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Occupational Stigma as a Primary Barrier To Health Care For Street-Based Sex Workers in Canada

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Abstract

Individuals working in the sex industry continue to experience many negative health outcomes. As such, disentangling the factors shaping poor health access remains a critical public health priority. Within a quasi-criminalised prostitution environment, this study aimed to evaluate the prevalence of occupational stigma associated with sex work and its relationship to barriers to accessing health services. Analyses draw on baseline questionnaire data from a community-based cohort of women in street-based sex work in Vancouver, Canada (2006–8). Of a total of 252 women, 141 (58.5%) reported occupational sex work stigma (defined as hiding occupational sex work status from family, friends and/or home community), while 125 (49.6%) reported barriers to accessing health services in the previous six months. In multivariable analysis, adjusting for socio-demographic, interpersonal and work environment risks, occupational sex work stigma remained independently associated with an elevated likelihood of experiencing barriers to health access. Study findings indicate the critical need for policy and societal shifts in views of sex work as a legitimate occupation, combined with improved access to innovative, accessible and non-judgmental health care delivery models for street-based sex workers that include the direct involvement of sex workers in development and implementation.

Keywords

Sex work; occupational stigma; barriers to health care; policy

Introduction

In many regions globally, sex workers experience an array of negative health outcomes, including high rates of violence, HIV and other sexually transmitted infections, and yet remain largely outside conventional health services. In criminalised and quasi-criminalised sex work environments, sex work is largely unregulated and highly policed, with sex workers experiencing high rates of violence, victimisation, and police crackdowns (Aitken 2002; Day and Ward 2007; Goodyear and Cusick 2007; Shannon, Rusch, et al. 2007). Although the buying and selling of sex are legal in the Canadian context, communicating in

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public spaces for the purpose of sexual transactions, working indoors in managed/supported environments, and living off the avails of prostitution are all prohibited under federal legislation. As such, sex work is highly criminalised and strict enforcement strategies has resulted in the emergences of informal tolerance zones of street-based sex work in outlying and industrial settings (Shannon et al. 2009). In criminalised and quasi-criminalised sex work environments, access to non-judgmental, adequate health services has been identified by UNAIDS (2002; 2009) as one of the fundamental pillars in ensuring HIV prevention in the sex industry and remains key to effective harm reduction strategies in the sex industry (Rekart 2005). As such, disentangling the factors shaping poor health access remains critical to public health approaches tailored to sex workers.

Importantly, a growing number of research studies globally have postulated that stigma may act as a key barrier to health access for sex workers (Cohan et al. 2006; Kurtz et al. 2005; Scambler and Paoli 2008). Goffman (1963) defined stigma as an "attribute that is deeply discrediting", with the stigmatised individual possessing an "undesirable difference" and a "spoiled identity". Stigma has also been defined as a social process (Goffman 1963; Link and Phelan 2001). Stigmas are social labels that can have a profound impact on the lives of the people to whom these labels are applied (Hallgrimsdottir et al. 2008). It is the process of labelling that leads stigmatised individuals to be linked to undesirable character traits, experience status loss and discrimination (Link and Phelan 2001). Whereas *enacted* stigma can result in shunning, avoidance or physical and emotional abuse, the impact of the stigmatised label alone can be internalised and cause the stigmatised individual to develop a negative self-identity (Hallgrimsdottir et al. 2008). This internalisation of the stigma process is what Goffman refers to as *felt* stigma (Goffman 1963). A significant pathway has been found to exist from enacted stigma to felt stigma to disclosure, pointing to the need to address stigma at both individual and community levels (Liu et al. 2006).

It is important to move past individual-level approaches to conceptualising stigma in order to understand the important role that power and structural conditions play in socially excluding and devaluing certain groups of people (Link and Phelan 2001; Parker and Aggleton 2003; Kinsler et al 2007). Stigma targets people with less power, and is often mediated by class, race, ethnicity and gender (Hallgrimsdottir et al. 2008; Link and Phelan 2001). In a study of media-enacted sex work stigma, Hallgrimsdottir et al. (2008) conceptualised stigma as structurally mediated, constructed and disseminated through discourse, and emerging from structures of social stratification.

Sex workers often face discrimination and rejection and, when combined with the perception of the illegal nature of sex work, the practice of sex work is often hidden (Benoit et al. 2005). "Whore stigma" has been conceptualised to predominantly characterise street-based sex work and shame women for transgressing gender norms, such as asking fees for sex; satisfying men's lust and fantasies; being vectors of disease; and being a source of transmission of sexually transmitted infections into mainstream society, including HIV/AIDS (Pheterson 1993; Scambler 2007). Sex workers come up with strategies to hide their involvement in sex work from others due to felt stigma, increasing their vulnerability to stress, depression and other diseases (Benoit et al. 2005). Hiding their involvement in sex work also places sex workers at risk of abuse from those who are more powerful, including the authorities (Benoit et al. 2005). Studies have cited police employing shaming techniques of disclosing sex workers' identities to others (Rhodes et al. 2008). In a study that looked at sex work in Australia, a setting where sex work is legalised in some states, women still valued anonymity and expressed concern about family and friends finding out their sex worker identity due to a fear of being rejected or hurting their family (Groves et al. 2008).

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Women involved in sex work often also face rejection from their home communities (UNAIDS 2009). A qualitative study exploring the environment and power structures in which sex work occurs in Vietnam found that sex workers attempted to hide their profession from family, friends and their home community (Ngo et al. 2007). Perceptions of stigma were found to influence the way these women represented themselves. Women who reported positive self-images were better able to negotiate condom use, resist abusive clients and attend to their personal well-being (Ngo et al. 2007).

Ethnographic and qualitative works reveal how sex work stigma may shape access to health care services. Qualitative research from Dublin with drug users who engage in or had engaged in sex work, found that participants tried to hide their drug use due to felt stigma and that this stigma was reinforced by the language used by health care professionals (Whitaker, Ryan and Cox 2011). In the United Kingdom, the narratives of sex workers reveal that fear of privacy and disclosure of their sex work status, including distrust of authority and fear of prosecution, may prevent sex workers from accessing health services (Day and Ward 1997), and yet rigorous epidemiological studies of this mechanism remain limited. In a qualitative and descriptive study in Florida among street-based sex workers, even when a woman located appropriate health care services, she was often stigmatised due to her involvement in sex work, poor hygiene, appearance, and drug use (Kurtz et al. 2005). This stigma exhibited by health providers may further entrench occupational sex work stigma felt among sex workers. Qualitative research has shown that when contact with health care professionals is high among female sex workers, non-disclosure of sex work status may still contribute to poor health (Jeal and Salisbury 2004). Reasons for not disclosing involvement in sex work to health care professionals have been suggested to include fear of arrest and prosecution (Rekart 2005), negative past experiences with disclosure, fear of disapproval, embarrassment, and believing that sex work was not relevant to their health needs (Cohan et al. 2006). Whereas women have hidden their involvement in sex work in an attempt to increase the likelihood of receiving services, this means that providers remain unaware of all their care needs (Kurtz et al. 2005).

Despite these growing qualitative and ethnographic analyses of sex work stigma, the prevalence of occupational sex work stigma and its empirical relationship to health access remains poorly defined. To our knowledge, our study is the first to measure the prevalence of occupational sex work stigma and model its association with barriers to health access. This study therefore aimed to evaluate the prevalence of occupational sex work stigma, defined as hiding involvement in sex work from friends, family or home community, and the association between experiencing occupational sex work stigma and barriers to accessing health care services among women involved in street-based sex work in Vancouver, Canada.

Methods

Data were drawn from a community-based HIV prevention research project, in partnership with local sex work agencies. The development, process and methodologies of this partnership have been described in detail elsewhere (Shannon, Bright et al. 2007). Briefly, the community-based research partnership commenced in 2005 and draws on multiple research methodologies, including qualitative research, social mapping and a prospective cohort study. The present study focuses on measures from the quantitative research, developed and piloted based on our initial qualitative research on stigma and barriers to health access.

Between 2006 and 2008, street-based female sex workers were enrolled in an open prospective cohort study and participated in baseline and six month follow-up visits that included an interview questionnaire, pre-test counselling questionnaire and voluntary

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screening for HIV. Eligibility criteria were defined as being a woman aged 14 years or older who used illicit drugs (excluding marijuana) and engaged in street-based sex work. Time-space sampling was used to systematically sample all women at staggered times and locations in outdoor solicitation spaces. Trained peer researchers, all of whom were past or current sex workers, administered detailed semi-structured surveys at baseline and follow-up visits. The surveys included questions regarding participants' demographics, health service use, working conditions, violence, and sexual and drug risk practices. Detailed health and violence questions were asked by the nurse in order to assure appropriate counselling and referral to support services. Baseline survey data collecting information on occupational sex work stigma were used in this analysis.

Dependent variables

The dependent variable of interest for the study was experiencing barriers to accessing health care services in the previous six months, due to one or more of the following: (a) limited hours of operation; (b) long wait times; (c) not knowing where to go to access services; (d) language barriers; (e) not being able to get a doctor of preferred gender (for example, not able to get a female doctor); or (f) having experienced poor treatment by a health care professional.

Primary Explanatory Variable

Guided by theoretical and qualitative research on stigma (Parker and Aggleton 2003; Benoit et al. 2005; Shannon, Rusch, et al. 2007), and developed and piloted through our initial qualitative work, occupational sex work stigma was operationalised as responding "yes" to either or both of: "hiding involvement in sex work from family and friends" and "hiding involvement in sex work from their home community". These measures were combined based on a sensitivity analyses that found that hiding involvement in sex work from family and friends or home community were highly correlated and over 90% of those who reported one, reported experiencing both.

Covariates of Interest

Covariates of interest and potential confounders were considered based on literature about female sex workers and a priori hypothesised relationships. All variables used the previous six months as a reference point. Environmental-structural variables considered included: living in the inner city community (Vancouver's Downtown Eastside (DTES)), known for its high concentration of poverty, economic and health inequities and drug use, as well as community and health resources; having been homeless (slept on the street); and working (soliciting clients) mostly on main streets or commercial shopping areas (as compared with alleys, side streets or industrial areas), and having accessed a hospital emergency department.

Interpersonal variables included: coercive unprotected sex by clients, client violence, recent and historical physical and sexual violence by non-commercial partners (including family, intimate partners, friends, acquaintances and strangers).

Individual demographic variables of interest included age (years, continuous), education (none, high school graduate or any college/university) and ethnicity. As Aboriginal identity has been linked to barriers to accessing culturally appropriate care (Benoit et al. 2003), we examined potential differences in stigma and health access between women of Aboriginal ethnicity, Caucasian, and other visible minorities. Drug use patterns included injection of cocaine, heroin or crystal methamphetamine in the last 6 months. As previously, given high rates of crack cocaine smoking (Shannon, Rusch et al. 2007) among street-based sex

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workers in this setting, we considered intensive daily crack use as smoking greater than 10 rocks per day (stratified at the median).

Statistical analyses

We used bivariate and multivariable logistic regression to assess the relationship between experiencing occupational sex work stigma and barriers to health care access. In multivariable analysis, we adjusted for all potential confounders that were significantly associated with barriers to health access on a p<0.10-level in bivariate analyses. Variables were retained in the multivariable model with an alpha cut-off of p<0.05. Bivariate odds ratios (ORs) and multivariable adjusted odds ratios (AORs) and 95% confidence intervals (CIs) were calculated for each and all p-values are two-sided. All statistical analyses were performed using SAS software version 9.1 (2002–03).

Results

A total of 252 women completed the baseline interview-administered questionnaire and responded to questions on occupational sex work stigma and were included in the analyses. As indicated in Table 1, the median age of the sample was 35 years (interquartile range [IQR]=25–41 years). Close to half the sample (n=125, 49.6%) experienced barriers to accessing health care services in the previous six-month period. Of the total, 122 women (48.4%) were Caucasian, 111 (44.0%) were of Aboriginal ancestry (First Nations, Metis, Inuit, non-status First Nations), and 17 (6.7%) were of a visible minority, with no statistical differences in barriers to accessing health care by ethnicity (p=0.12). Overall, 82 women (32.5%) had high school education or higher, and women with high school education or higher were more likely to report barriers to health access. One hundred and forty-one women (55.9%) reported occupational sex work stigma (defined as hiding sex work occupational status from family, friends and/or home community)

Table 2 shows the bivariate and multivariable logistic regression analyses of factors associated with experiencing barriers to health access. In bivariate analysis, occupational sex work stigma (OR=1.76; 95% CI=1.05, 2.95) was associated with increased likelihood of experiencing barriers to accessing health care services. Women who worked on main streets and commercial areas as compared to alleys and industrial settings were less likely to experience barriers to accessing health services (odds ratio [OR]=0.46; 95% confidence interval [CI]=0.21, 1.00). Both accessing a hospital emergency room in the last six months (OR=2.08; 95% CI=1.12, 3.856) and having completed some college or university level education (OR=3.25; 95% CI= 1.31, 8.12) were positively associated with experiencing barriers to accessing health care services. Experiencing coercive unprotected sex by clients, current and historical physical violence were associated with increased odds of barriers to health access. In the final multivariable logistic regression analyses, adjusting for potential confounders, occupational sex work stigma (AOR=1.85; 95% CI=1.07, 3.20) remained independently associated with experiencing barriers to accessing health services.

Discussion

Our results reveal a high prevalence of occupational stigma among street-based sex workers, with close to half of sex workers reporting immediate barriers to health access. Of particular concern, occupational stigma remained significantly and independently associated with increased barriers to health access in the previous six months, irrespective of individual demographics, social and work environment factors. This study provides among the first empirical evidence that we are aware of the independent relationship between occupational sex work stigma and barriers to accessing health care among women in street-based sex work, extending narratives from previous qualitative studies.

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The results support growing evidence of the critical need for policy and societal shifts in views of sex work as a legitimate occupation, in order to create conditions where women feel both safe to disclose their involvement in sex work to their support networks and able to access non-judgmental health care services. Social mobilisation has proven to be one of the most effective ways of combating stigma and oppression in the HIV/AIDS epidemic, and evidence strongly suggests that models of community mobilisation must occur alongside structural and environmental interventions (Parker and Aggleton 2003). Shifting societal views of sex work can begin at the community level with collectivisation as an effective structural intervention (Blakenship et al. 2006). The success of sex work collectivisation and empowerment in reducing HIV risk in some developing country settings have been attributed in part to their ability to confront social stigma (Halli et al. 2006; Jana et al. 2004; Reza-Paul et al. 2008). Policy shifts combined with community-based empowerment models of care have been shown to be highly effective in increasing access to health services in other settings, including India (Jana et al. 2004; Ghoose et al. 2008). Notably, the Sonagachi Project in Kolkata, India considered a WHO and UNAIDS best practice in HIV prevention among sex workers, has used a model of structural policy support combined with peer-based empowerment to decrease stigma, resulting in an increase in condom use and a decrease in HIV prevalence when compared to sex worker sub-populations in other Indian urban centers (Ghoose et al. 2008). Peer-based models can provide direct support to individuals in disclosing their involvement in sex work to family, friends and health care providers, resulting in increased access to appropriate care. The success of the Sonagachi Project has led to the development of similar combined structural and peer-based interventions in other parts of India (Reza-Paul et al. 2008), and Brazil (Murray et al. 2010), though challenges remain in adapting this model to settings without structural policy support.

In Canada, the largely criminalised and policed nature of the sex industry prevents sex work from being recognised as a legitimate occupation, leading individuals involved in sex work to hide their profession from friends, family and their home community. Current policy debates and legal cases are considering the role of decriminalising sex work in Canada as a means to improve health and safety of sex workers, and this data supports the public health importance of the removal of criminal sanctions on sex work to reduce stigma and improve health access. Qualitative work in Canada suggests that this occupational stigma increases vulnerability to stress and diseases (Benoit et al. 2005), compounding health care needs while simultaneously acting as a barrier to health care services. While more research and evaluation of the role of legislative and policy changes (such as decriminalised approaches to prostitution, safer work environments) in shifting societal perceptions of stigma is needed, existing evidence from decriminalised and managed sex work environments suggest that the removal of criminal sanctions on the collectivisation of sex work, safer indoor work spaces, and reduced policing targeting the sex industry can support health access and reduce societal stigma (Doorninck & Jacqueline 1998; Halli et al. 2006; Jana et al. 2004; Reza-Paul et al. 2008). Of note, in a recent study in Australia, a setting where sex work is decriminalised in some states and not others, women still valued anonymity and expressed concern about family and friends finding out their sex worker identity due to a fear of being rejected or hurting their family (Groves et al. 2008). This lack of shift in societal perceptions may be attributed to a number of factors, including historically and culturally-embedded norms on “acceptable” displays of sexuality and sexual mores in many settings, the necessary decades of time to shift public perceptions following legislative changes, and/or the persistence of stigma in a country where the sex industry remains prohibited in some states and debated regularly by government and policy makers.

Alongside with structural policy interventions and collectivisation that address stigma at the societal level, there is an urgent need to improve access to innovative, accessible and non-judgmental health care services for street-based sex workers. Examples of innovative

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approaches to service delivery include the St. James Infirmary (SJI) in San Fransisco, which operates a free medical clinic that provides health care and social services to male, female and transgendered sex workers. The majority of staff are former or current sex workers and services encompass comprehensive biological, psychological and social care (Cohan et al. 2006). A study looking at the characteristics of sex workers accessing care at SJI found that the majority of participants had never previously disclosed their sex work involvement to health professionals (Cohan et al. 2006). In lieu of experiential staff, sensitivity training of health care professionals could also improve the acceptability of sex work and sex workers health care needs, resulting in a more welcoming environment and a higher uptake of services (Rekart 2005).

Furthermore, previous research has shown that flexible hours of operation and geographic location of services is critical to promoting health access for sex workers (Jeal and Salisbury 2004; Kurtz et al. 2005; Shannon et al. 2005; 2008). For example, a study in the United Kingdom of sex workers' experiences in accessing health care found that integrated services located close to places of work, with extended operating hours (evenings and nights) and provision of condoms, showers, food, drinks and needle exchanges were overwhelmingly preferred among participants (Jeal and Salisbury 2004). Previous research has shown that policing strategies that displace sex workers to the margins of society increase health-related harms and experiences of violence faced by women (Day and Ward 2007; Goodyear and Cusick 2007), while simultaneously increasing barriers for women attempting to access health care (Shannon, Rusch, et al. 2007). These earlier results concur with our current findings herein that demonstrate that sex workers who work along main streets and commercial shopping areas have improved access to health care, and support the removal of policy and enforcement approaches that displace sex work away from health services. The lack of accessible and non-judgmental comprehensive health care services for sex workers may also be responsible for an over reliance on emergency departments for health care delivery noted in this study. High rates of emergency room use among sex workers has been tied to the overall poor health status of the women, highly unstable lifestyles and high rates of drug use, as well as to inaccessible clinic hours and a lack of women specific services (Palepu et al. 1999; Shannon, et al, 2005). Persistent barriers to care even among those sex workers accessing emergency care services supports the need for more integrated and targeted approaches to health care delivery for sex workers (Jeal and Salisbury 2004; Rekart 2005; UNAIDS 2009).

Finally, and somewhat unexpectedly, our findings found that participants who reported higher levels of educational achievement (college, university versus less) were marginally more likely to experience increased barriers to accessing health care services. While these results differ from previous research showing that Canadians with higher educational attainment have a significantly increased probability of visiting a physician or specialist (Allin 2006), much of the earlier research has been derived from the general population. Instead, our study suggests that other underlying factors may play a more significant role in determining health access than educational achievement among marginalised women in the street-based sex industry. Alternatively, women with higher education levels may be in different social and/or familial networks and face increased stigma at being engaged in non-traditional occupations that increase compound barriers to accessing conventional health services. Further research is needed to better understand the complex and intersecting pathways of stigma and education in shaping experiences of health access for sex workers.

Limitations

Several limitations to the study must be considered. This study uses cross-sectional data, and thus causal relationships cannot be determined. The study relies on self-reported

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information, and thus more sensitive questions may have been subjected to social desirability and underreporting. Similarly, the primary explanatory variable of "occupational sex work stigma" only accounts for one definition of stigma, felt stigma, and therefore other experiences of stigma are likely not represented here. As such, the actual prevalence of both felt and enacted stigma are likely much higher. This bias would have resulted in attenuating our effect size towards the null. Of note, our results are supported by previous qualitative and theoretical work on this topic. Secondly, this cohort was not a random sample of participants. However, our time-location sampling across sex work strolls has been a standard for accessing more hidden populations and combined with close community partnerships and sex work involvement, is likely to have reached some of the most marginalised. Finally, results of the study may not be generalisable to male sex workers or sex workers working in other aspects of the sex industry, such as escort agencies, exotic dance clubs or massage parlours. However, the results offer insight into prevalence of occupational sex work stigma and barriers to health access among women in street-level sex work, and warrant the need for further research on the experiences of occupational stigma across other sectors of the sex industry, different legal environments of sex work, and with inclusion of male sex workers.

Conclusions and policy implications

There is a critical need for policy and societal shifts in views of sex work as a legitimate occupation, in order to both decrease the stigmatisation of sex workers and improve access to health care services. The quasi-criminalisation and stigmatisation of sex work leads sex workers to hide their involvement in sex work from family, friends and their home communities and acts as a major barrier to accessing health care services. Structural policy support combined with the collectivisation of sex workers and community-based empowerment models of care have been shown to be highly effective both in decreasing stigma and promoting access to health services elsewhere, and should be piloted and evaluated in the Canadian context. Further, consideration to the creation of innovative, accessible and non-judgmental health care delivery models is needed for street-based sex workers, including integrated and targeted approaches to care that include the direct involvement of sex workers.

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TABLE 1

Individual, Interpersonal and Environmental-Structural Factors among Street-Based Female Sex Workers, Stratified by Barriers to Accessing Health Care Services

Characteristic	Total (*n*)	Barriers to Accessing Care		*p* - value
		Yes (%)	No (%)	
Individual and socio-demographic factors				
Age (median, interquartile range)	35 (25–41)	36 (27–43)	34 (24–39)	<0.001
Injection cocaine use	82	42(51.22)	40 (48.78)	0.722
Injection heroin use	123	61 (49.59)	62 (50.41)	0.998
Injection crystal methamphetamine use	34	17 (50.00)	17 (50.00)	0.960
Intense crack cocaine smoking	99	53 (53.34)	46 (46.46)	0.316
Social and interpersonal factors				
Coercive unprotected sex by clients	61	36 (59.02)	25 (40.98)	0.091
Client violence	54	33 (61.11)	21 (38.89)	0.050
Physical violence	68	40 (58.82)	28 (41.18)	0.060
Sexual violence	11	6 (54.55)	5 (45.45)	0.704
Historical physical violence	165	89 (53.94)	76 (46.06)	0.059
Historical sexual violence	160	82 (51.25)	78 (48.75)	0.491
Occupational sex work stigma	141	79 (56.03)	62 (43.97)	0.033
Physical and structural environment factors				
Did not complete high school	178	81 (45.51)	97 (54.49)	0.039
High school graduate	47	24 (51.06)	23 (48.94)	0.327
Post secondary education (college/university) vs. less than	26	19 (73.08)	7 (26.92)	0.024
Lives in Vancouver's inner city core	48	25 (52.08)	23 (47.92)	0.725
Homeless (slept on the street)	107	54 (50.47)	53 (49.53)	0.768
Work on main streets/commercial areas (vs. alleys, industrial settings)	33	11 (33.33)	22 (66.67)	0.049
Used hospital emergency department	55	35 (63.64)	20 (36.36)	0.020

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TABLE 2

Unadjusted and Adjusted Odds ratios for Associations Between Experiencing Sex Work Stigma and Barriers to Accessing Health Services Among Street-Based Sex Workers

Characteristic	Unadjusted Odds Ratio (95% CI)	Adjusted Odds Ratio (95% CI)
Individual and socio-demographic factors		
Age, continuous	1.04 (1.01–1.06) *	1.03 (1.00 –1.06) ***
Aboriginal ethnicity (vs. White or visible minority))	0.67 (0.41–1.11)	…
Inject cocaine, past 6 months	1.10 (0.65–1.87)	…
Inject heroine, past 6 months	1.00 (0.61–1.64)	…
Inject crystal methamphetamine, past 6 months	1.02 (0.49–2.10)	…
Intense crack cocaine smoking, past 6	1.30 (0.78–2.15)	…
Social and interpersonal factors		
Coercive unprotected sex by clients	1.67 (0.92–3.04) *	…
Client violence	1.86 (1.00–3.46) *	…
Physical violence	1.73 (0.98–3.06) *	…
Sexual violence	1.27 (0.38–4.27)	…
Historical physical violence	1.66 (0.98–2.81) *	…
Historical sexual violence	1.20 (0.72–2.00)	…
Occupational sex work stigma	1.76 (1.05–2.95) *	1.85 (1.07–3.20) ***
Physical and structural environment factors		
Education, high school graduate	1.25 (0.66–2.38)	…
Education, any college/university	3.25 (1.30–8.12) *	2.24 (0.86–5.85) **
Live in Vancouver's inner city core	1.12 (0.60–2.10)	…
Homeless	1.08 (0.65–1.76)	…
Works on main streets/commercial areas (vs. alleys, industrial settings)	0.46 (0.21–1.00) *	0.45 (0.19–1.03) **
Used hospital emergency department	2.08 (1.12–3.86) *	2.04 (1.06–3.90) ***

* Variables significant at p<0.01 in bivariate analyses and entered into the multivariable model;

** Variables that remained significant at p<0.01 in multivariate analyses;

** Variables that remained significant at p<0.05 in multivariate analyses