Unmet health care needs among sex workers in five census metropolitan areas of Canada

Cecilia Benoit, PhD,[1] Nadia Ouellet, MA,[2] Mikael Jansson, PhD[3]

ABSTRACT

OBJECTIVES: This paper examines unmet health care needs in one of Canada's most hard-to-reach populations, adult sex workers, and investigates whether their reasons for not accessing health care are different from those of other Canadians.

METHODS: Data gathered in 2012–2013 from sex workers aged 19 and over (n = 209) in five Canadian census metropolitan areas (CMAs) were analyzed to estimate the perceived health, health care access and level of unmet health care needs of sex workers, and their principal reasons for not accessing health care. These data were collected using questions identical to those of the Canadian Community Health Survey (CCHS) Cycle 2.1, 2003. The results were compared with those of residents aged 19 and over in the same CMAs who had participated in the CCHS.

RESULTS: Sex workers reported notably worse perceived mental health, poorer social determinants of health (with the exception of income) and nearly triple the prevalence of unmet health care needs (40.4% vs. 14.9%). Those with the greatest unmet health care needs in both groups were younger, unmarried or single and in poorer health, and reported lower income and a weaker sense of community belonging. Even without these within-group risk factors, sex workers were more likely to report unmet health care needs compared with CCHS respondents. Sex workers were also more likely to identify "didn't get around to it", "too busy", "cost", "transportation problems" and "dislike doctors/afraid" as reasons for eschewing care.

CONCLUSION: Equity policies that reduce cost and transportation barriers may go some way in helping sex workers access needed health care. Qualitative research is needed to better understand the realities of sex workers' personal and work lives, including the degree of freedom they have in accessing health care when they need it, but also their experiences when they do manage to engage with the health care system.

KEY WORDS: Social determinants of health; access to health care; sex workers; unmet health care needs; barriers

La traduction du résumé se trouve à la fin de l'article.

Can J Public Health 2016;107(3):e266–e271
doi: 10.17269/CJPH.107.5178

Canada's health system aims for equity by guaranteeing access to needed health care irrespective of social position or personal circumstances. Yet surveys indicate that a substantial minority of Canadians report that their health care needs are not being met. In a 2003–2004 survey, 11.7% of Canadians reported unmet health care needs, defined as any instance that health care was not received when it was needed.[1] This was an increase from an estimated 4% in 1994–1995. Unmet health care needs are also more pronounced among people with low income; the homeless and vulnerably housed; sexual minorities; women; people with one or more mental disorders, substance dependence or co-occurring disorders; and adults with disabilities.[2–10]

The reasons people give for not accessing needed health care range from the cost and organization of health services to personal concerns and perceptions.[11] The most commonly reported barriers as worded in the Canadian Community Health Survey (CCHS) Cycle 1.1 are 1) "waiting time too long", 2) "service not available when needed", 3) "too busy", 4) "didn't get around to it/didn't bother", 5) "felt would be inadequate" and 6) "cost".[12] The salience of such barriers can vary with population characteristics; for instance Wu et al. found that from the same list of options immigrants were more likely than non-immigrants to claim "language problems", "felt would be inadequate" and "not knowing where to access care" as primary reasons for not accessing care.[13]

The unmet health care needs of adult sex workers, a hard-to-reach population, has received less attention. Some studies have found that sex workers in Canada and elsewhere are reluctant to seek conventional health services, with reasons such as conflicts with other life commitments, not being aware of health clinics in their community, negative past experiences when seeking health care, embarrassment, fear of judgement, and discrimination.[14–17] Yet small participant numbers and homogenous samples weaken the generalizability of this body of work. Other studies focus only on those working for supervisors (e.g., for escort agencies or massage parlours) or on independent escorts typically delivering services in their own home or the client's locale. As well, this

Author Affiliations

1. Scientist, Centre for Addictions Research of BC and Professor, Department of Sociology, University of Victoria, Victoria, BC
2. Research affiliate, Centre for Addictions Research of BC, University of Victoria, Victoria, BC
3. Scientist, Centre for Addictions Research of BC, University of Victoria, Victoria, BC

Correspondence: Cecilia Benoit, PhD, Scientist & Professor, Centre for Addictions Research of BC, University of Victoria, PO Box 1700, Victoria, BC V8W 2Y2, Tel: 250-853-3132, E-mail: cebenoit@uvic.ca
Acknowledgements: This research was funded by the Institute of Gender & Health, part of the Canadian Institutes of Health Research. We thank those who participated in the interviews; without their input, this work would not have been possible.
Conflict of Interest: None to declare.

© 2016 Canadian Public Health Association or its licensor.

literature uses few validated measures of key concepts and lacks comparison with other groups. Without comparative data it is impossible to understand the fundamental causes of health inequities faced by sex workers and develop policies to remove access barriers to material and social resources that may improve their health.[18,19]

Below we examine the level of unmet health care needs and perceived barriers to health care access of a non-probability sample of sex workers from five census metropolitan areas (CMAs) of Canada. We intentionally interviewed a diverse sample of participants who advertised for clients and delivered sexual services in a variety of settings. One in five respondents delivered services to clients at the street level, a quarter worked in some type of supervised situation, and the remainder worked off-street as independent escorts. Specifically, we asked: What are the similarities and/or differences in the prevalence of unmet health care needs and types of barriers experienced between sex workers and other adults residing in the same CMAs?

METHODS

Data

The data for this study were drawn from a multi-project community-based study that examined the perspectives and experiences of each of the following: 1) those who sell sexual services, 2) intimate partners of workers, 3) those who buy sexual services, 4) those who manage the services and 5) those involved in regulating the industry. Collaborators were organizations representing sex workers and individuals/organizations providing services to sex workers or generally interested in improving their health equity. Collaborators assisted in designing the multi-project study, aiding in the recruitment process and interpreting the results.

Respondents who sell sexual services, the focus of this paper, were 19 years or older at the time of interview, legally able to work in Canada and had received money in exchange for sexual services on at least 15 different occasions in the previous 12 months. The team decided on this “conservative” measure of sex worker because it was interested in understanding the factors linked to the health and safety of individuals who engaged in sex work at least on a part-time basis. Sexual exchange was defined as the exchange of sexual services for money, which necessarily, but not exclusively, includes direct physical sexual contact between a worker and a client.

Sex workers were interviewed in 2012–2013 in six CMAs: St. John’s, NL; Montréal, QC; Kitchener (including Waterloo and Cambridge), ON; Wood Buffalo (Fort McMurray), AB; Calgary, AB; and Victoria, BC. These research sites were selected from a sample of 93 Canadian CMAs on the basis of 14 census measures that reflect six social and institutional factors. Our objective was to represent the diversity of social, political and cultural contexts that are likely to affect the organization and practices relating to the sex industry in Canada. For example, there is considerable variation in the percentage of the population who are visible minorities, in social/cultural homogeneity as measured by ethnic concentration, in population mobility (i.e., the percentage of people who report a dwelling change in the past year), in educational level and in median household incomes. A variety of purposive sampling strategies were employed to locate a diverse sample of adult workers for face-to-face interviews. These strategies included contacting by phone and e-mail those escorts advertising online; advertising the study in local newspapers; placing study notices in sex work-related websites and on bulletin boards in sex worker outreach agencies, social support offices and health clinics; and respondent-driven sampling. Interviews lasted 1.5 hours on average, and respondents each received an honorarium of $60. The project was approved by the research ethics board at the University of Victoria. For this analysis, we are excluding the Wood Buffalo site because of too few participants to conduct comparisons that would result in valid and reliable conclusions. Our final sample for analysis was 209 respondents about evenly distributed across five CMAs.

The closed-ended component of the sex worker survey included a range of questions that were taken from the CCHS Cycle 2.1, 2003, including whether respondents had experienced an unmet health care need in the previous 12 months and, if yes, what were the reason(s) why, given a list of options.[20] The CCHS 2.1 survey collected information from 134,072 respondents (in all provinces and territories). For this paper, we weighted the CCHS data to represent the Canadian population 19 years of age and over residing in the five relevant CMAs. The primary reason for choosing our questions from this earlier survey rather than the CCHS 2010 (which is much closer to the time when we developed the questionnaire for our sex workers study) is that the CCHS 2.1 includes “transportation problems” and “dislike doctors/afraid” as reasons for forgoing needed health care, whereas the CCHS 2010 survey excludes them; both lack of health services and fear of discrimination are highlighted in the sex work literature as potential major barriers to health care.[14–17]

In an attempt to control for time variance in reasons for perceived health need, we compared relevant results from the 2003 and 2010 CCHS with regard to the reasons for unmet need, which were items present in both surveys (analysis available on request). While there was a slight increase in the prevalence of unmet health care needs between the earlier and later periods (14.9% vs. 17.2%), there were no significant differences in the proportion of the two main reasons for unmet need (“waiting time too long” and “not available when required”) between the CCHS 2003 and 2010 surveys in the five CMAs. There were significant decreases in the prevalence of two minor barriers “didn’t get around to it” (from 8.6% to 4.3%) and “cost” (from 10.3% to 5.7%). As we will show below, a significantly greater percentage of sex workers said “didn’t get around to it” and “too busy” when compared with the higher CCHS 2003 figures. These comparative findings support the validity of the comparison between the important barriers in our 2012–2013 data and the data in CCHS cycle 2.1, which we report on next.

Study variables

Dependent Variable

The dependent variable, *unmet health care needs,* was measured in our survey by asking: “How often in the previous 12 months did you feel you needed health care but did not receive it?” Response categories were never, rarely, sometimes, a lot of the time, almost every time and all the time. The latter five categories were collapsed into a single category “ever” to allow for comparisons with the CCHS 2.1, which asked respondents: “In the previous 12 months,

did you [ever] feel you needed health care but did not receive it?" Respondents in both the CCHS 2.1 and our survey were asked to choose from a list of 13 options to describe why they did not access health care (multiple responses were allowed): "wait time too long", "not available when required", "not available in the area", "cost", "transportation problems", "too busy", "didn't get around to it", "didn't know where to go", "felt it would be inadequate", "dislike doctors/afraid", "personal/family responsibilities", "language problems" and "other".

Socio-demographic Factors

We analyzed several socio-demographic characteristics that are important determinants of the need for health care: age (years) as a continuous variable; education (defined as completed high school vs. not); marital status (currently married/common-law, single, widowed/separated/divorced/other); visible minority (people, other than Aboriginal peoples, who do not identify as Caucasian or "white"); Aboriginal ancestry (refers to First Nations, Métis and Inuit peoples); gender (women/men/trans people).

The respondents in our survey were defined as women or men on the basis of their current gender identity in their personal life. Respondents were defined as trans people if they self-identified as transwomen, transmen, transitioning, intersex, gender queer, androgynous, or as having a fluid gender identity.[7]

Material and Social Resources

We used income and sense of community belonging as proxies for resources that impede or enable the use of health care services. We assessed income by asking respondents to state their personal income (before taxes) for the previous year, including all declared and undeclared income sources (including sex work). Sense of community belonging involved respondents' sense of belonging to their local community during the previous 12 months, with four options: very strong, somewhat strong, somewhat weak, very weak. The categories very strong and somewhat strong were grouped together and coded as "strong", and the categories somewhat weak and very weak were grouped together and coded as "weak" for ease of comparison with the CCHS, which used the same options.[21]

Perceived Health Need

People experiencing poor health tend to have a greater need for health care. We measured perceived health using two self-rated measures, one for general health and one for mental health (excellent, very good, good, fair and poor).

Analysis procedures

We used bivariate analysis to compare the following metrics for sex workers with the CCHS respondents: prevalence of unmet health care needs, correlation between needs and socio-demographic indicators, self-reported health status and sense of community belonging, and prevalence of reported barriers to accessing care. We used conventional tests for statistically significant differences between proportions and means.[22] All analyses of CCHS data were conducted in a Statistics Canada Secure Data Centre.

RESULTS

As shown in Table 1, compared with CCHS respondents from the same CMAs, adults working in the sex industry reported a higher prevalence of socio-demographic characteristics related to structural disadvantage: they were significantly more likely to self-identify as Aboriginal, to be younger and to identify themselves as women; they were less likely to have completed high school and less likely to be married. Regarding material and social resources, sex workers were less likely to report a strong sense of belonging in their local community but reported higher personal incomes than the CCHS average. Self-reported overall health and mental health followed a similar pattern: sex workers were significantly less likely than CCHS respondents to report good or excellent general health (53.8% vs. 72.0%) as well as mental health (39.4% vs. 77.0%). Finally, sex workers' unmet health needs were significantly higher than CCHS respondents' (40.4% vs. 14.9%).

Our next task was to determine which population characteristics and related factors were linked to unmet health care needs and to report any differences in this regard between sex workers and CCHS respondents (see Table 2). With the exception of two categories in which comparisons were either not possible because of missing data (i.e., trans people did not self-identify in the CCHS 2.1) or were based on a very small number of respondents (i.e., widowed/separated/divorced/other in the sex worker sample), all comparisons showed that a significantly greater percentage of sex workers had unmet health care needs than the corresponding Canadians in the five CMAs studied.

As indicated in Table 3, many of the most common barriers to health care identified by sex workers were also reported by CCHS respondents, including "waiting time too long", "not available when required", "not available in the area", "decided not to seek care" and "felt it would be inadequate". However, sex workers were significantly more likely to identify "didn't get around to it/didn't bother", "too busy", "cost", "transportation problems" and "dislike doctors/afraid".

Table 1. Socio-demographic and health profiles of sex workers and those aged 19 through 60 in five census metropolitan areass

	Sex workers (*N* = 209)	CCHS 2.1
Race/ethnicity		
Aboriginal	17.7%	0.7%**
Visible minority	11.5%	12.7%
Other	70.8%	86.5%**
Age (years)		
Mean	34.0	38.8**
Median	33.0	42.0
Female	76.1%	50.0%**
Marital status		
Married/common law	30.6%	61.4%**
Single	57.9%	29.3%**
Widowed, separated, divorced, other	11.5%	9.3%
Completed high school	70.8%	88.9%**
Annual personal income, before taxes		
Mean	$49,080	$37,830**
Median	$36,500	$30,000
General health (very good or excellent)	53.8%	72.0%**
Mental health (very good or excellent)	39.4%	77.0%**
Community belonging (very/somewhat strong)	45.2%	52.8%*
Unmet health care needs	40.4%	14.9%**

Notes: CCHS, Canadian Community Health Survey. CCHS weighted sample size: 3,344,000; standard errors calculated using unweighted sample size.
* $p < 0.05$; ** $p < 0.01$.

Table 2. Unmet health care needs (previous 12 months) by selected characteristics, sex workers and CCHS respondents

	Sex workers (*N* = 209) (%)	CCHS 2.1 (%)
Age (years)		
20–29	45.5%	17.7%**
30–39	39.7%	14.8%**
40–49	26.7%	14.0%*
Gender		
Men/male	39.2%	13.5%**
Women/female	38.9%	16.4%**
Trans persons	57.1%	N/A
Marital status		
Married/common law	39.7%	14.0%**
Single	43.0%	16.0%**
Widowed/separated/divorced/other	29.2%	17.5%
Education		
Did not complete high school	45.0%	14.9%**
Completed high school	38.5%	15.1%**
Personal annual income (before taxes)		
$1,000–$14,999	53.3%	17.5%**
$15,000–$29,999	35.4%	17.3%**
$30,000–$49,999	39.1%	13.8%**
$50,000–$79,999	43.2%	13.4%**
$80,000+	35.0%	11.0%**
General health		
Very good/excellent health	33.0%	12.4%**
Good/fair/poor health	49.0%	19.6%**
Mental health		
Very good/excellent health	28.0%	12.7%**
Good/fair/poor health	48.4%	22.7%**
Community belonging		
Very/somewhat strong	33.0%	12.3%**
Very/somewhat weak	46.5%	18.1%**

Notes: CCHS, Canadian Community Health Survey; CCHS weighted sample size: 3,344,000; standard errors calculated using unweighted sample size.
*$p < 0.05$; ** $p < 0.01$.

Table 3. Reasons for unmet health care needs, sex workers and CCHS respondents

	Sex workers (*N* = 84) (%)	CCHS 2.1 (%)
Waiting time too long	35.7%	41.3%
Didn't get around to it/didn't bother	28.6%	8.6%**
Too busy	25.0%	8.8%**
Not available when required	19.0%	18.2%
Cost	19.0%	10.3%*
Dislike doctors/afraid	16.7%	2.1%**
Transportation	17.9%	0.9%**
Decided not to seek care	13.1%	7.6%
Not available in area	8.3%	6.5%
Felt it would be inadequate	8.3%	8.8%
Didn't know where to go	4.8%	3.4%
Personal/family responsibilities	3.6%	1.4%
Language problems	1.2%	0.5%
Other	31.0%	1.6%**

Notes: CCHS, Canadian Community Health Survey; CCHS weighted sample size: 499,000; standard errors calculated using unweighted sample size.
*$p < 0.05$; ** $p < 0.01$.

DISCUSSION

In this study, we sought to better understand the prevalence of and factors associated with the unmet health care needs of a non-probability sample of adult sex workers and CCHS respondents in five Canadian CMAs. Within a trend of increasing unmet health needs in Canada,[4] our findings suggest that sex workers were almost three times more prone to missing needed health care than were CCHS respondents. In fact, the sex workers in our study were more likely to report unmet health care needs than several other subpopulations, including people with chronic illness, young adults, people with a mental health disorder, and the homeless and precariously housed.[6,9,23–25]

Importantly, sex workers were significantly more likely to report unmet health care needs than CCHS respondents across nearly all of the demographic groups, supporting the appropriateness of a social determinants of health perspective for understanding the multiple overlapping health inequities faced by sex workers in Canada.[18,19,25] Those with the greatest unmet health care needs in both groups were younger, unmarried or single and in poorer health, and reported lower income and a weaker sense of community belonging. These groups have been shown to be at greater risk of experiencing unmet health care needs in other studies.[2,26,27] Yet even without these within-group risk factors, sex workers were more likely to report unmet health care needs compared with CCHS respondents. Although trans sex workers were more likely than other sex workers to report unmet health care needs, there was no trans gender identity option in Statistics Canada's surveys to allow for comparison. Notably, the PULSE Project in Ontario has documented the difficulties that people who are trans/nonconforming face in attempting to access health care services; these barriers include identifying information and institutional "trans-erasure".[7]

Despite having greater personal incomes, on average, sex workers were more likely to identify cost and transportation problems – barriers typically associated with lack of wealth. A possible explanation for apprehension about cost may be that sex workers' health care needs are disproportionately related to counselling, prescription drugs and other therapies not covered by public health insurance. This explanation may be supported by the high prevalence of poor mental health in our sample. Further, employee extended health plans are rare in the sex industry, possibly resulting in prohibitive out-of-pocket costs.

As for transportation, a possible explanation is that sex workers may experience reduced access to credit (as a result of not being recognized as having a legitimate occupation), which impedes car ownership; more than one in four respondents in our study reported discrimination when getting credit, bank loans or a mortgage (data not shown). Another likely explanation that would need support from in-depth qualitative analysis may be that the circumstances of their work and personal lives are such that they do not have the freedom to leave their work and seek health care when needed (more likely for those working in supervised situations) or that their familial and other responsibilities prevent them from seeking care, especially if it is at a distance from their home or place of work. Further, since sex workers reported, on average, a weak sense of community belonging, many may not have personal connections to facilitate transportation. In short, while transportation as a substantial barrier to health care access could be, to some extent, mitigated by stronger transportation policy as well as place-based health care service design, we need also to investigate more complex processes and contexts that might diminish these barriers.[28]

Sex workers' comparatively elevated dislike of doctors or fear of services was another salient difference from CCHS respondents.

Research on unmet health care needs among Canadians who are homeless and vulnerably housed or have co-occurring mental and substance use disorders has also called attention to anticipation of negative experience in health care seeking.[6,9] In one of our earlier studies, sex workers reported worse health than that of other frontline service workers and greater negative judgement from doctors and other health care providers.[29,30] A recent needs assessment of street-based sex workers in different regions of Ontario reported that judgemental health care and social service providers was the single most important reason for not accessing services.[14] Future analyses should investigate the link between fear of judgement, disclosure of sex work involvement and experiences of discrimination when health services are accessed.

CONCLUSION

There are limitations to our study, including potential self-reporting bias in personal interviews and the cross-sectional nature of the data. Although health and social services systems vary across provinces and may influence our interpretations, it is not possible to control for such geographic variation. Finally, quantitative data such as those reported here do not provide a means to explore further what sex workers mean when they say their health care needs are unmet and why. We hope to address this latter concern in a subsequent analysis of sex workers' narratives of health care encounters.

These limitations should not discourage development of policy to help reduce the formidable cost and transportation barriers faced by less advantaged sex workers. Recent efforts to expand community-based centres offering a variety of harm-reduction and preventive health and social services may reduce personal costs and improve sex workers' access to family doctors, nurse practitioners and mental health providers. Recent public funding and increased availability of health services for trans sex workers are also positive steps forward. At the same time there is an urgent need to better understand why sex workers report they are "too busy", "don't get around to it", or "dislike doctors/afraid" as barriers to accessing needed care.

REFERENCES

1. Carr W, Wolfe S. Unmet needs as sociomedical indicators. *Int J Health Serv* 1976;6(3):417–30. PMID: 955751. doi: 10.2190/MCG0-UH8D-0AG8-VFNU.
2. Williamson DL, Stewart MJ, Hayward K, Letourneau N, Makwarimba E, Masuda J, et al. Low-income Canadians' experiences with health-related services: Implications for health care reform. *Health Policy* 2006;76(1):106–21. PMID: 15978694. doi: 10.1016/j.healthpol.2005.05.005.
3. Allin S, Grignon M, Le Grand J. Subjective unmet need and utilization of healthcare services in Canada: What are the equity implications? *Soc Sci Med* 2010;70(3):465–72. PMID: 19914759. doi: 10.1016/j.socscimed.2009.10.027.
4. Sibley L, Glazier R. Reasons for self-reported unmet healthcare needs in Canada: A population-based provincial comparison. *Healthc Policy* 2009; 5(1):87–101. PMID: 20676253.
5. Wallace B, MacEntee M. Access to dental care for low-income adults: Perceptions of affordability, availability and acceptability. *J Commun Health* 2012;37:32–39. PMID: 21590434. doi: 10.1007/s10900-011-9412-4.
6. Argintaru N, Chambers C, Gogosis E, Farrell S, Palepu A, Klodawsky F, et al. A cross-sectional observational study of unmet health needs among homeless and vulnerably housed adults in three Canadian cities. *BMC Public Health* 2013;13(1):577. PMID: 23764199. doi: 10.1186/1471-2458-13-577.
7. Bauer G, Pyne J, Francino M, Hammond R. Suicidality among trans people in Ontario: Implications for social work and social justice. *Serv Soc* 2013; 59(1):35–62. doi: 10.7202/1017478ar.
8. Bryant T, Leaver C, Dunn J. Unmet healthcare need, gender, and health inequalities in Canada. *Health Policy* 2009;91:24–32. PMID: 19070930. doi: 10.1016/j.healthpol.2008.11.002.
9. Urbanoski KC, Bassani D, Rush B. Perceived unmet need for mental health care for Canadians with co-occurring mental and substance use disorders. *Psychiatr Serv* 2008;59(30):283–89. PMID: 18308909. doi: 10.1176/ps.2008.59.3.283.
10. McColl MA, Jarzynowska A, Shortt SED. Unmet health care needs of people with disabilities: Population level evidence. *Disabil Soc* 2010;25(2):205–18. doi: 10.1080/09687590903537406.
11. Andersen RM. Revisiting the behavioral model and access to medical care: Does it matter? *J Health Soc Behav* 1995;36:1–10. PMID: 7738325. doi: 10. 2307/2137284.
12. Cheng J, Hou F. Unmet needs for health care. *Health Rep* 2002;13(2):23–34. PMID: 12743954.
13. Wu Z, Penning MJ, Schimmele CM. Immigrant status and unmet health care needs. *Can J Public Health* 2005;96(5):369–73. PMID: 16238157.
14. Neal N, Schrader T, Hyndman J, Boyce B, Phillips D, Smith R, et al. Street Based Sex Workers Needs Assessment – Toronto, Barrie, and Oshawa. Toronto, ON: Street Health and Regent Park Community Health Centre, 2014. Available at: http://www.streethealth.ca/downloads/sex-workers-needs-assessment.pdf (Accessed June 12, 2014).
15. Lazarus L, Deering KN, Nabess R, Gibson K, Tyndall MW, Shannon K. Occupational stigma as a primary barrier to health care for street-based sex workers in Canada. *Cult Health Sex* 2012;14(2):139–50. PMID: 22084992. doi: 10.1080/13691058.2011.628411.
16. Jeal N, Salisbury C. Self-reported experiences of health services among female street-based prostitutes: A cross-sectional survey. *Br J Gen Pract* 2004;54: 515–19. PMID: 15239913.
17. Scorgie F, Nakato D, Harper E, Richter M, Maseko S, Nare P, et al. We are despised in the hospitals: Sex workers' experiences of accessing health care in four African countries. *Cult Health Sex* 2013;15:450–65. PMID: 23414116. doi: 10.1080/13691058.2012.763187.
18. Marmot M, Friel S, Bell R, Houweling TA, Taylor S, Commission on Social Determinants of Health. Closing the gap in a generation: Health equity through action on the social determinants of health. *Lancet* 2008; 372(9650):1661–69. PMID: 18994664. doi: 10.1016/S0140-6736(08)61690-6.
19. Whitehead M, Dahlgren G. *Concepts and Principles for Tackling Social Inequities in Health: Levelling up Part 1*. Copenhagen, Denmark: WHO Europe, 2006.
20. Canadian Community Health Survey (CCHS) 2003. *User Guide for the Public-Use Microdata File*. Ottawa, ON: Statistics Canada, Health Statistics Division, 2005.
21. Statistics Canada. Health Profile, December 2013. Catalogue no. 82-228-XWE, 2013.
22. Knoke D, Bohrnstedt GW. *Basic Social Statistics*. Adelaide, Australia: FE Peacock Pub, 1991.
23. Ronksley PE, Sanmartin C, Quan H, Ravani P, Tonelli M, Manns B, et al. Association between chronic conditions and perceived unmet health care needs. *Open Med* 2012;6(1):e48–58. PMID: 23696769.
24. Marshall EG. Do young adults have unmet healthcare needs? *J Adolesc Health* 2011;49(5):490–97. PMID: 22018563. doi: 10.1016/j.jadohealth.2011.03.005.
25. Public Health Agency of Canada. *What Makes Canadians Healthy or Unhealthy?* Ottawa, ON: Public Health Agency, 2013.
26. Remschmidt H, Belfer M. Mental health care for children and adolescents worldwide: A review. *World Psychiatry* 2005;4:147–53. PMID: 16633533.
27. Allin S, Masseria C. Unmet Need as an Indicator of Health Care Access. Brussels, Belgium: The London School of Economics and Political Science, 2009. Available at: http://www.ec.europa.eu/social/BlobServlet?docId=4741&langId=en (Accessed XX, 2009).
28. Syed ST, Gerber BS, Sharp LK. Traveling towards disease: Transportation barriers to health care access. *J Commun Health* 2013;38(5):976–93. PMID: 23543372. doi: 10.1007/s10900-013-9681-1.
29. Benoit C, McCarthy B, Jansson M. Occupational stigma and mental health: Discrimination and depression among front-line service workers. *Can Public Policy* 2015;41(Suppl 2):S61–69. doi: 10.3138/cpp.2014-077.
30. Benoit C, McCarthy B, Jansson M. Stigma, sex work, and substance use: A comparative analysis. *Sociol Health Illn* 2015;37(3):437–51. PMID: 25688450. doi: 10.1111/1467-9566.12201.

Received: June 20, 2015
Accepted: February 14, 2016

RÉSUMÉ

OBJECTIFS : Examiner les besoins de soins de santé insatisfaits dans l'une des populations les plus difficiles à atteindre du Canada, les travailleuses et travailleurs du sexe d'âge adulte, et déterminer si les raisons pour lesquelles ces personnes ne se prévalent pas des soins de santé sont différentes de celles d'autres Canadiens.

MÉTHODE : Nous avons analysé des données recueillies en 2012–2013 auprès de travailleuses et de travailleurs du sexe de 19 ans et plus (n = 209) dans cinq régions métropolitaines de recensement (RMR) canadiennes afin d'estimer leur santé perçue, leur accès aux soins de santé et le niveau de

leurs besoins de soins de santé insatisfaits, ainsi que leurs principales raisons de ne pas accéder aux soins de santé. Les données ont été recueillies à l'aide de questions identiques à celles du cycle 2.1 de l'Enquête sur la santé dans les collectivités canadiennes (ESCC) de 2003. Nous avons comparé leurs réponses à celles de résidents de 19 ans et plus vivant dans les mêmes RMR et ayant participé à l'ESCC.

RÉSULTATS : Les travailleuses et travailleurs du sexe ont fait état d'une santé mentale perçue remarquablement moins bonne, de moins bons déterminants sociaux de la santé (à l'exception du revenu) et de près de trois fois la prévalence de besoins de soins de santé insatisfaits (40,4 % c. 14,9 %). Les répondants des deux groupes ayant le plus de besoins de soins de santé insatisfaits étaient plus jeunes, non mariés ou célibataires et en moins bonne santé, et ont fait état d'un revenu inférieur et d'un moindre sentiment d'appartenance communautaire. Même sans ces facteurs de risque à l'intérieur des groupes, les travailleuses et travailleurs du sexe étaient plus susceptibles de dire avoir des besoins de soins de santé insatisfaits que les répondants de l'ESCC. Les travailleuses et travailleurs du sexe étaient aussi plus susceptibles d'indiquer les réponses « N'a pas eu l'occasion de s'en occuper », « Trop occupé-e », « Coût », « Problème de transport » et « Aversion pour les médecins/peur » pour expliquer leur évitement des soins.

CONCLUSION : Les politiques d'équité qui réduisent les obstacles du coût et du transport peuvent en partie aider les travailleuses et travailleurs du sexe à accéder aux soins de santé dont ils ont besoin. Il faudrait faire de la recherche qualitative pour mieux comprendre les réalités de la vie personnelle et professionnelle de ces personnes, notamment leur degré de liberté lorsqu'il s'agit d'obtenir des soins de santé lorsque c'est nécessaire, mais aussi leurs expériences quand elles réussissent à interagir avec le système de soins de santé.

MOTS CLÉS : déterminants sociaux de la santé; accès aux soins médicaux; travailleuses et travailleurs du sexe; besoins de soins de santé insatisfaits; obstacles

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.