

## **Pregnancy prevention and contraceptive preferences of online sex workers in the UK**

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## **ABSTRACT**

**Objectives:** The internet has changed the organisation of sex work. The risk of sexually transmitted infections has frequently been a research focus, but less is known about sex workers' use of contraception for pregnancy prevention. The aim of this research was to gain a better understanding of contraceptive preferences and provider interactions of online sex workers.

**Methods:** Data were obtained from a multi-methods study of sex workers in the UK who advertise on the internet and have sexual contact with clients, particularly in the Birmingham and Solihull areas. The study comprised an online survey among 67 participants and eight qualitative interviews.

**Results:** Reported high rates of condom use with clients led to sex workers considering pregnancy prevention to be a personal rather than an occupational issue. Disclosure of sex working to health professionals is often seen as unnecessary and/or undesirable due to concerns about stigma. A clear distinction between contraceptive needs for commercial and non-commercial partners was evident.

**Conclusion:** Service providers need to take account of both personal and commercial needs during contraceptive consultations and avoid making assumptions based on homogeneous understandings of sex work. Encouraging disclosure of sex work to facilitate appropriate discussions may need new approaches to combat privacy and stigma concerns.

## **KEYWORDS**

Contraception; disclosure; internet; pregnancy; sex work; stigma

## Introduction

The internet has changed the organisation of sex work, and in the UK much of the ‘indoor’ sex-market now operates online [1]. The internet has led to an increase in the number of providers advertising online, not – or not only – to a migration of existing providers [2,3]. A recent study identified 12 different types of online sex work spaces, including a variety of purpose-built platforms for advertising sex work, digital hook-up apps and websites of individual sex workers [4]. Online sex work includes a range of practices, including performing live sex acts via a webcam, advertising for those who work as escorts or in parlours, and charging for occasional ‘hook ups’ via dating apps. Online sex work here is defined as where the initial approach is via the internet, which then leads to an encounter that includes sexual contact.

Data about the population of online sex workers is complex to quantify owing to the transient nature of the work [4,5]. A recent large survey of the UK industry found that most online sex workers identified their ethnicity as white UK (73%), most were aged 25-44 (60%), and many were educated to degree level or higher (37%) [1]. The women were more likely to be sexually diverse, with 51% stating they were heterosexual [1]. Many online sex workers regularly work in areas other than where they live, and touring has been identified as important to those who work independently [1].

Sex work research has previously focused on the health risks associated with the transmission of sexually transmitted infections (STIs), including HIV, with less attention given to pregnancy prevention [6,7]. In the UK, condom use during vaginal intercourse with clients has been reported to be high, reducing rates of STI transmission [8,9]. For sex workers, the health risks of working, including pregnancy, may be perceived as less significant than other risks such as violence or unwanted occupational disclosure [9]. Sex workers are, however, less likely to use condoms with non-commercial partners, thus increasing their STI risk when not working [8,10]. This highlights a potential need for other forms of contraception to prevent pregnancy.

Many sex workers have children, with pregnancies occurring during, as well as before commencing, sex work [11,12]. Canadian research found pregnancy intentions are often similar to those of women who are not sex working [11]. Sex work stigmatisation, which can associate sex work with ‘bad motherhood’, means that sex workers may experience negative

judgements about their being or becoming mothers [11,12]. For example, in the UK, some public health programmes set targets for the use of long-acting reversible contraception (LARC) among sex workers. The rationale for this is usually unexplained but is likely to be related to assumptions about pregnancy intentions and/or perceptions that motherhood is undesirable for this group of women. This may be perceived as part of a longer history of reproductive discrimination against women in marginalised groups [13]. It also suggests that sex workers are being seen as a homogenous group, with individual preferences overlooked. This study set out to ensure a better understanding of contraceptive preferences and interactions with service providers to ensure service provision is appropriate.

The overall aim of the study was to gain an in-depth understanding of the sexual health practices of online sex workers in the UK, particularly in the Birmingham and Solihull areas, with a focus on contraceptive methods used and associated interactions with service providers.

## **Methods**

The research was an interpretive multi-method study using the ‘following a thread’ technique to integrate quantitative and qualitative data [14]. Although it focused on online sex workers based in Birmingham and Solihull who advertised on the internet and had sexual contact with clients, it recruited across the UK. The study was carried out to inform service development in Birmingham and Solihull. As sex workers are a mobile population, however, it was felt important not to limit the geographic scope. Significant numbers of Romanian women undertaking sex work in Birmingham and Solihull.

Online sex workers completed an online survey (in English or Romanian) and participated in qualitative interviews which took place from March to September 2017. The survey questionnaire emphasised the focus on Birmingham and Solihull but indicated that participants from elsewhere were welcome to complete the survey. The survey also included specific questions on the use of Birmingham and Solihull services. Survey participants were recruited through advertising (e.g. contacting escort agencies and posting calls on social media) and via sex work support organisations. Apart from initial screening (for eligibility and to identify geographic location), all questions were optional, including those asking for demographic details, to address any privacy concerns. The survey asked a range of sexual health questions including about sources of sexual health information, contraception usage,

and use of service providers. Whilst advertising the study, and within the online survey, participants were asked if they would consider being interviewed. Interview participants were purposefully chosen to cover a range of online sex work experiences, including those managing others (i.e. an escort agency manager who was also an online sex worker). The interviews covered similar topics to the survey, aiming to add depth to the survey findings rather than being generalisable. The data presented here are from participants who stated they could physically become pregnant (67/102 in the survey and 8/10 during interviews). Recruitment to the Romanian version was low (10/102, of whom seven indicated they could become pregnant). The English language survey included closed and open questions, but to contain costs the Romanian version only had closed questions.

Participant information (with details necessary to ensure informed consent such as the remit, funding and ethics approval) was provided at the beginning of the online survey and on an information sheet for interviewees. After permission was obtained, interviews were audio recorded and transcribed verbatim or detailed notes were taken if recording was declined. The interviews were conducted by three researchers (PL, KP, and VW) who were all experienced in performing qualitative research. IBM SPSS, version 23 (IBM, Armonk, NY, USA), was used to analyse the quantitative data; cross-tabulations and  $\chi^2$  tests were used where appropriate. Thematic analysis of qualitative data (including survey open text responses) was undertaken by close reading, developing codes inductively from the data systematically, and then combining these into themes [15]. Quotations used here are verbatim. The study was given ethics approval by Aston University Ethics Committee.

## **Results**

A total of 62/67 survey participants provided demographic information (Table 1). Approximately half the respondents were aged 26-35. Just under a third of participants were from outside the UK and almost half of the sample identified as bisexual or queer. Sex workers chose interview locations (three in person and five via phone/Skype).

A large majority of respondents reported that they always used condoms with clients for vaginal sex: 59/67 (88%) for regular clients and 64/67 (96%) for new clients ( $p=0.116$ ). Only one participant stated that she never used condoms with clients. Condom use with non-commercial partners was less common: 10/67 (15%) with regular non-commercial partners

and 25/67 (37%) with casual non-commercial partners ( $p=0.003$ ). In the survey, only 3/67 (4%) indicated that they did not use another form of contraception in addition to condoms.

The most common method of pregnancy prevention (aside from condoms) was the contraceptive pill (Table 2). In interviews, the pill with condoms was identified as being a good combination to prevent both STIs and pregnancy. It also meant that periods were predictable, which was an important occupational issue. One participant commented: ‘The two main reasons to go on the pill are because then the periods are sorted, you haven’t got to worry about coming on when you’ve got someone booked because that’s awkward and then just because if the condom does break, you know that you’re protected that way.’ Other survey comments confirmed a separation between clients and partners. One respondent wrote: ‘Condoms at work, and in my personal life my partner has had a vasectomy.’ One interview participant was not using contraception with her partner as she was currently trying to conceive.

The survey asked participants about their interaction with health care providers for STI screening and contraception. The majority of participants reported use of a sexual health clinic or sex worker project for STI screening but general practitioner (GP) services for pregnancy prevention (Table 3). Open text responses and interview data also indicated that whilst STI transmission was considered an occupational risk (mitigated by routine condom use), pregnancy prevention was more of a private matter. Many comments mentioned longstanding use of GP practices for contraception, including: ‘I have always seen my GP about contraception and happy with them so do not feel the need to go elsewhere’ and ‘Went on the pill quite young and was not aware or comfortable going anywhere other than the GP.’

When participants had gone elsewhere, it was not necessarily out of choice. Comments included: ‘I would really like to go to my GP but that isn’t an option any more’ and ‘My GP is overbooked.’ Others were more positive about choosing a sexual health clinic as an understanding provider and source of specialist contraceptive knowledge: ‘They should know more’ and ‘It’s easier and less embarrassing for me.’ Negative experiences were also recorded in the survey about a lack of choice, including the promotion of LARC: ‘Should stop trying to push the implant on people who don’t want it. I’m fed up with being lectured about it.’

The majority of online sex workers did not disclose their occupation when accessing contraception. Excluding those who accessed contraception from a sex worker project, only

9/67 (13%) stated that they told their contraceptive provider that they were a sex worker. Reasons for non-disclosure centred around concerns about privacy and confidentiality, including not wanting their work listed on their health 'record'. One interviewee stated that she had not disclosed to her GP because: 'I do always worry because I have got a child and I worry about people's reactions and what they might think about how I live my life ... I don't want to discuss it.'

Some participants did not think their sex working status was relevant for GPs. Comments included: 'That would be irrelevant. Contraception should be reliable for everyone; they don't have to be different for sex workers.' One survey comment mentioned being treated 'like a pariah' when she disclosed her profession to her doctor, and another interview participant discussed a particularly inappropriate response from her GP when she disclosed it to him: 'He asked me about the job and then asked for my business card. Oh my God. Awful.' She said she felt that this was worse because it was 'my actual doctor that I've been going to since I was, like, a child'. Where online sex workers did disclose, it was likely to be at a sexual health clinic and/or because they wanted a specific service such as hepatitis vaccination.

## **Discussion**

### *Findings and Interpretation*

Online sex workers in this study were highly aware of STI risks associated with unprotected vaginal intercourse, but pregnancy prevention was predominately seen as an issue in their personal lives. The large majority of participants consistently used condoms with clients to minimise infection risks, and also frequently undertook STI screening.

Concerns about pregnancy prevention were complex. Whilst there is an acknowledged risk of pregnancy in sex work, it is mitigated by high rates of condom use. Pregnancy prevention with non-commercial partners was delivered by a variety of service providers, and over half of women obtained contraception from their GP. Many participants had always seen their GP for contraception. However, the cultural understanding of the GP as the 'family doctor' significantly decreased the likelihood of disclosing sex work. Some thought it was irrelevant, but others worried about privacy and stigmatisation. Particular concerns were raised by participants who had children, as disclosure threatened their position as 'good' mothers and increased fears of losing their children.

As contraception is not considered as solely an occupational issue, online sex workers are no more likely than the general population to find LARC methods acceptable. In addition, the need for regular periods may decrease the acceptability of methods associated with irregular bleeding. Moreover, some sex workers may be trying to conceive with a partner but trying to prevent pregnancy whilst working.

#### *Differences and similarities in relation to other studies*

This supports previous research findings that the routine use of condoms was seen as minimising the occupational risks involved in sex work including pregnancy [8,9]. We also found lower rates of condom use with non-commercial partners [8,10]; condom use was frequently seen as a significant demarcation between clients and partners [10]. High pill usage and low uptake of LARC among sex workers is broadly in line with the situation among the general population [16]. Previous research has also identified perception of condoms as not being considered to be ‘proper contraception’ for long-term relationships may explain their low use in private relationships [10,17]. The concerns about discourse, and in particular judgements about motherhood have fears consistent with previous reports [12].

#### *Strengths and weaknesses*

In this study, the survey was publicly advertised so the response rate is unknown. The representativeness is uncertain although broadly in line with other recent research [1]. The study limitations include a small, self-selected sample and limited engagement from non-British online sex workers.

#### *Relevance of the findings: implications for clinicians and policy-makers/health care providers*

The internet has profoundly changed a significant part of the organisation of sex work and it is important that health care providers understand these changes. Evidence from other studies suggests that online sex workers are often mobile, sexually diverse and have high levels of education [1]. Selling sex alone is not necessarily a cause of poor health or risky behaviour [18]. Street sex workers have been found to have more health issues, but these are associated with other issues such as drug dependency [18]. Despite this, sex workers are often treated as a homogenous population in which it is assumed that pregnancy prevention is of paramount



importance. This position is stigmatising and overlooks the fact that sex workers have non-commercial partners and may want to be mothers.

Research has shown that personalised contraceptive counselling based on individual women's needs and preferences is more likely to be effective [19], and this needs to be applied equally to sex workers. Specific targets for LARC may be inappropriate and risk further stigmatisation of sex workers.

#### *Unanswered questions and future research*

Additional research is needed to be able to better understanding the needs of migrant women in particular and to ensure the generalisability of these results

### **Conclusion**

In line with previous research, this study found high rates of condom use with clients, which meant that pregnancy was not considered a high occupational risk but was more an issue for personal lives. Nevertheless, considerations did include issues such as impact of menstruation on working. Stigma was considered a significant issue, and many online sex workers were reluctant to disclose their occupation to contraceptive providers. The study suggests that online sex workers are not a homogenous group and, rather than focusing on maximising pregnancy prevention (such as setting targets for LARC fitting), contraceptive preferences and provision need greater consideration at an individual level.

### **Data availability**

No data are available. Additional unpublished data from this study are unavailable, as they may identify participants.

### **Disclosure statement**

JDCR reports personal fees from GSK Pharma, Hologic Diagnostics, Mycovia and Janssen Pharma, as well as ownership of shares in GSK Pharma and AstraZeneca Pharma. He is author of the UK and European guidelines on pelvic inflammatory disease; a member of the European sexually transmitted infections guidelines editorial board; a member of the National Institute for Health Research (NIHR) Health Technology Assessment (HTA) Commissioning

Board; and a past member of the NIHR HTA Primary Care, Community and Preventive Interventions Panel (2013-2016). He is an NIHR journals editor and associate editor of *Sexually Transmitted Infections* journal. He is an officer of the British Association for Sexual Health and HIV (vice-president) and of the International Union against Sexually Transmitted Infections (treasurer).

CR is a member of the Clinical Governance Committee and Adolescent Special Interest Group for the British Association for Sexual Health and HIV.

VW is an employee of Taylor and Francis.

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### **Contribution statement**

PL was the principal investigator of the project and, with KP, contributed to the research concept, study design and data collection, analysis and reporting. HP and CR contributed to the study design and data reporting. JDCR contributed to the research concept, study design and data analysis and reporting. VW contributed to the study design and data collection, analysis and reporting. All authors commented on and approved this paper.

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Table 1. Demographic characteristics of survey participants, where provided (62/67).

Characteristic	<i>n</i> (%)
Age	
18-25	18 (29)
26-35	32 (52)
36-50	12 (19)
Gender	
Female	60 (97)
Non-binary/queer	2 (3)
Sexual orientation	
Straight	32 (52)
Bisexual	27 (44)
Queer	3 (5)
Nationality	
British	44 (71)
Romanian	7 (11)
Other EU	11 (18)
Sex work income	
Sole income	30 (48)
Regular, but other income	23 (37)
Infrequent	9 (15)

Table 2. Methods of contraception used in the last 5 years (other than condoms).

Method of contraception	<i>n</i> (%)
Contraceptive pill	41 (62)
Implant	11 (16)
IUD/LNG-IUS	10 (15)
Injection	6 (9)
Vaginal ring	4 (6)
Female condom	2 (3)
Diaphragm/cap	1 (2)
Patch	1 (2)
Condoms only <sup>a</sup>	3 (4)

Numbers may not add up to 100% as more than one selection was available.

<sup>a</sup>Including one participant who indicated that her non-commercial partner had had a vasectomy.

IUD, intrauterine device; LNG-IUS, levonorgestrel-releasing intrauterine system.

Table 3. Site of last STI screening and sources of contraception in last year.

Variable	<i>n</i> (%)
Site of last STI screening	
Sexual health clinic	43 (64)
Sex worker project	17 (25)
GP	3 (5)
Other	2 (3)
None	2 (3)
Total	67 (100)
Contraception provider <sup>a</sup>	
Sexual health clinic	22 (33)
Sex worker project	10 (15)
GP	34 (51)
Other	19 (2)

<sup>a</sup>Numbers may not add up to 100% as more than one selection was available.