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"It Is Important for Everyone as Humans to Feel Important, *Right*?" Findings from a Community-Based Participatory Needs Assessment with Street-level Sex Workers

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ABSTRACT

A community-based participatory research design informed the development and conduct of a needs assessment with street-level sex workers within a mid-sized city in Ontario, Canada. The research question was: What would help street-level sex workers to live with enhanced safety and dignity within their community? Twenty-four women who accessed a peer-driven drop-in center (SafeSpace) participated in in-depth interviews. Observational data of items requested by women who accessed SafeSpace were also documented over a 6-month time period. The overarching theme of relationships was identified as vital to participants' ability to live and work with enhanced safety and dignity in their community. Subthemes included: *Informal/formal surveillance*: Relationships to public space(s); *Nowhere to go for us*: Relationships with/in community services; and *You're given the time you need*: Relationships in a peer-driven drop-in center for/with/by sex workers. Our findings demonstrate how central relationships are, particularly peer, to enhancing or diminishing sex workers' sense of dignity, self-worth, safety, and enhanced their access to services.

KEYWORDS

Public health; needs assessment; street-level sex work; health promotion; community-based research

Introduction

Street-level sex work (SLSW) involves the exchange of sexual services for resources related to basic survival, which may include money, shelter, drugs, or other commodities (Shannon, Kerr, Bright, Gibson, & Tyndall, 2008). Within Canada, where selling sexual services is purported to be legal, it remains criminalized by virtue of the fact that all associated activities are illegal (Klambauer, 2017), including communicating in public with potential clients, the purchase of sexual services performed by others, and profiting or benefiting materially from income obtained from others' sexual services (Bill C-36, the Protection of Communities and Exploited Persons Acts, s.286.2, 2014). The lack of public awareness regarding how the Canadian Criminal Code plays out in the lives of sex workers, the criminalization of sex work, and the moral judgments attached to sex work fuels the stigmatization of sex workers and contributes to their social exclusion, vulnerability, and risk of violence and harassment from police, clients, and the public at large (Shannon, 2010; Vanwesenbeeck, 2017). The discriminatory context of sex work drives SLSW into more isolated areas, truncates screening time

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with potential clients, and deters workers from seeking help from police and health-care providers when needed (Bodkin, Delahunty-Pike, & O'Shea, 2015; Howard, 2019; Kurtz, Surratt, Kiley, & Inciardi, 2005; Lowman, 2000; Orchard, Farr, Macphail, Wender, & Young, 2012; Shannon, 2010).

When compared with other locations where sex trade activities occur (e.g. adult entertainment facilities, massage parlors), the public nature of SLSW leads to perpetual policing and highly scrutinized working conditions. SLSW is characterized by repeated acts of coercion, exploitation, surveillance, and violence at the hands of "johns"/clients, pimps, fellow workers, service providers, the police, and the community at large (Krüsi, Kerr, Taylor, Rhodes, & Shannon, 2016; Reid, 2011; Wright, Heynen, & van de Meulen, 2015). Furthermore, sex workers are often housed precariously. A lack of affordable, safe housing creates a dependency on community services and overburdened shelter systems, which obliges women into all gendered transitional housing where violence against them by fellow residents frequently occurs (Lazarus, Chettiar, Deering, Nabess, & Shannon, 2011).

Such occupational risks are not inherent to SLSW but are generated at the intersections of complex social, political, legal, and health policies that make it nearly impossible for sex workers to take precautions to enhance their safety (e.g. work indoors), without fear of negative consequences (e.g. eviction, arrest, loss of privacy, harassment). In many respects, sex workers' heightened risk of victimization is a consequence of punitive laws and widespread stigmatization directed at them from every direction. This is particularly true for sex workers and those who exchange sexual services who are Indigenous women (Sayers, 2017), and for others who face systemic discrimination and inequities because of rampant homophobia, transphobia, racism, agism, and ableism (Shannon et al., 2008).

The legal status of sex work has specifically been highlighted as a key indicator in shaping patterns of violence in the lives of sex workers around the world (Amnesty International, 2016; Deering et al., 2014). Nearly all policing and anti-prostitution concerns are directed toward SLSW, which has garnered considerable critique from activists, academics, sex workers, and non-governmental organizations. Such groups have documented how the laws governing sex work have resulted in more isolated working conditions, less ability to screen clients effectively, less ability to access and implement needed supplies (e.g. condoms), and a reluctance among sex workers to seek assistance from authorities when needed (Krüsi et al., 2014). A recently published systematic review concluded that there is considerable evidence demonstrating the extensive harms associated with the criminalization of sex work, highlighting the tactics used by law enforcement to "end demand", such as arresting clients of sex workers (Platt et al., 2018) and releasing their names to the public. Additionally, sex workers are being caught up in mainstream initiatives aimed at eradicating exploited and coerced sexual labor, framed by prohibitionists as sex trafficking. Efforts by prohibitionists are directed toward preventing any form of exchanging sexual labor for money or other resources, by equating sex work with violence by men, against women and girls (Jackson, 2016).

These policies construct contradictory identities of sex workers as simultaneously "criminal", "sexually deviant", and "victim". For each identity, sex workers have a different set of interventions deployed at them. For instance, when sex workers are positioned as criminals, they are subjected to surveillance, prosecution, and detainment. When sex workers are seen as sexually deviant, then a host of psychiatric interventions are aimed toward rehabilitating their "maladaptive" behaviors. When sex workers are perceived as victims, resources are made available premised on the need to "rescue" them from their circumstances (Jackson, 2016). Each intervention is delivered as a "corrective moment", with the intent to divert individuals away and out of sex work (Wahab, 2006; Wahab & Panichelli, 2013).

The overwhelming majority of public health research on SLSW has typically focused on biomedical issues of disease transmission and prevention (e.g. HIV/Aids and HepC) and health surveillance. This narrow focus serves to deepen the stigma workers face as "vectors of disease" (Nova, 2016; Pirkle, Soundardjee, & Stella, 2007), while ignoring how structural arrangements contribute to an increased risk of contracting a sexually transmitted infection (STI). For instance, the way sex workers are subjected to surveillance practices (i.e. the presence of Closed Circuit Television Cameras (CCTV)) increases both their visibility and criminalization, which may deter workers from accessing those services (Wright et al., 2015). Furthermore, policing practices aimed at

repressing sex work through the arrest of clients has been identified as increasing condomless sex and is associated with increased risk of sexual/physical violence (Platt et al., 2018). More recently, the focus of public health research has widened to include evaluations of harm reduction initiatives, such as needle exchange and overdose prevention sites (Tait & Woo, 2017), and health interventions aimed to exit women out of the sex trade (Farley & Kelly, 2000).

Furthermore, the majority of Canadian sex worker research is conducted in larger urban settings, such as Toronto, Vancouver, and Montreal. As a result, sex work in medium-sized (100,000–1 million) Canadian cities is not well understood (Orchard et al., 2012). This lack of research results in local service providers and policymakers developing health and social programming informed by research findings that do not account for the experiences of workers or the contextual factors of relevance in smaller communities (Orchard et al., 2012). Furthermore, there are also the political realities of the day, economic constraints, lobbyists, habits, traditions, and values within communities and among service providers that define what is constructed as a "need". These various stakeholders make decisions about how provisions of services are allocated, how services are provided, who provides such services and to whom.

The purpose of this community-based participatory research (CBPR) study was to develop and conduct a needs assessment with SLSWs who accessed a drop-in center for sex workers in a medium-sized urban setting in Southern Ontario. In this article, findings demonstrated that sex workers' needs centered around relationships: relationships to public space(s); relationships with/in community services; relationships to a drop-in center for sex workers; and relationships to one another and to one's self.

Methodology

The conduct of a community-based participatory research (CBPR) study is underpinned by our commitment to social justice and harm reduction (Bagley, 2003), and an ontological position that people living an experience are the experts at their own lives and should control the processes of change (Peralta, 2017). Furthermore, CBPR shifts research away from a realist perspective of reality, toward a relativist epistemology wherein knowledge is understood to be subjective, tentative, conditional, and mediated (Blumer, 1969). The adoption of a CBPR approach recognizes that sex workers have the greatest vantage point to articulate their needs, and have not only the capacity to identify problems but offer pragmatic solutions to the problems that affect their working conditions, health and well-being of themselves, and the wider sex worker community (Jeffreys, 2009).

Within CBPR, partners contribute their expertise and share responsibilities and ownership of the research process to increase understanding of a given phenomenon, and incorporate the knowledge gained into action (Israel, Schulz, Parker, & Becker, 2001). The tenets of CBPR reflected in the design of this study and tailored to working alongside sex workers in our community were as follows: (1) the recognition that sex workers are a community that has cumulative strengths and resources; (2) the use of processes involving collaborative engagement of all partners in all phases of the research; (3) knowledge and action generated throughout the study was integrated to the benefit of all partners; (4), a co-learning environment that supported empowerment of study participants; (5) a cyclical and iterative data collection and analyses process; (6) dissemination of research findings to and with all participants (as desired) would occur in ways that respected workers' preferences; and (7) a long-term commitment was made by all toward identifying services and other forms of support and resources that could address the needs of sex workers in an effective and sustainable manner.

The final direction of the research purpose, research question, and intended outcomes were determined in partnership between academic and peer researchers, and sex workers through a 2-month iterative process of determining priorities and considering what was feasible. The resultant research question that guided this study was: *What would help street-level sex workers to live and work with enhanced dignity and safety in our community?* Prior to recruitment, ethics approval was obtained from the research ethics boards of researchers' home institutions.

Methods

Setting

Since 2009, SafeSpace London has operated as the only sex-worker specific organization within the community, offering continuous services with, to and for women and gender non-conforming individuals in a peer-driven approach that respects individuals' right to self-determination. While other organizations within the study's community provide services geared toward sex workers, these are housed in organizations with a broader mandate of addressing the needs of marginalized women. Drop-in hours occur at the space Monday and Tuesday evening from 6:00pm to 11:00pm, where harm-reduction supplies (e.g. clean needles, condoms and lubrication, and information on safety), companionship, cosmetics, food, infant formula, clothing, and personal hygiene products are provided. Outside of the drop-in hours, peer support may be provided in the way of court accompaniment, attendance at appointments with various service providers, and advocacy with organizations such as child protection and landlords. SafeSpace is operationally reliant entirely on money received through donations and fundraising, and all services are provided on a voluntary basis. Donations of clothing, toiletries, and harm reduction supplies from various individuals and organizational allies from within the community are provided to SafeSpace. SafeSpace is situated in an area depicted in the media and in popular opinion, as ridden with crime, with higher rates of poverty, and open drug use (Orchard et al., 2012).

Recruitment

A purposive, convenience sampling strategy with network and snowball sampling was utilized (Onwuegbuzie & Collins, 2007). Potential participants were informed about the study through posters placed at locations sex workers were known to access throughout the community, such as shelters for homeless people, the food bank, and community services for women who were marginalized. Women were eligible to participate if they self-identified as a past or present sex worker, resided in the study's home location or a nearby surrounding community, could speak English, and were 18 years of age or older.

Data collection

In consultation with peer researchers, the following methods of data collection were decided upon: semi-structured interviews with service providers in the wider community, key stakeholders (e.g. adult children of women who accessed the space), and drop-in center volunteers, and focus group interviews with SafeSpace volunteers. In-depth, semi-structured interviews were conducted with women who accessed SafeSpace, which included a demographic questionnaire. Additionally, items requested of volunteers at SafeSpace were captured through observation and recorded by peer researchers during drop-in hours. Each time someone accessing the space requested an item, this item was recorded and categorized (e.g. toiletries, self-care items, cosmetics, clothing, resources in the community, harm reduction supplies). While data were collected from a variety of participant groups (e.g. stakeholder interviews/service providers), "needs" that enhanced safety and dignity as defined by the women accessing SafeSpace as primary participants are reported here.

Potential participants were offered the opportunity to meet with a research assistant at a time and location of their choosing and could be interviewed by an academic member of the research team, a peer researcher, or a peer researcher and academic researcher together. Most women chose to be interviewed by a peer-based researcher located at the drop-in center in a private room. All interviews were digitally recorded and transcribed verbatim.

As part of the CBPR process, the entire team gathered to review the data collection process. Academic-based researchers provided 4 training sessions, facilitated over a month, to peer

researchers on the basic components of conducting research (e.g. obtaining informed consent, building rapport, working a digital recorder) and research skills (e.g. using a semi-structured interview guide, bringing an interview to a close, making a referral), with ongoing opportunities for peer researchers to refine their skills during everyday dealings with university and college researchers. In a reciprocal fashion, peer researchers guided academic researchers through potential challenges for participants, such as prolonged sitting and the need for frequent breaks and refreshments. Peer researchers also provided training on colloquialisms used within the space and related to sex work that may have been unfamiliar to the wider research team. As the study unfolded peer researchers observed academic researchers conducting interviews and vice versa, which provided rich learning opportunities for all involved.

Data analysis

An iterative, collaborative approach to data analysis was undertaken (Fawkes, 2005b). All researchers, academic and peer, independently analyzed each interview transcript, then together cross-compared insights, and negotiated emerging themes. Codes were tracked in a tabular matrix using exemplar quotes from interview transcripts to demonstrate the meaning of the code. Thematic findings were displayed on the walls at SafeSpace for women who accessed the space to review, and were invited to contribute their feedback by writing on the posters, or were written on by a member of the research team when requested. A content analysis was conducted on the observational data of the items requested by sex workers when accessing the drop-in center (Hsieh & Shannon, 2005). Analysis continued throughout the writing phase of the study, refining interpretation of the data based on peer researchers' insider knowledge and the academic researchers' respective expertise (Degeling, Rock, Rogers, & Riley, 2015). Trustworthiness of the data was attended to through extensive dialogue and negotiation of identified themes, reflective memoing that peer and academic researchers alike engaged in throughout data collection and analysis, keeping a detailed audit trail of processes and decisions, and member-checking (Koelsch, 2013). A descriptive analysis of the demographic data was conducted using Microsoft Office Excel (2010).

Findings

Twenty-four women who accessed the drop-in center (SafeSpace) participated in in-depth interviews. The age of participants from SafeSpace ranged from 24 to 57 years, and just over a third of participants reported completing high school or post-secondary education. The majority of participants reported having significant health concerns inclusive of heart disease, diabetes, HIV/AIDS, cancer, emphysema, acquired brain injuries; many reported past or present substance abuse. Most participants had some form of housing at the time the interview took place. Their length of involvement in sex work was an average of 9 years (see Table 1). The duration of the interviews ranged from 25 minutes to 90 minutes. Three women requested, and subsequently participated in a second interview.

Emerging from the analysis of observational data, requested needs were categorized as personal, relational, and supplies related to occupational health and safety. Personal hygiene items requested included toiletries (e.g. soap, shampoo, hairspray, deodorant, toothpaste, and toothbrushes), tampons, toilet paper, adult diapers, laundry/dish soap, and cosmetics. Identified needs also included nutritional support in the form of food staples (e.g. bread, canned food), meal replacement drinks and protein bars, and snacks. Clothing items were inclusive of winter wear (sweaters, coats clothing, gloves), bedding, undergarments, pajamas, and shoes. Children's toys were also requested by women accessing SafeSpace. Relational needs included social support (e.g. someone who would actively listen, offer feedback and suggestions), and information support regarding other community resources. Identified occupational needs included harm reduction kits (e.g. clean needles, alcohol swabs), condoms, perfume, cosmetics (e.g. makeup, nail polish), undergarments, sex workers specific

Table 1. Demographics of sex workers who participated in interviews.

Characteristic	Mean (Range) (N = 24)
Age	41 years (24– 57 years)
Length of time as a sex worker	9 years (Less than one month – 30 years or more)
	Percentage Response
Self-identified as belonging to a racialized group	33%
	71% of women who identified as a minority, identified as Aboriginal
Housing:	
Apartment	67%
House	9%
Homeless	9%
Unknown	14%
Past or present substance abuse:	
Yes	71%
No	19%
Unknown	9%
Self-Reported Health Issues:	67% yes
Yes	23% no
No	10% unknown/unanswered
Unknown	

clothing, and bus tickets. Women reported how significantly different the process was to access needed items at SafeSpace where they were not required to present identification, to conform to agencies' rules around quotas, they were not required to itemize through documentation the resources they accessed, and any requested item was regarded by volunteers as a legitimate request, rather than a luxury (e.g. gluten-free products, make-up, "sexy" undergarments).

The overarching theme of relationships was integral to participants' needs being met, enhancing their ability to live and work with a greater perception of safety and dignity in their community. The subthemes of *Informal/formal surveillance*: Relationships to public spaces; *Nowhere to go for us*: Relationships with/in community services; and *You're given the time you need*: Relationships in a peer-driven drop-in center for/with/by sex workers are discussed below.

Informal and formal surveillance: relationship to public spaces

Participants discussed the way they were subjected to surveillance when in public spaces. They discussed the way their movements and behaviors were policed in both informal and formal ways; formally through systemic, regulated forms of policing. As one participant articulated:

> I try to go and work on the street and it's the cops that wreck our ability to be able to work properly. We have to stand out there a little extra longer because they feel like harassing us.

The way workers were formally and publically policed did not stop them from working; however, they had to extend their working hours longer than necessary because of, or to avoid, possible harassment.

Workers also felt informally policed and subject to surveillance by members of the community at large, regardless of what they were doing. For example, participants were subjected to surveillance through glares from strangers or unsolicited comments from people passing by. As one participant shared:

> A lot of the girls get a lot of criticism from like public places, restaurants …. It seems so many people get hated on. Like even they go in to purchase something … They're riding them when they're in the bathroom. It's so rude that they can't even put their makeup on, nothing.

With few options to earn a living wage, some participants felt like they had little choice but to engage in sex work. Faced with harassment and ticketing when busking, one participant describes being caught in a double bind regarding the options available to support her:

> This place [London], I think it kind of forces people into that profession [sex work] because honestly like trying to busk – going around trying to busk or anything like that, like I get a lot of criticism for that and I'm like okay. So great. So am I just supposed to go put a dick in my mouth for money, what am I supposed to do since I'm over 25 years old and, you know, in a jam somewhere where I don't know anything and don't know anyone. That's great. It's like I'll go do that then instead of play my guitar.

Street-level sex workers often live with complex mental health issues, co-occurring with addiction and multiple forms of interpersonal trauma (e.g. childhood) and without adequate access to stigma-free services and supports (Lazarus et al., 2012). In response to this reality, participants also talked about the lack of a private, accepting space for women who were struggling with their addiction and/or mental health. Participants talked about the vulnerability of being in public spaces, without adequate protection from the glares and judgment of people passing by. As one participant shared:

> I think sometimes it would be nice just to have a little room or something cause a lot of women are either on drugs or abused … they need a little corner, a little space that they can go that's closed in where they can cry or whatever you know, get their emotions out because they have no place else where they can do it. That I think is really important because there is nothing worse than being on the street and you have a meltdown and right away the cops on you thinking you know you are out of control.

This participant wanted a place for women to feel safe, a place that offered privacy, away from the risks of being criminalized or pathologized through these informal and formal mechanisms of surveillance that occur in public spaces.

Due to their interaction with others in public who were not sex workers, many participants described carefully constructed routines to mitigate the impacts of being seen as "obscene" in public spaces, such as avoiding certain retail stores where they were treated poorly, to only venturing out into public spaces after dark. As one participant shared: "It's nice to be seen. I'd rather be seen, than obscene." This comment points directly to the stigma and shaming leveled against sex workers in public spaces.

Other workers described how, given the public nature of their working conditions, that even when they were not in public to meet clients, they were perceived as working by merely being visible in their community (e.g., walking along the street) where they sometimes worked:

> You know, just because I'm in this area, does not mean I'm working. … And it bothers me and it irritates me because I couldn't even go – if my grand-daughter was here, she's 5 years old and she wants to go everywhere.

Nowhere to go for us: relationships with/in community services

Participants talked about the repetitive nature of conforming to various identities or roles in order to access community services. As sex workers, they were not often seen as being the "right" kind of victim eligible to access services. Their ability and desire to perform the identity of the "right victim" would determine the material benefits and social acceptance they would or would not receive when seeking information and support within the community. Exemplified in the following quote, workers felt that shelters for women experiencing interpersonal violence (IPV) were not accessible to them, that those services were reserved for specific types of victims:

> I think they should have like a shelter for women that were on the street that are trying to get off the street because we're kind of actually considered a plague, ok, to other shelters … They'd say 'no' [you do not fit the criteria for an 'abused woman']. You're a working girl – you're not allowed in here'. And I thought "Well, where the hell am I supposed to go?"

Many of the policies that operate within shelters for women experiencing abuse (i.e. curfews) or to get access to a bed in a homeless shelter, directly impacted sex workers' ability to earn an income without the risk of being removed from shelter for violating said policies:

> So like what about us? *Where do we go?* You know, crash beds. … That really screws us up for working the street because we have to be in crash beds from 9:00pm at night until 6:00am in the morning. So much for working nights, eh? And that screws that us up for a woman. Like we have nowhere that we can go.

Having to make a "choice" between earning an income that was necessary to support their basic living needs, and to open up options to secure their own housing, was held in direct tension with policies developed to monitor the coming and going of women experiencing abuse from intimate partners. Furthermore, participants talked about the way they were treated when accessing services, and the need to be on their "best behavior":

> I avoided most of them [community services] because between addiction and sex work and for the most part, being on street level, people are not pleasant so – unless I put on my articulate voice and – and I'm sober enough to use it.

Other participants talked about the "subsistence" nature of community services. While appreciated and beneficial, these supplies and services were not in and of themselves adequate to carve pathways out of a life of poverty and/or addiction:

> Like a lot of the community resources, it keeps you on the same level. It doesn't – it's not actually to better you. … They`re just there to deliver the resource that they have available and that`s it. Nothing – not too much more. "Like you need cleans [syringe/needles]?"; "Here, get your cleans. Okay, take care, you know".

Participants spoke of the need to be personally accountable to understand and be able to negotiate very complex systems that were supposedly set up to assist them with their day-to-day survival. The high degree of "systems" literacy' required of participants to access services was highlighted as a barrier to living with safety and dignity. A particularly poignant quote from a participant reflected the challenges they faced:

> You have to work your ass off to learn the system and the ghost systems within the system and then know the right people and network and all that is really really hard to do when you have no energy … they sent an outreach worker to help me find resources in the community and she brought like out-dated books of resources of things that don't even exist anymore. So I gave her an updated one, which I had.

Not only does the aforementioned quote exemplify the work of navigating our complex community systems, the participant also draws our attention to the need for service providers to remain abreast of existing services that often fluctuated or ceased to exist at the end of funding cycles.

Participants also talked about the inability to access services relative to the hours sex workers must work. Most agency services are only available Monday–Friday, open 9am–5pm, and very few offered extended or evening hours.

> [Having] things like counselling and food banks and things like that only open during work and school hours. Some people are supposed to take off of work which they need – like they're already clearly struggling financially so – or in some way and you want them to take off work? … It's like – why? I don't understand. And same with like – employment counselling, that sort of thing. I don't get it. It's not logical at all.

The above quote demonstrates limited access to community services, and how difficult it can be to book and attend appointments during their hours of operation without negatively impacting other areas of their lives.

As well, participants expressed feeling discriminated against, because of their current living circumstances when searching for employment other than sex work:

> Trying to get ahead, trying to get people to – trying to get somebody to employ you is insane especially when your only place for them to call you is the shelter. As soon as they find out you're there, they instantly discriminate [against you].

The above quotes highlight the structural and material ways in which the participants' relationships to community services were so often oppressive and limiting. The participants were navigating between multiple positions: as "obscene", as being transgressive, needing the right kind of housing, and the "right", aka "articulate voice" in order to qualify for services, or be seen as worthy enough to receive support. The participants named the ways that community services were constructing their very identities (i.e. the right kind of victim), and how this restricted (or enabled) their access to needed services.

You're given the time you need: relationship to SafeSpace

SafeSpace as an organization was seen by participants as operating outside of the traditional model of service provision. The participants referred to the unique and valuable sense of community that SafeSpace provided; gaining a sense of belonging and the opportunity to realize themselves as something other than a public nuisance. SafeSpace also represented a place where sex workers could access help free from others' efforts to "reform", "rescue", or "rehabilitate" them. SafeSpace enabled the participants to see themselves more broadly than the work they undertook. Reportedly, SafeSpace created a sense of belonging for women, a space where their choice to engage or not engage in sex work was respected, and met with whatever resources were available to enhance their personal safety (e.g. harm reduction supplies, access to a "bad-date" line where workers could get/give descriptions of potentially dangerous clients), and to earn an income (e.g. make-up and clothing). Women who accessed SafeSpace were also engaged in running the drop-in activities through a peer-driven model of service provision. All key decisions about activities within the space were done in consultation with the women who accessed SafeSpace. Sex workers participated in activities that assisted in making the space function, from sorting donations to offering referrals (e.g. health-care providers who are knowledgeable and supportive of sex workers) to other people in the space.

Of all the services provided within SafeSpace, participants most often commented on how they felt when being there:

> [What is really useful?] … actions that suggested I had value and since you were there consistently when you said you were going to be, I was able to like gain trust and you didn't judge me so you didn't like fuck up that because it's really easy for me to be like, no, I hate you. … A space where I could feel like, if not completely safe, then safer and surrounded by people who had a good head on their shoulders and knew how to deal with situations that weren't safe. … Like there's a difference between being safe and feeling safe."

Participants talked about the way relationships with SafeSpace volunteers created a new template for what a healthy relationship could feel like:

> I think if I were to be completely honest, before I was in that space, I'd probably never had a positive relationship in my life, like a healthy positive relationship. … . And I've learned since then that that's probably like one of the most valuable things anyone can do for anyone is have – like make a model for a healthy relationship with them.

In forming genuine, caring relationships, participants came to trust SafeSpace volunteers. In describing SafeSpace, a participant stated:

> It also services as a place for women to come when they do not have a compass or are lost with no direction and you guys give them a compass.

The way people interacted within SafeSpace generated different types of relationships between "providers" (people who hold the space) and the person accessing services. The way participants described their relationships with SafeSpace volunteers was akin to friendship. Within these relationships there was an inclination toward care-taking for one another, creating opportunities for ones' self and for others to see their strengths and resourcefulness:

> There's a different kind of relationship. It's friendship. It's not, you know, you're in a 'position'. I don't know what it is but something. But it's friendships. It's not red tape and you're not getting paid to sit there and talk to me or whatever. So it's a very different sort of dynamic. That's huge … You don't really have your own agenda as to what's happening. It's just – it's a safe space and besides keeping it safe, and keeping folks safe who enter, that it's not like oh, like, "we're going to get you out of this lifestyle. We're going to save you. We're going to, you know – no". That's not – and I don't know if that's really present anywhere else in the community as far as resources go.

Traditional boundaries that seek to clearly define the service user from service provider were intentionally blurred, producing relationships premised on reciprocity, wherein every person had something valuable to offer and receive from someone else. The unscripted way services were

provided rippled throughout every aspect of the way SafeSpace operated. In the following quote a participant talked about how time is not restricted, which is uncharacteristic within more typical service provider – consumer models of care:

> You're not given half an hour. You're not given five minutes. You're given the time that you frigging need without somebody looking at the clock and saying "okay, well, this appointment's over". SafeSpace isn't like that, you know. You can talk your mouth off for hours, you know, if you need to.

The lives of SLSWs could be chaotic at times, juggling the demands of day to day living within the context of criminalization, marginalization, and the inadequate provision of basic resources. SafeSpace offered a place to be in a moment where significant life decisions needed to be made. In addition to the pragmatic supplies, they also sought out the space as a "pause" to catch their breath, to seek input and talk through their options and possible consequences, in order to move out of the space feeling more adequately prepared for their next decision:

> Like if they are scared to go to the hospital or anything there is just that beforehand space where they [sex workers] can make decisions or you know where they can catch up on their thoughts – life and death situations where they can make life or death choices.

Participants shared that accessing SafeSpace was at times what motivated them to move forward:

> Like when I started going to SafeSpace, it got me out of bed and got me out of my depression and at least Monday and Tuesday. I can die all weekend and lay here and feel sorry for myself and then at least Monday I had something to do so it kind of helped me in that sense.

SafeSpace enabled new ways for participants to exist, without judgment or pathologizing their choices or requests. It is important to note that limited by funding, the sustainability of SafeSpace and the predictability and consistency of resources, like many community services, was a concern among participants. This had major implications for the sustainability of relationships between women who accessed SafeSpace and volunteers:

> But I mean the key thing is that you're open when you say you're going to be open … Like there have been a few groups that have tried to start up in the community specifically for sex workers and they give up so fast and they're not there when – like they cancel at last minute or they change locations constantly or it's a different person every time or, you know, it's just not consistent or really sustainable. … . Yeah, consistency is huge because if I'm going to access a service, that means I've broken down and said I'm going to access the service, which takes a big hit out of my ego and takes a little bit for me to work up to. So if I go to access it and it's not there, I'm just like I hate you. I hate you so much. And this grudge'll probably last for another few years.

Discussion

The overarching theme of relationships was defined as integral to participants' ability to live and work with enhanced safety and dignity in their community. The subthemes included: relationships to public space(s); relationships with/in community services; and relationships to a drop-in center for sex workers (SafeSpace). Across these relationships, approaches to intervening in the lives of sex workers were deployed based on contradictory categories of "criminal", "sexual deviant", and "victim". SafeSpace was a place where participants actively articulated their resistance to these *positionings*, in the things they said and through their participation in community activities that defied these labels.

Our study findings align with previous studies that have documented how sex workers are often confronted with stigma associated with their work in the course of seeking assistance (Lazarus et al., 2012; Pauly, 2008). Their significant and complex health issues, combined with a paucity of sex-worker-competent service provision, perpetuate their poor health outcomes. The cyclical nature of this relationship between stigma and poor health outcomes underscores the importance of relationships in the course of seeking care, which is congruent with previous research exploring stigma, social exclusion and encounters with providers in the health-care system, social services and policing (Bodkin et al., 2015; Krüsi et al., 2014). Furthermore, research findings have substantiated that

disclosing one's status as a sex worker is, in and of itself, a barrier to adequate care. As a consequence, rarely do sex workers disclose their occupational activities to health-care providers (Bodkin et al., 2015; Regent Park & Street Health, 2014).

Fears of disclosing their involvement in sex work are particularly heightened among those who experience intersecting stigmas, discrimination, surveillance, and policing, such as trans and Indigenous sex workers and those exchanges sexual services for resources (Benoit, Jansson, Smith, & Flagg, 2017). The relational components of care that participants identified (e.g. belonging) speak loudly to the need for enhanced understanding and education among service providers with regard to the role stigma and discriminatory attitudes play out in the lives of sex workers. Such attitudes create inequities in care provision, deter sex workers from seeking care, or from disclosing their work to care providers (Bodkin et al., 2015). At its very core, these attitudes and behaviors impede health promotion activities with this population (WHO, 1986).

Insufficient and inappropriate services, partnered with the criminalized nature of participants' work, meant they were often left to utilize services intended for individuals not engaged in street-level sex work, such as women experiencing interpersonal violence, the working poor, those who were homeless and/or those at risk of homelessness, and emergency health services to fill the gaps. Consequently, oftentimes they felt as though they were not the "right kind" of victim. While street-level sex workers are represented within and across these different categories of marginalized groups, such services are neither developed nor delivered with the occupational health and safety needs of sex workers in mind. For instance, counseling and shelter policies (e.g., curfews) made it difficult for sex workers to access these resources, to meet the intake criteria or to successfully adhere to "house rules" (van Olphen, Eliason, Fredenberg, & Barnes, 2009). Counseling appointments are pre-booked and available almost exclusively during day-time hours. Furthermore, community outreach workers' hours are often misaligned with the afternoon and night shift hours of sex workers.

When we take seriously the "needs" as articulated by workers' themselves, and these articulations are treated as legitimate and necessary, we hear how central relationships are to enhancing or diminishing their dignity, safety, and adequate access to services. Tangible resources, such as harm reduction supplies, basic subsistence items (e.g. food and weather appropriate clothing), and personal hygiene items were requested in order to meet day-to-day needs. While these resources were available at other locations throughout the city, it was the way that participants were made to feel when accessing these items that set apart SafeSpace from other organizations. Women reported how significantly different the process was at SafeSpace for accessing needed items. The process engendered a sense of dignity, of being trusted to ask for what one needed, and every request was seen as acceptable.

By engaging women in the act of sorting of donations, each person was invited to participate in activities that supported the operation of the space. Such activities helped to shift power and blur the lines between service providers and those who accessed support. The process of resource access undertaken at SafeSpace aligns with emerging models of services delivery that affords people self-determination and agency in the course of seeking items. For instance, programs that provide grocery cash cards instead of requiring individuals to access a pre-determined selection of items at a food bank (Keenan, 2015).

Many sex workers face pressure to exit the sex trade in the course of seeking support from organizations that directly benefit from funding received for offering "prostitution diversion" programming (Shdaimah & Wiechelt, 2012; Wahab & Panichelli, 2013). This was consistent with our findings. Participants discussed feeling the need to hide their involvement with sex work or lie and say they were trying to exit from sex work in order to receive services (Dowd & Jacobs, 2003). However, unlike their experience seeking resources from other community services, participants referred to the unique and valuable community that SafeSpace provided for them regardless of whether they were entering, actively engaged in, or looking to leave sex work.

When talking about SafeSpace they spoke to feeling like they belonged, and while in the space they could realize aspects of themselves as something other than a public nuisance, or a site for an intervention to be deployed upon in an effort to "reform", "rescue", or "rehabilitated" them. This

opportunity to belong, to be in relationships with others that extended beyond a singular identity of sex worker was a matter of need, not nicety. To this end, participants of this study spoke to how a personal sense of agency is situational, emerging out of the individual's interactions with their environments, and under specific conditions or contingencies (Moore, 2016). In discussing SafeSpace, participants voiced the ways in which the space itself enabled them to be seen as something other than a nuisance/obscene/victim/wrong kind of victim/criminal.

Limitations

As with all research, there are limitations. This research was limited to women who could speak English. Women with English as a second language may not have felt confident in participating in the study. The assessment of SLSW's needs was limited to women who accessed the drop-in center, SafeSpace. Women accessing other organizations (e.g. community health clinics) may have emphasized one need over another and/or identified additional needs not captured within this research.

Conclusion

Of paramount importance to women accessing SafeSpace was the need for acceptance as they were, and to be encouraged to take responsibility for activities that went on in the space. Participants did not want to be treated merely as recipients of services or as service users. In doing so, women perceived SafeSpace as something other than an organization or typical social or health service. Instead, it operated as a community, with bonds, attachments, obligations (Somerville, 2016), and expectations, all of which contributed to relationships that were central to living with enhanced safety and dignity within their community. These findings have significant implications for educational curricula and health promotion practice standards among service providers across all community and health-care settings that profess relational, person-centered care.

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