health-endangering factors, we argue it is the syndemic environment [5].

Syndemic theory, developed within medical anthropology, addresses the empirically observed tendency of pathologically different health conditions to co-occur and overlap in certain populations in relation to their living conditions [6, 7]. Studies inspired by this notion stress "elucidating specific biological, behavioral, emotional, or other mechanisms of adverse interaction among co-morbid diseases, and the social environments of sufferers that facilitate multiple disease clustering and deleterious interactions" [8]. Syndemic theory is not a medical theory designed to predict and explain exact co-occurrence but a social science medical related research program which aims to backup epidemiological research by suggesting likeliness of having such developments when social factors like poverty, poor housing, social exclusiveness, or violence regularly co-occur within a population.

The social environment of (the street) sex work plays a significant part in producing factors responsible for worsening health conditions and is regularly researched as a type of risk environment in which mutual fuelling of diverse health problems proved to be understood best by applying qualitative research methods, as developed in social science [5, 9, 10, 11].

Our aim is to present results of the qualitative ethnographic study and reflect upon social environment factors influencing syndemics development and production within population of street FSWs in Belgrade. By identifying and interpreting these factors we seek to demonstrate the importance of the interplay between social and medical factors of the diseases

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particularly affecting this population, and thus demonstrate the need for an interdisciplinary interpretation of health-related policy issues.

METHODS

Sixteen adult street FSW in Belgrade were interviewed during 2015. Each interview has been performed after the written consent, lasted approximately 60-90 minutes, was tape-recorded and transcribed for analytic purposes. Participants were chosen according to predefined criteria [1, 3], and according to the standard structure of sample in qualitative research (sixteen participants [12], two participants [13], three participants [14], seven participants [15]). They were provided with information on aims, purpose, and ethics of this study, and have been let known that they can retreat at any time and without obligation to explain.

In-depth, semi-structured interviews used in this study are designed to enable informants to feel as comfortable as possible, to provide them with the themes of interest to which they can choose to respond or not, and to offer them the time necessary to present and explain their thoughts, stances, attitudes or beliefs. The purpose of in-depth interviewing is to gain first-hand accounts of experience on the matter of research by the respondents themselves, i.e. it is purposively based on self-reporting [16–21].

The interviews were devised after the study topic guide, a standard orientation tool in qualitative research, containing principle topics of interest according to the aim of the research. The topic guide and the corresponding coding frame (Table 1) were modified after the one used in pivotal studies of FSW in Serbia (1, 3).

These broad topics enabled the coverage of the set of more precise concerns regarding FSWs' social setting, such as daily routines; initiation into sex work; relations to partners and/or pimps; their micro-social environments; services provided or not; amount of money for which they are willing to perform services they otherwise do not engage in; their socioeconomic status and health expenditures particularly; health status, including if they recall the occasions when they were harmed by an infectious disease or physical violence, or were diagnosed with a chronic or mental illness; the ways they take care of their health, including social service status and attitudes towards healthcare providers; the troubles and health-related consequences of the lack of legal status of their profession; violent nature of their working environment, etc.

The basic criteria for including the participants in this study were as follows: women who have been offering

Table 1. The coding frame

First-level code	Second-level codes
1. Personal information	1.1 Living conditions 1.2 Family
2. Sex work initiation	2.1 Reasons 2.2 First experience (where, how, expectations, clients, condom use) 2.3 Influence of other SWs/friends 2.4 Environment (police, location, negotiations)
3. Personal sex work organization	3.1 Ways of reaching clients 3.2 Place of service provision 3.3 Pimps, protection, other persons involved 3.4 Negotiations (location, types of service, payment, condom use, influences) 3.5 Hours (seasons) 3.6 Earnings, costs (tips, types of sex work, condom use, client type)
4. Clients	4.1 Client types and numbers (regular, one-time) 4.2 Client description (where from, age, marital status, etc.) 4.3 Client preferences 4.4 Drug use
5. Condom use	5.1 Reasons 5.2 Purchase and provisions 5.3 Environment (role of external factors)
6. Sex work without a condom	6.1 Reasons 6.2 Client refusal 6.3 Environment (role of external factors)
7. Drug use	7.1 Drug use patterns (especially as related to sex work) 7.2 Drug use and alcohol use with clients 7.3 Drug use and alcohol use with other SWs 7.4 Injecting drug use (access to sterile equipment and sharing) 7.5 Environment (role of external factors)
8. Violence	8.1 Client violence (reasons, how often, strategy) 8.2 Police violence (reasons, how often, strategy)
9. Risk	9.1 Perceptions (HIV/STI risk) 9.2 Non-HIV risk (e.g. violence, arrest) 9.3 Risk behavior change and risk reduction
10. STI/HIV	10.1 Past experiences 10.2 Knowledge of STI/HIV
11. Testing	11.1 HIV testing, diagnosis and experience 11.2 STI testing, diagnosis and experience

STI – sexually transmitted infections; SWs – street workers

Table 2. Results

No.	Age	FSW experience	IDU	Health status	Education	Marital status	Children	Health insurance	Tested for HCV, HIV at least once
1	29	11	+	Chlamydia, HCV+	SE	S	/	+	+
2	22	6	/	Broken rib, pneumonia, alcohol abuse, HPV	PE	S	/	/	+
3	33	12	/	Pediculosis pubis, alcohol, injuries from being beaten up, pneumonia	PE	Sep.	1	/	+
4	22	1	/	Epileptic, broken arm, BV	PE	M	/	/	/
5	21	10	/	Alcohol abuse, gonorrhea, mental disorder	iPE	S	/	/	/
6	30	11	+	Pediculosis pubis, TBC	SE	D	1	+	+
7	19	3	+	HCV+, mental disorder	PE	S	/	+	+
8	29	2	+	HCV+, heart issues	PE	M	1	+	+
9	25	6	/	Gonorrhea, injuries from being beaten up	PE	S	/	+	+
10	29	5	+	Alcohol abuse, mental disorder, injuries from being beaten up	PE	M	/	+	+
11	31	16	+	HCV+, HIV+	PE	S	/	/	+
12	33	8	+	Genital herpes, heart issues	iPE	Sep.	/	/	+
13	26	3	/	HCV+, pediculosis pubis	PE	S	/	/	+
14	23	5	/	BV, TBC, alcohol	iPE	S	/	/	/
15	22	2	+	HIV+, TBC	PE	S	/	/	+
16	38	14	/	Genital herpes, HPV, BV	PE	S	2	/	+

FSW – female street worker; IDU – injecting drug user; D – divorced; S – single; M – married; Sep. – separated; PE – primary education; iPE – incomplete primary education; SE – secondary education; HCV – hepatitis C virus; HPV – human papillomavirus BV – bacterial vaginosis; TBC – tuberculosis

commercial sex services in the streets for at least five years; have provided commercial sex services in the previous thirty days; abuse alcohol and/or drugs; and have medically documented reports on two or more conditions, or have had them in the last three years. Out of many known sites of sex work, FSWs from the vicinity of the Main Railway Station, the Blue Bridge ("Plavi most"), and another purposively undisclosed location in the urban core of Belgrade were interviewed.

RESULTS

All of the participants stated that they have been initiated in sex work in their teens. All of the injecting drug users (IDUs), exactly one half of the responders, claimed that they had commenced providing sexual services before they began injecting drugs, mostly heroin. Alcohol abuse has been reported as more frequent among those who do not inject drugs, as well as injuries caused by physical violence and STI. On the other hand, HIV and HCV infections were reported as more frequent among FSWs who inject drugs, while mental disorders and other illnesses are nearly evenly distributed.

The following co-occurrences of medical conditions were self-reported by IDUs: chlamydia and HCV; pediculosis pubis and TBC; HCV and mental disorder; HCV and heart issues; mental disorder and injuries from being beaten up, together with alcohol abuse; HCV and HIV; genital herpes and heart issues; HIV and TBC.

Participants who do not inject drugs reported co-occurrences of the following medical conditions: bacterial vaginosis and TBC, together with alcohol abuse; HCV and pediculosis pubis; gonorrhea and injuries from being beaten up; gonorrhea and mental disorder, together with alcohol abuse; epilepsy, broken arm, and bacterial vaginosis; pediculosis pubis, injuries from being beaten, and pneumonia, together with alcohol abuse; broken rib, pneumonia and human papillomavirus, together with alcohol abuse; chlamydia and mental disorder.

All of the diagnoses were self-reported, i.e. they do not necessarily correspond to a professional medical opinion but illustrate the perception and knowledge of the respondents themselves.

Basic social features of street FSWs

In contrast to the places of their work, the participants live mostly in distant suburban neighborhoods. They normally rent small apartments or single rooms, the latter sharing running water with other tenants. Most of them often move, seeking lower rent.

Eleven of them claimed that they do not have a pimp, but seven of those stated that they live with their boyfriends, which is usually close to or even the same as having a pimp, according to the previous findings [1]. Others who admitted having a pimp claimed the pimp was also their boyfriend.

Only two respondents reported they have completed secondary school, and three of them stated that they did not complete elementary school. All of the informants claimed domestic disturbance in their pre-sex work family lives: their parents divorced and consequently they were being neglected by the remaining parent and their step-parent; they were abandoned by a parent and left with financial hardship; they were being abused by parents or siblings (including half-siblings); they went away from home after completing primary education to search for a job due to economic hardships of their families; they had chronically ill parent(s) not capable of taking full care of them, etc. A few of them maintain relations with their parents in order to take advantage of remaining on their health insurance policies.

Their common claim was that they have engaged in sex work either for having no qualifications or/and for seeing the sex work as an opportunity for earning easy money. Some of them thought of the sex work as a temporary solution but the claim that they would like to find the way out of it was unanimous (though admitting they are not actively looking for another job).

Basic health-related risk features of street sex work social environment

Knowledge about illness related to risks produced by sex work is gained either personally or transmitted by other FSWs. It is subject to change and so is its related behavior: it could be empowered positively (as a result of the outreach work of some health institutions like JAZAS) or negatively, for example, when money shortage is urging them to hustle for clients no matter what the weather conditions or clients' request are, when they abandon safety procedures on obviously false, albeit habitual, presupposition "that condoms are efficient only in heterosexual intercourse" [21, 22].

The respondents' usual claim is that they do not work without using a condom, but when asked if they recollect whether they used it or not on the last four to 10 occasions, it is found they mostly did not. The unprotected sex could bargain them a bit higher price for their services; the other usual answer is that clients prefer it that way or that the clients could get nasty if they firmly oppose. Oral sex is regularly provided without a condom and all of the participants were positive about providing such a service. Some of them are reluctant and others are disgusted by the notion of ejaculation into the mouth or over the body. Nevertheless, they state that they can hardly avoid direct contact with clients' sperm, and by knowing that, they do not try to do it at all.

Save for three of the participants who claimed they have never provided anal sex, and two more that are willing to provide it upon request, the others do it now and then, mostly if they cannot earn money needed at the moment, and mostly without any protection. Some of the respondents reported they agree upon such service only if the client uses a condom, but also admit that a "fair price" to do it without a condom is convincing enough to them.

Pre-sex hygiene is mostly not an issue for FSWs and their clients. Providing services takes place out in the open, in hidden or visually not distinctive places (dark parking lots, remote parts of parks or woods); indoors (purposely rented rooms in the vicinity of the sex work route); in vehicle cabins. It usually has to be quick. Using lubricants is the only reported preparation for sex, and using wet wipes is the most usual way of cleaning oneself after providing sex service.

Providing services in vehicle cabins is the least favored by the FSWs, so they try to avoid it whenever possible. Not going to the client's place of residence is a rule, as they fear clients can get rough there or even try to rob them or force them to the sexual acts they are unwilling to perform. Nevertheless, violent acts happen at the regular working places by clients refusing to pay after being provided the sex service; clients incapable of performing the sexual act; clients of ill temper or "control freaks" – all of them physically harm street workers now and then.

Three main resources of physical violence were indicated: boyfriends/pimps; clients; and police officers. While the violence committed by policemen could be described as brutality, that produced by boyfriends/pimps and clients could result in more serious health consequences. As previously reported, police violence is restricted to brutal treatment when having FSWs arrested, like pushing, slapping and cuffing; there are also random tries of coercing sex by the policemen that is noted for threats of being arrested or ousted from the territory the FSWs are working in [23].

Violence produced by boyfriends/pimps and clients usually results from quarrels, bad temperament, mental instability, etc., and it can result in serious injuries, from deep bruises and black eyes to broken arms and ribs. The syndemic-specific problem in that regard is that FSWs are unanimously reluctant to seek help from police or social service and to go to ask for medical help. When suffering from fractures, they usually wait for a day or two before seeing medical doctor, trying to ease themselves with analgesics. The main reason they hesitate to seek the institutional help is the fear of being recognized as illicit sex solicitors and treated with neglect by both healthcare workers and police officers, as reported for Serbia and worldwide [24–27]. The second most important reason is the fear of retribution by those who hurt them, which stems again from the highly uncertain legal and social position FSWs occupy in Serbia.

Most of the respondents do not have healthcare insurance and rely only on private medical practitioners. They seek medical help only if they cannot resist the health problems or when those prevent them from working. "Petty" problems such as cold, fever, coughing or "bearable" pains do not prevent them from working, nor do their menstrual periods, for most of their duration.

Those participants who inject drugs attribute equal shares of their injecting habits to doing it alone and to doing it with another injector or injectors (the same goes for alcohol use or abuse). Sharing of the injecting equipment, including cooking together, occurs whenever the usual injecting routine is ruptured. It usually follows prolonged periods of money shortage or as a kind of sociality – exactly the same pattern as with the IDU in Belgrade in general [28]. Regular alcohol consumers admit to drinking with clients although they know they shouldn't, for safety reasons. Those who binge drink are strict about the rule of not drinking with clients, as they fear things can get out of control and they can end up physically hurt. Their diet and clothing show certain pattern as well. As they spend most of their time outside their dwelling places wearing clothing pieces suitable for their work, due to their working hours (from some time in the late afternoon until deep into the night, depending on the season and weather), their costume usually does not follow the weather conditions and stays light during the course of the year. Their diet is all but regular and is predominantly based on fast food. They eat when they can during the day, usually having two main

meals – one after they return from work and the other before work, but not very close to it, as they do not want to be "heavy" when going to work, fearing they can feel nausea if they perform sexual acts with their stomachs full.

DISCUSSION

Social environment of sex work is widely considered risky to sexually and blood-transmitted diseases, as confirmed by numerous studies [1, 3, 21, 22, 23, 29, 30]. However, it proved to be receptive for many other illnesses as well, whose syndemic character has been insufficiently addressed. Congruence between results presented here and in several similar studies indicates that certain social behavior works in favor of syndemic production, regardless of drug use. While it is intuitively expected that HCV will be more frequent among the IDU in general than within the non-injecting FSWs, frequency of the alcohol abuse among the non-injectors comes as a kind of a counterweight; that is, sex work is hard to cope with individually without substance abuse [31].

Physical violence to which street FSWs are exposed almost regularly, illegal status of their profession, and inability/unwillingness to access public healthcare and social services confirm such findings, making them double-excluded, i.e. personally and socially stigmatized. However, it is important to stress the limitation of this study: no questions on a chosen medical doctor have been asked.

Gender shows to be an issue as well, for their week social position is likely attributed to their "biopolitical" vulnerability, i.e. the interaction of biological factors with social and political ones in causing higher health-related risks among women [32].

Their adhesiveness to STI comes then not only from the nature of their work but from the lack of proper medical care, prevention and treatment alike. Faced with judgment and reportedly neglect by law, institutions and the general public, they dispose not only aversion towards asking for protection from violence but also coercion, unwilling to reveal profession-related circumstances of their injuries or health conditions to medical professionals. Furthermore, their self-reported lack of healthcare insurance prevents them from receiving help from medical specialists, as seeing private medical practitioners is scarcely affordable to most of them. Their hygienic habits stem at least partially from the need to be as quick as possible when their service is over, in order not to be caught in the act. Constantly in economic deprivation, they do not hesitate engaging in unprotected sexual acts in order to earn more money or to prevent clients from going to another sex worker. Street FSWs rank lowest in the sex work world, thus charge low for their services, which faces them with the need of having as much clients as possible per working hour.

The way of providing services at places which are health- and hygiene-wise highly problematic; the fact of them being up and on their feet outdoors for almost all and every night; the presence of stress, uncertainty, lack of formal education; and constant economic deprivation, illegal status of the profession and generally poor living conditions all act as social impellers of health endangerment and must not be excluded from the explanation for their increasing susceptibility to different health issues when compared to the general population [24].

An urge to acknowledge the value of qualitative social research in addressing socially-and culturally-specific medical issues has already been recognized in other social contexts [33, 34, 35]. In that regard, it would be of utmost importance to consider the methodological specificities of research among vulnerable populations [36, 37, 38]. As the study confirmed a clear syndemic basis for such co-occurrences, it should be further investigated and taken into account in policy development and implementation.

Prevention and harm reduction recommendations

A wider and more aggressive national strategy and action plan regarding the use of condoms, including during oral sex, should be deployed. More frequent outreach education of FSWs on STI and easing their access to condoms should be a priority.

Stronger outreach of medical support to FSWs should be considered in relation to their stigmatization, which results in reluctance or even aversion towards healthcare professionals and institutions.

Policing actions more oriented towards clients of FSWs should be introduced.

National policy plans and actions on women empowerment in the society should include and emphasize the category of FSWs as a vulnerable population and a group at most risk in regard to partner violence, and sexually and gender-related violence.

CONCLUSION

The study confirmed that the street sex work is such an environment where the risk of multiple diseases is produced in the syndemic mode. Besides STI, as the most obvious possible consequence of the very nature of their work, the FSWs are faced with frequent substance – heroin and alcohol – abuse. This increases their proneness to other infections, mostly HCV but also HIV and pulmonary diseases, as well as to the non-infectious medical conditions like mental health problems or heart issues. The illegal status and overall social image of their profession, together with chronic scarcity, make them additionally vulnerable to various types of violence.

NOTE

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Женски улични сексуални рад у Београду као ризично окружење за изазивање синдемије – квалитативно истраживање

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САЖЕТАК

Увод/Циљ Уличне сексуалне раднице контекстуално су подложне бројним факторима који угрожавају здравље, али и саме учествују у њиховом репродуковању. Овој синергији смо приступили из перспективе теорије синдемије, развијене у оквирима медицинске антропологије.

Циљ рада је био анализа резултата квалитативног етнографског истраживања спроведеног у Београду током 2015. године и указивање на факторе социокултурног окружења који утичу на синдемијски развој болести.

Метод Употребом стандардне квалитативне антрополошке методологије приступили смо чиниоцима ризичног окружења који увећавају могућност појаве специфичних обољења. Нагласак је стављен на полуструктурисане интервјуе и анализу података о којима извештавају сами испитаници.

Резултати Друштвено окружење сексуалног рада, које се у начелу сматра ризичним од сексуално и крвљу преносивих болести, у овом истраживању се показало као подложно за ширење многих других болести чији синдемијски карактер до данас није довољно проучен. Истраживање је потврдило синдемијски карактер уличног сексуалног рада.

Закључак Перспектива друштвених наука може допринети концептуализацији и имплементацији здравствене политике, како у фазама тумачења друштвених услова који утичу на појаву медицински релевантних стања, тако и за разумевање тога како се медицинска стања и друштвени услови у којима они настају међусобно конституишу.

Кључне речи: медицинска антропологија; квалитативно истраживање; улични сексуални рад; ризично окружење; синдемија; здравствена политика