Health and the Sex Trade: An Examination of the Social Determinants of Health Status and Health Care Access among Sex Workers

By

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ABSTRACT

Drawing on interview and survey data from a non-random sample of 201 males and females located in the Capital Regional District, this thesis examines the health status and health care access of individuals currently and formerly involved in the sex industry from a *social determinants of health* perspective. The empirical findings include respondents' status according to common social determinants of health, indicators of mental and physical health, measures of health care utilization, and qualitative descriptions of experiences accessing health services. Where possible, the findings from the research population are compared with findings from other populations outside the sex trade. In addition, differences among the respondent population are explored to investigate potential explanations for why some workers report relatively good health and/or have good access to health care, whereas other do not. The findings complicate assumptions regarding the inherent health risks of the sex trade as many respondents report diminished health resources prior to entering sex work and continue to have significant health problems even after leaving the sex trade, while others report relatively good health prior to entering the sex trade and/or throughout their involvement in the sex trade. It is concluded that further research on the topic of the social determinants of health among sex workers is required in order to build on the tentative conclusions drawn in this project. In particular, research models that seek to address the sampling limitations intrinsic to hidden populations and the drawbacks of cross-sectional data are required.

Table of Contents

List of Tables

List of Figures

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Chapter 1: Introduction

The sex trade loosely refers to the commercial exchange of sexual services or fantasies for payment[1]. It encompasses a diverse grouping of activities and venues ranging from escort agencies, massage parlors and telephone services, to exotic dancing, street work, and home-based services. Although some activities associated with the sex trade are illegal in Canada, the act of selling sexual services is not illegal[2]. However, the few activities prohibited by the Canadian Criminal Code – most notably public solicitation, operating a bawdy house, and living off the avails of prostitution – make it difficult to engage in the sex trade business without running afoul with the law (Lowman, 1999). Consequently, persons involved in the trade must develop savvy and non-traditional approaches in order to vend their services legally; this challenge has been described as greatest for female, street-based workers who have historically represented a disproportionate presence in Canadian statistics on prostitution-related crimes (Boritch, 1997; Brock, 1998). Sex trade venues such as massage parlours, exotic entertainment clubs, and escort agencies continue to be licensed by local municipalities across Canada, and in cities such as Calgary, the municipality also licenses individual escorts. The apparent contradiction whereby sex trade businesses are eligible for business license, but workers are subject to criminal sanctions, has been criticized by sex trade scholars who argue that the ambivalent legal status of the sex trade contributes to the vulnerability of sex workers in their workplaces (Lowman, 1999). At the root of the sex trade's ambivalent legal status, is the social stigma associated with sex work: the selling of sexual services for profit is generally regarded as immoral, dirty and unsafe for both the vendor and the purchaser, although greater public attention has historically be directed toward the vendor (Shaver, 1994). Persons who in engage in the sex trade have been variously (and sometimes simultaneously) cast in popular culture as

victims of abusive circumstances, illicit drug addicts, wanton entrepreneurs, and are almost always depicted as female. Indeed, it has been said that sex workers epitomize the image of the "fallen" or "criminal" woman and provide the negative standard against which feminine virtue and characteristics of the good woman are defined (Boritch, 1997:89). Rarely viewed as a legitimate occupation, sex workers are unable to access the basic legislative protections typically associated with employment in Canada. Further, because of the ambivalent legal context of the sex trade, workers are generally unable or unwilling to seek police protection when they are criminally victimized in their places of work; the right to public protections are in effect forfeited because engaging in the sex trade is widely perceived as a calculated risk on the part of the vendor, making him or her responsible for any ensuing negative outcomes. As a consequence of the negative social construction of sex work in Canada, the majority of venues and freelance workers are located in hidden or marginal spaces (both socially and geographically), and most of the revenue from the sale of sexual services is generated outside the formal economy. Even sex trade related businesses that operate with a visible business storefront - such as exotic entertainment clubs - often use contract arrangements whereby the dancers' earnings remain separate from the businesses they work within in order to free the business from responsibility for any on-site activities that may compromise liquor license standards, labour standards or open the business up to criminal charges (Bruckert, 2002).

Given the Canadian setting described above, it is not surprising that sex work is widely perceived as involving many health risks, both to the individuals involved and to the public at large (Shaver, 1996). The health risks most commonly depicted in association with the sex trade include: Sexually Transmitted Infections (STI's), exposure to violence, and illicit drug use (Day and Ward, 1997). The tradition of linking sex work with sexually transmitted disease is

well entrenched in public thought and this has been the case for some time (Brock, 1998; Farley and Kelly, 2002). As a case in point, the United States, Canada and Britain enacted contagious disease legislation in the nineteenth century in order to address the spread of venereal diseases among the military (Day and Ward, 1997; Shaver, 1996). This act was never proclaimed in Canada, but in Britain and the United States it allowed the state to engage in compulsory health screening and the incarceration of women suspected of "prostitution" - on the pretense of protecting public health, in particular the health of the military (Brock, 1989; Day and Ward, 1997; Shaver, 1996). In Canada, provincial statutes, such as the British Columbia Venereal Diseases Suppression Act (1920-1940), were disproportionately applied to poor women and racial minorities, many of whom were thought to be prostitutes (Chunn, 1997). Some historians argue that these public health policies were instrumental in shaping sex work from a transient and widespread practice among poor women, to the segregated and socially condemned activity it is today – a shift that further marginalized those who trade sexual services and, paradoxically, heightened the risk of contracting STI's by pressing workers and clients to engage in more clandestine exchanges (Day and Ward, 1997).

The view that sex workers act as "conduits of disease" remains in much of the contemporary academic research and persists as the dominant public opinion. One of the more recent reincarnations of the "diseased prostitute" image is found in the flurry of literature produced in the 1980s through the 1990s on prostitution, illicit drug use and HIV transmission[3]. Sex workers (particularly those working as street "prostitutes") were depicted as a "high risk" population, capable of bridging the spread of HIV from the gay population to the heterosexual population (Jackson, Highcrest and Coates, 1992: 281). This view was extrapolated from the combination of high rates of STI's among sex workers, high rates of HIV among intravenous

drug users, and high rates of HIV among sex workers in parts of Africa. It was assumed, by extension, that the prevalence of HIV was likely high among sex workers in general (ibid.). Around the same time, and often connected with the literature on sex work and HIV transmission, a body of equally sensationalizing research was being produced on the influence of crack cocaine on low-income North American communities. Crack cocaine was linked with the derogatory stereotype, the "crack whore", a term which referred to a most desperate individual described as even more prone to engage in reckless sexual behaviour that might endanger herself and others because of *her* insatiable desire for crack cocaine (Erickson et. al., 2000; Maher and Daly, 1996; Murphy and Rosenbaum, 1997).

Several scholars have resisted the connections drawn between sex work and the transmission of disease (in particular HIV/AIDS) and have suggested that it is simply "scapegoating" a population that society is all-too-ready to condemn (Alexander, 1998; Brock, 1998; Downe, 1997). Similarly, researchers focusing on the social construction of illicit drug use have argued that the public panic concerning crack cocaine was biased by inattention to the social and cultural factors shaping illicit drug use and the diversity of drug consumption patterns among those who consume illicit drugs (Reinerman and Levine, 1997; Morgan and Lynn Zimmer, 1997). In addition, several Canadian researchers are taking a more critical stance with regard the social construction of health in the sex trade and embarking on research that moves beyond the health risk paradigm to paint a more complicated picture of the health among sex workers (Benoit and Millar, 2001; Jackson, 2001, 2002; Maticka-Tyndale et. al., 2000; Shaver, 1996, 1999). Increasingly, research is highlighting both the heterogeneity of the sex trade as a loose grouping of businesses and the variability of circumstances among those who become involved. For example, much of the recent Canadian literature is, at a minimum, sensitive to

both gender and the particular work environment when investigating health and safety in the sex trade, recognizing that both play an important role in the experiences one will have while working (Allman and Myers, 1999; Benoit and Millar, 2001; Maticka-Tyndale et. al., 2000; Shaver, 1999). With respect to the transmission of STI's and unsafe sexual practices, a recent, but substantial body of evidence suggests that safer sex practices in the commercial context are indeed high among the majority of sex workers, but not in their personal relationships. This makes the latter context an overlooked, yet important area for further research on STI's among sex workers (Benoit and Millar, 2001; Jackson 1992; Maticka-Tyndale and Lewis, 1999). In addition, although the rate of sexually transmitted infections among sex workers has been found to be higher than the rate among the general populace, the incidence of HIV/AIDS among sex workers in higher income countries is reported to be far lower than what was previously assumed (Benoit and Millar, 2001; Pyett and Warr, 1997)[4]. Among those reporting higher incidence of sexually transmitted and blood borne infections, including HIV/AIDS, are those who consume illicit drugs intravenously (Benoit and Millar, 2001; Campbell, 1991; Vanwesenbeeck et. al., 1993). However, only a sub group of injection drug users are involved in the sex trade (and vice versa); therefore, one must be attentive to safer drug use practices in addition to safer commercial sexual practices in order to accurately assess the risks faced by those whose circumstances encompass both. Indeed, it could be the case that commercial sexual exchanges are practiced safely, even if one's drug consumption practices outside the commercial context are not (or vice versa). In addition to focusing more attention on the interface between private and commercial contexts and a more diverse array of health concerns, recent research also demonstrates increased interest in the social and cultural factors that shape "risk" behaviour in cities across Canada (Jackson, 1992; Lewis and Maticka-Tyndale, 1999;

Lewis, Maticka-Tyndale and Shaver, 1999, unpublished research proposal). Taken together, these emerging research trends suggest that a multi-faceted investigation of the health status and health practices of sex workers, one that moves beyond the presumed risks of commercial disease transmission, is both appropriate and timely.

In addition to a lack of specificity, with regards to the heterogeneity of individuals and circumstances in the sex trade, the literature also suffers from a dearth of information on the status of sex workers with regards to basic population health determinants such as income, education, work and access to appropriate health services. Thus, the literature emphasizes health risks, but does so largely in the absence of corresponding background information on the social, economic and cultural health resources that contextualize the health behaviour of those in the sex trade. The omission of population health determinants in research on the sex trade is curious given the centrality of this model in contemporary sociological research on the health inequalities among and between populations (Darcy, 1998; Evans, et. al. 1994; Marmot, 1999; Williams, 2002), and results in two important problems in understanding the health of sex workers. First, by focusing exclusively on the health risks posed by commercial sex work, the complex interplay of factors that are recognized as having an influence on the health status of all individuals - genetic endowment, gender, income, education, early childhood experiences, social support and access to health services, are subsumed under one activity: occupation. Thus, the commercial sex trade occupies the foreground of conversation in both academic and public dialogue on health and sex work and little consideration is specifically focused on other potential causes of good or poor health. Although at first glance this may seem appropriate given the disreputable location of the sex trade, such a strategy would be considered unusual were it applied to a less stigmatized group of persons, and is itself confirmation of the ingrained

tendency to conflate all aspects of the stigmatized identity with the stigmatized designation – in this case, the *prostitute* identity. The second oversight brought about by the absence of data on population health determinants is that comparatively, little data have been collected using standardized, established health measures, which makes comparing the health of sex workers with other populations, including other populations of sex workers, problematic. As a result, it is difficult to assess the impact of sex work on health vis-à-vis other potentially health-determining factors and there is relatively little data on what distinguishes the health of sex workers from other populations, or on what might account for the differences in health status among different groups of sex workers. Thus, in addition to requiring a more diverse investigation of the health status and health risks faced by sex workers, the literature would also be strengthened by some basic data on population health determinants, particularly information that lends itself to inter-group comparison with other populations and intra-group comparison among sex workers.

When the conceptual framework of the population health model is applied to sex workers, one can envision the health of these individuals as a confluence of potential factors including the socio-economic and political environment that contextualizes the sex trade in Canada, the economic and social resources available to individual workers or groups of workers, the different working conditions encountered across the sex trade, personal coping strategies and the availability of appropriate health services. Such a view is complementary to the recommendations being made by sex trade scholars with regard to correcting gaps in the literature on the sex trade and health and fits with the theoretical orientation of sociologists working in the field of social inequities in access to health (Darcy, 1998; Denton and Walters, 1999; Mhatre and Deber, 1992). For example, with respect to safer sex practices, sex trade

researchers have recommended further research on how the structural and interactive context of the workplace influences health practices (Jackson, 1992; Maticka-Tyndale and Lewis, 1999). Alexander (1998) argues that a greater investigation of the more mundane workplace health risks faced by sex workers, including exposure to viruses, unclean work sites, urinary tract infections and musculoskeletal strain would go a long way in expanding knowledge concerning the health conditions that the workers themselves may be most concerned with. Others have suggested that a greater investigation of the psychological risks faced by those who work in the sex trade is needed, particularly because of the stigmatized social context in which the sex trade exists and because of the emotional toll on workers who provide personal services (Benoit and Millar, 2001; Bruckert, 2002: Hochschild, 1983). An investigation of the topics noted above is rationalized by the population health model under the occupational health determinant category, and would be enriched by complementary data on education, income, and gender, which are also encompassed by the population health model and have been shown to have a relationship with occupation (Brooks et. al., 1999; D'Arcy, 1998; Denton and Walters, 1999; Hodson and Sullivan, 2002; Keating & Keating and Hertzman, 1999; Ross and Wu, 1995).

1.1 Research Purpose

In response to the gaps in the literature noted above, the broad purpose of this thesis is to investigate the health status and health care access of sex workers from a sociological perspective, taking into account the social determinants of health found in the population health framework and empirical indicators of health status and health care access. This endeavour is theoretically framed by sociological formulations of class, stigma, and social marginalization as they have been applied to theories of social *inequalities* in health and *inequities* in access to

health. Where possible, the data regarding respondents' health status and service usage will be matched with data from other populations in order to highlight any apparent differences between the sex trade sample and other groups of Canadians or the population as a whole. Such comparisons are useful in illustrating the potential differences among the respondent population and other populations, but must be interpreted cautiously as they are based on the non-random, modified, snowball sample that forms the empirical basis of this project. Further, in recognition of the heterogeneity of the sex trade and the individuals who work within it, the analysis will also include attention to any apparent intra-group differences, especially as these differences may provide indications of the *specific* conditions that shape the health and health care access of those involved in the sex trade. The latter is indispensable with respect to determining whether sex work itself is a prominent determinant of health or if it is a surrogate for more proximal health-determining conditions that may be encountered by some individuals involved in the sex trade, but not others. In summary, the research objectives of this project are threefold:

1. Examine the health status, health care utilization, and health care access of sex workers in a medium size metropolitan area of Canada based on secondary analysis of an existing data set.

2. Situate the findings within the population health model, which, among other things, requires a corresponding examination of the social context of the sex trade as it is currently organized in Canada and offers the potential for comparison with other populations;

3. Identify policy, program and service delivery conditions that encourage (or conversely, discourage) health and health care access among the sex trade population, on both a socio-structural level and on a more micro or individual level.

In undertaking this project, I hope to contribute to ongoing efforts by researchers in the sociology of health to elucidate the inter-relationships between social structure, agency and

access to health. I also hope to contribute to ongoing efforts in order to better understand the health of sex workers according to a broad range of health determinants.

As will be discussed in greater detail in Chapter 4, this investigation is limited to secondary data analysis[5] of a non-random sample of 201 sex workers located in the Capital Regional District and must be regarded as an exploratory investigation rather than as a generalizable study.

1.2 Definitions of Key Concepts

A few definitions of key research concepts, some of which have been briefly introduced above, are discussed below. These definitions are pivotal to the theoretical framework of the thesis and lay the groundwork for the empirical analysis presented in succeeding chapters.

The Sex Trade

As noted earlier, the sex trade encompasses a diverse grouping of activities and venues, including indoor work, outdoor work, freelance contract work, independent businesses (self-employment) and more traditional employment situations that include a manager or boss to whom the employee reports. Sex trade activities include selling physical services or fantasies that are sexual in nature for money or payment in kind, including well-known services such as street prostitution, escort services (on-site or out call), exotic dancing (private or stage), internet services, erotic modeling or film, adult massage, telephone services and fetish-oriented services such as domination. Given the emphasis on "work" in this thesis, the actual transfer of money directly to the worker may be more relevant than payment-in-kind since the latter may be more typical in coercive sex trade circumstances, which are sometimes described as "survival sex". The term "survival sex" is more commonly applied to individuals (most often depicted as

young) who engage in the sex trade on an irregular or regular basis in order to avoid punishment from a third party or to obtain particular goods or basic necessities. The distinction between survival sex and sex work remains murky and is not easily resolved conceptually.

Sex Work

As will be discussed in fuller detail in succeeding chapters, one of the central determinants of health in the population health model is occupation (Hamilton and Bhatti, 1996). Accordingly, this research is informed by an understanding of the sex industry as a place of work, where individuals sell services or fantasies in order to earn a living and where the exchange of services or fantasies is governed by the needs of the customer, the wishes of management, and the local economy or marketplace –not unlike other low status personal service jobs commonly performed by working class individuals (Benoit and Millar, 2001; Brock, 1998; Lewis and Maticka-Tyndale, 1999a). Framing the sex trade as a place of work is somewhat controversial, particularly because it conjures up strong feelings with respect agency and sex work. Some scholars maintain that the sex trade is inherently exploitative and is predicated on patriarchal sexual relations, racism, poverty and violence, and therefore it is a misnomer to neutralize these conditions under the more liberal language of "work"[6]. Others, myself included, argue that the sex trade presents a labour opportunity that may appear attractive to some, and is often likely the means to a necessary end for those who have economic needs and few employment options. Also, stressing the economic and labour facets of sex work, Canadian sociologist Deborah Brock (1998: 12) states "I consider the context of the work; the social and economic power relations of living under capitalism that determine how women may be freely compelled…to find work in prostitution". Therefore, while on the one hand, it is arguable that the *sex work* construction falls short in explaining the experiences of some individuals who become involved

in the sex trade, on the other hand, arguments concerning the inherently exploitative nature of the sex trade do not explain, and may in fact, unwittingly silence, the experiences of those who regard their sex trade involvement as a work relation that is at once, and at different times, both exploitative and rewarding (Barton, 2002; Bruckert, 2002). The latter conception, which is more pluralistic and dynamic, challenges the common assumption that the discourses of "work" and "exploitation" in the sex trade are mutually exclusive or that individuals might not have a number of seemingly contradictory experiences over time. While recognizing that the most theoretically defensible conception of the sex trade is likely found between the work and exploitation paradigms, given the emphasis of this thesis on the social determinants of health, it is most appropriate to stress the work perspective because it shifts attention away from questions of morality, deviance, and coercion, and legitimizes a more pragmatic line of inquiry concerning the conditions that determine health and safety within a highly marginalized and stigmatized line of labour.

Health

Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity (World Health Organization, 1946)[7]. Accordingly, the study of health involves more than the study of the causes of disease, the treatment of sickness and the provision of services to those who are ill. Rather, the study of health involves a macro through micro level analysis of the social, psychological, bio-genetic, behavioral and environmental conditions that promote health and well being. Such an endeavour is interdisciplinary by nature and beyond the expertise of any one discipline. Sociological explanations of health and well being tend to focus on those aspects of health for which biological or medical explanation is either weak or insufficient (Coburn and Eakin, 1993). These aspects of health are said to be

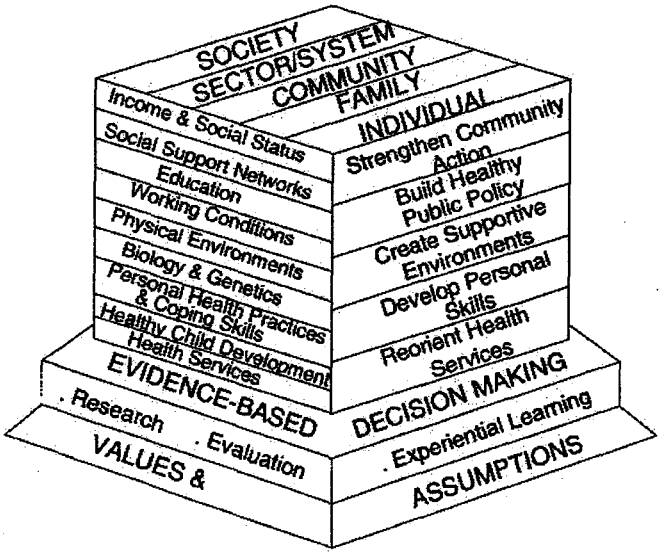
influenced by determinants, which include among other things, socio-economic status, gender, social relationships, and occupation.

Population Health (Social Determinants)

Current understandings of population health tend to mirror current definitions of health, in which indicators of sickness and disease have taken a back seat to factors that influence the health of entire populations and are implicated in personal achievement, growth and access to social resources (Health Canada, 1999). The Federal, Provincial and Territorial Advisory Committee (1997) defined population health as the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations or sub-populations over the life course, identifies systematic variations in their patterns of occurrence and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations (ibid).

The social determinants of health represent a particular subset of variables contained within the overall population health framework that are more "social" rather that genetic or biological, and thus, are most appropriate for sociological investigation. The primary social determinants of health that have been correlated with disease, disability or illness include: gender, ethnicity, social support, stress and socio-economic variables including work, income and education (Health Canada, 1999).

Figure 1: Hamilton and Bhatti's Population Health Promotion Model (1996)



Health Care Access

Health care access includes the provision and geographic availability of health services as well as the capacity to access services that are perceived as relevant and sensitive by clients (Stevenson, 1992). In Canada, where universal health care funding is theoretically available (however fees are charged by some provincial governments for certain health care services based on income), differences in access to basic health care are in some cases better explained by social and cultural variables than by economic and geographic variables.

Medical Dominance

Medical dominance refers to the supremacy of the bio-medical framework in conceptions of health. Medicalization – a corollary of medical dominance – can be described, rather than defined, as the process by which human activity and physical attributes are brought under the scope of medical evaluation and then subsequently defined and governed within the authority of the medical professions. Medicalization is a process of social control whereby medical knowledge is used to regulate definitions of physical, mental, and sexual health and

related behaviours (Conrad, 1992; Foucault, 1973). Medical dominance is relevant to the thesis topic when considering definitions of ill health and the patient – provider service encounter, both of which are pivotal to accessing health care.

Stigma

Prominent sociologist Erving Goffman (1963) defined stigma as a social attribute that is discrediting for an individual or group. It radically changes an individual's self-concept and typically spoils their identity, resulting in degrees of social exclusion that may span difficulty engaging in normal social interaction because of secrecy or shame to a societal discrediting of the stigmatized individual or group of individuals. The social emphasis on idealized, normative identity and conduct limits the ability of the discredited individual to achieve full acceptance by the society that he or she lives amidst and changes the nature of social interaction. Thus, stigma not only shapes the psychological and physical health of stigmatized individuals by limiting access to social and economic resources, it also shapes their access to health services and the interactions they have with health providers.

Having identified the main research purpose and defined the key research concepts, a brief overview of the remaining chapters is outlined below before moving into a fuller exploration of the sex trade and health literature.

1.3 Organization of Thesis

This thesis is divided into eight chapters. This chapter has provided an introduction to the research topic, research objectives and key research concepts. Chapter Two provides a review of the empirical literature on the sex trade and health, with a concentration on Canadian research literature and supplementary international literature. Dominant themes emerging from

the literature are summarized and areas requiring further research are also noted. Sociological perspectives on health, including the social determinants of health, the social gradient in population health, medical dominance and dimensions of access to health care, are introduced in the third chapter in order to situate the research within a broader sociological research program. Chapter Three concludes with a consideration of the interface between sociological perspectives on health and the empirical literature concerning the health of sex workers. Chapter Four provides an overview of the research methodology, including a brief description of the original project and an overview of the secondary data analysis procedures. A model of the variables under consideration is presented. Chapter Four also includes some reflection on methodological and ethical considerations in research on stigmatized populations, including: recruiting respondents in the absence of a sampling frame, the benefits and challenges of employing indigenous research assistants, and executing research in the context of a community-academic partnership. The purpose and procedures of a follow-up focus group meeting with local health practitioners regarding the research findings will also be presented. This chapter concludes with a discussion of the limits of the data set and resultant findings.

The presentation of research findings begins in Chapter Five, which opens with an empirical summary of the respondents' positioning along key population health determinants such as gender, income, education, family of origin, occupation and access to social support. Following this, a description of respondents' health status according to select mental and physical health indicators is presented in Chapter Six. Qualitative data representing respondents' views on their health and sex work are interwoven throughout the chapter to illustrate the descriptive statistics with the words of the respondents themselves. This chapter concludes with a summary of the main health and occupational safety concerns vocalized by

respondents. Chapter Seven is dedicated to findings concerning health care access. Qualitative data on relationships with health professionals and needed health care services are presented alongside select, descriptive, statistical data concerning the use of existing health services. In Chapter Eight, I revisit the material introduced in earlier chapters and discuss whether the research findings lend support to, or differ from, existing research and current knowledge on the sex trade and health. Chapter Eight concludes with insights provided by local health and social service professionals during a focus group meeting regarding the research findings, some consideration of the policy and program implications of the thesis findings, and areas for further research.

Chapter 2: A Review of the Empirical Literature on the Sex Trade and Health

The available literature on the sex trade is multidisciplinary and diverse, spanning disciplines such as history, women's studies, criminology, law, sociology, social work and psychology. Curiosity concerning the social deviance of commercial sexual exchange has prompted a great deal of empirical and theoretical literature on *who* becomes involved in the sex trade, *why* they become involved and *how* the socio-cultural context has been implicated in shaping the Canadian sex trade over time. Given the diversity of literature available regarding the sex trade, it is important to note that the review presented below is largely confined to studies relevant to the determinants of health and well-being among sex workers, including where applicable the social and legal context of sex work, and for the most part, does not include the large bodies of literature written by historians, feminists and criminologists.

As noted earlier, much of the empirical literature takes for granted a "social problem" or "health risk" perspective, and tends to concentrate on topics such as the personal and psychological characteristics of those that become involved in the sex trade and the health and social problems associated with sex work. Sex work is often viewed as exploitative for the individual or, alternatively, as a problem in residential neighborhoods. However, a handful of researchers have sought to circumvent debates regarding where sex work should be located and whether or not it is exploitative, and have instead focused on sex work as a marginal form of employment taken up by those with limited options in the labour market. By focusing on sex work as a labour relation, attention is shifted away from the apparent psychopathology of the individual who engages in what is regarded as deviant sexual behaviour, and toward the larger economic, legal and social factors that shape the sex industry as a diverse collective of work venues in which individuals encounter both benefits and drawbacks while earning a living.

Research from this perspective is more amenable to an analysis of the social determinants of health because it places sex workers in a comparable position to other members of society whose health and daily lives are shaped by work, income, education and the array of mechanisms through which the former become entangled with identity, health behaviour and family life. The *sex work* perspective is also more amenable to an examination of the heterogeneity of the sex trade because it affords some degree of normalization and individuality to those involved and avoids the inclination within the *social problem* perspective to typecast the identity of the sex worker in an effort to define and subsequently offer a solution to the problem of the sex trade.

It is important to remember that the two general perspectives noted above – social problem and work – are neither mutually exclusive, nor exhaustive, in their theoretical and empirical depiction of the sex trade. It is also possible to forge a compromise at the intersection of both perspectives, particularly in light of the heterogeneity of the sex trade and the diverse experiences had by individuals within it. Both bodies of work have made important contributions to our current understanding of the sex trade in Canada and elsewhere, and are an important indicator of contemporary social constructions of the sex industry and identities of "prostitution". An overview of the themes relevant to work, health and access to health care arising from both perspectives is presented below, along with some observations regarding areas for further research. The summary begins with the social and legal context of the sex trade, entering the sex trade and then moves on to topics regarding health and well-being.

2.1 The Legal Context

The law and regulatory frameworks that deal with the sale of sexual services differ substantially from those found in other labour contexts. As a semi-illegal occupation, sex workers are structurally denied access to the same rights, benefits or responsibilities as workers in legitimate occupations (Lewis and Maticka-Tyndale, 1999a); they have no legal status as workers, they are not protected by labor codes and therefore, are not eligible for the benefits enjoyed by socially-legitimated workers, such as sick leave, health insurance, social security, or worker's compensation. Even when employed in more formalized work settings such as escort agencies or massage parlours, workers are not protected by labor laws regarding working conditions and remain vulnerable to management exploitation (Phoenix, 1995).

There are three main classes of Federal law in Canada dealing with the sex trade: 1) procuring and living off the avails of prostitution; 2) bawdy house offenses; and 3) communicating in a public place for the purpose of buying or selling sexual services; However, as noted earlier, none of these laws actually make selling sex illegal. As Boritch notes, "the ambivalence of a law that criminalizes prostitution-related activities, but not prostitution itself, reflects long standing differences in how the problem of prostitution is construed and, consequently, what is deemed to be the appropriate legal response" (1997: 98). The legal ambiguity surrounding prostitution laws bestows a wide range of discretion on regulatory bodies in terms of how the laws are to be interpreted and subsequently enforced. As Lowman (1991: 124) notes, "the law contains within it the power to be mobilized against prostitution—whether at the behest of the police or some other lobby group able to influence law enforcement activity—no matter where it occurs". When the federal laws are combined with municipal bylaws and community norms, the sex trade can potentially become the focal point of

competing regulatory frameworks. Thus, as Lewis et. al. argue (1999, unpublished research proposal), the convergence of policies from several levels and sectors of government and their agencies creates a situation of competing jurisdiction that can impede - rather than enhance - the development of policies and programmes to improve work environments and the health and well-being of sex workers. In municipalities that license sex work occupations such as escort or body rub parlours, city employees, administrators and agencies of the city must be cautious that their actions, programmes, licensing policies cannot be seen as implying that what is being licensed involves the exchange of sex for money (ibid.). If such an implication could be drawn, the city could be found in violation of s. 212 of the *Criminal Code* (ibid.). Similarly, employers in sex trade venues must steer away from work practices that can be interpreted as evidence of solicitation or the on-premise exchange of sexual services, or they too can be similarly found in violation of section 212 (Procuring Offence) of the *Criminal Code* (ibid.). Thus, employers, even if willing, are discouraged from allowing workers and clients to openly negotiate service contracts, unable to openly supply workers with health resources, and are thus constrained in their ability to support workplace safety practices. This is not to say that the safety strategies described above are unilaterally prohibited; on the contrary, the organization of sex trade venues varies according to the extent to which prostitution laws are applied in a given location and during a particular period of time; therefore the practices of sex trade businesses vary tremendously. As a case in point, in the Capital Regional District, the Municipality of Victoria has only a handful of licensed sex trade venues because the business license fee and escort license fee is very costly in comparison to the neighbouring Municipality of Saanich, which as a result of the more reasonable business licensing fees, has more licensed sex trade businesses (See Benoit and Millar, 2001).

As noted earlier, prostitution laws have historically been more likely to be applied against women who sell sex, than they are to be applied against male clients and male sex workers. Lowman (1990: 63-64) has argued that this has been because of a commonly held view that most customers are "square johns who would not otherwise fall afoul with the law, while prostitutes are members of a criminal underclass whose lifestyle involves various types of law breaking" (Lowman, 1990: 63-4). Consequently, as it is legally constructed and enforced, the sex trade has been largely depicted as a female "crime". Shaver (1993) found that for every year between 1974 and 1991, the proportion of women charged with a prostitution-related offense was significantly greater than the proportion of men charged. Not only were male clients underrepresented in those charged, but male sex workers and pimps were also described as significantly less likely to be charged (Boritch, 1997). The discriminatory nature of prostitution law has historically not only been evident at the level of enforcement, but it is also notable in sentencing patterns. As Helen Boritch has summarized, "prostitutes are more likely than their male customers to be charged, to be convicted, to end up with criminal records, and to receive more severe sentences" (1997: 123).

However, more recent statistics suggest that some changes in patterns of laying criminal charges related to prostitution have taken place. The enactment of the communicating law has resulted in a substantial increase in charges against clients, to the extent that that police now appear to be charging sex workers and clients in close to equal numbers (Wolff and Geissel, 1997 in Lowman, 1998). While some of the male "johns" recently charged with the communicating offenses are likely to be male sex workers, the current situation in Canada with respect to the application of prostitution laws indicate that the historical bias to mainly charge female sex workers with prostitution offences appears to have eased somewhat.

In addition to gender-based patterns in the application of prostitution laws, enforcement patterns have also been discriminatory with respect to the type of sex work carried out, concentrating almost exclusively on the most public manifestation of the sex trade—the street trade. As Lowman notes, "police action against exploiters of prostitutes in the form of living off the avails and procuring charges is relatively minimal when compared to the effort devoted to the street trade" (1991: 120). A look at Canadian crime statistics further demonstrates how the street trade makes up the vast majority of prostitution related offenses. In 1992, police charges laid against individuals involved in the street trade represented 95 percent of all prostitution-related offenses (Boritch, 1997). Even amidst the changing patterns in the application of prostitution related laws, particularly those relating to "communicating" and "living off the avails", the street visible client (john) and the street visible "pimp" remained the target of police intervention throughout the 1990s; the burgeoning indoor sex industry, run by business managers who profit from the sale of sexual services and frequented by clients who purchase services outside of the public eye, remains largely ignored by politicians and law enforcement bodies, except in cases of public complaints (Lowman, 1998).

Needless to say, the law complicates the health and safety of sex workers by forcing the commercial exchange of sexual services to occur in hidden places, complicating efforts on the part of workers, employers and support persons to engage in organized workplace safety practices, discouraging workers from seeking public protection and services, and allowing the law enforcers to incarcerate workers and their clients upon their discretion. Thus, irrespective of the potential health problems associated with the work, the social and legal context of sex work in Canada is hazardous to workers. Putting the context of the sex trade on hold for a

moment, I would like to turn to the large body of literature that attempts to explain why individuals become involved in the sex trade in the first place.

2.2 Entering the Sex Trade: Demographics and Background Conditions

The question of what motivations and circumstances lead an individual to the sex trade is central to the literature on the sex trade, more so for those who work within the problem paradigm, because sex work is presumed to be both deviant and inherently undesirable. The antecedents of sex trade involvement are likely numerous and complex, however common causes typically noted in the social problem-style literature, include: history of trauma, including sexual and physical abuse (Badgley and Young, 1987; Shaver, 1993; Silbert and Pines, 1981); inadequate social support and disconnection (Silbert and Pines, 1981; 1982a; British Columbia, 2000); parental absence or neglect (Badgley and Young, 1987; British Columbia, 2000); low self-esteem and isolation (Silbert and Pines, 1982a; 1982b); homelessness or street involvement (Nadon et. al.,1998; Committee for Sexually Exploited Youth in the CRD, 1997; Earls and David, 1990); child welfare involvement (Earls and David, 1990; Nixon et. al 2002); drug and/or alcohol dependence (Green et. al., 1993; De Graaf et. al.,1995); and complications related to fetal alcohol syndrome (British Columbia, 2000). Early sexual abuse is perhaps one of the most commonly cited precipitating factors, with Canadian researchers reporting rates of incidence ranging from 28 percent (Shaver, 1993) to 73 percent (Badgley and Young, 1987) among those involved in the sex trade. The connection between childhood sexual abuse and later involvement in the sex trade has been found to be both independently linked to sex trade involvement through pathological sexual identity formation post-abuse (Simons & Whitbeck, 1991), and indirectly, by precipitating early departure from

the home, which in turn, is also linked with sex work involvement (Earls and David, 1990; Hagan and McCarthy). Bagley and Young (1987:23) sum-up the theory that child abuse leads to sex trade involvement as follows:

> Family disruption and family violence undermine children's capacity to avoid prevalent sexual and physical assaults. Sexually abused children act out in various ways; physically abused children react by running. Children who have been both physically and sexually abused are doubly at risk. On the streets these traumatized children have little psychological strength to resist the predators who lead them into drug and prostitution subcultures. The girl who finally tries prostitution is one who is already degraded and demoralized, in a state of psychological bondage, with grossly diminished self-confidence.

A corollary of the "cycle of abuse" argument is the position that sex work cannot be regarded as a choice because it is not possible to make an informed choice amidst conditions of psychological damage and deprivation from basic social and economic resources (Badgley and Young, 1987; Silbert and Pines, 1982a). As noted above, the childhood victimization narrative typified by Badgely and Young (1987) is more common among those who conceptualize the sex trade as a social problem, with many adherents emphasizing the vulnerability of young people to the preying tactics of recruiters – those whose job it is to seek out and entice new workers. For example, a recent report by the Government of British Columbia (2002) estimates that the average age of youth entering the sex trade is 15 years, with some entering as young as 11 years of age. Accordingly, both provincial and federal governments view sexual exploitation as a child welfare priority and have invested a great deal of programming resources at intervention.

Canadian sociologist Deborah Brock (1998) takes exception to the view presented above, arguing that government commissioned reports such as the Badgely Report (cited above) have set the standard for a new social problem – the sexual exploitation of youth. In doing so, these reports have obscured the economic reasons people enter the sex trade and have constructed an arbitrary distinction between youth and adult antecedents to sex trade involvement.

> The organization of the moral panic surrounding juvenile prostitution emphasized sexual abuse and pimping as determinants that adults were 'allowing' to take place through inaction. The

> perspectives of young people themselves, which emphasized lack of job skills and employment opportunities as causal, were effectively ignored (Brock 1998, 132).

Drawing on the work of Fred Matthews, a youth services provider, Brock (1998) argues that the focus on individual pathology caused by factors like sexual abuse, early sexual experience, family problems and coercion, is a problematic one because for many young people, entrance to the sex trade represents a solution in a given time and place, and not a problem. According to Brock's (1998) view, the troubles faced by young people who enter the sex trade are social, familial and economic, occurring long before they enter sex work. Finding themselves without family support, having limited job skills and education, sex work appears to these youth as an economically rational alternative in a free market economy that values youthful beauty and wealth (ibid.). Speaking on behalf of adult exotic dancers, Criminologist and former exotic dancer, Chris Bruckert (2002) makes a similar claim when she argues that for some working class women, stripping may be a viable strategy to realize the economic and social benefits afforded by participation in the paid labour force, while offering the flexibility to support other commitments (Edwards, 1988; Ishida, 1998; McLeod, 1982; McIntosh, 1978). Indeed, for those with limited employment options and financial responsibilities, sex work may appear as an efficient way to achieve the highest standard of living in a short period of time. The distinction between the psychologically scarred view (social problem) that was first presented and the economically motivated view is significant. While both acknowledge the social, economic and, in some cases, psychological vulnerability of those who work in the sex trade, the latter construction affords some agency and strategic initiative to individuals who become involved, as opposed to constructing them as passive victims playing out a cycle of lifelong abuse. Further, the *social problem* perspective supports the potential of government-endorsed child protection initiatives and legal sanctions as a strategy to curb the recruitment of

vulnerable young adults, whereas the second perspective places the problem of the sex trade more squarely within the economic, class and gender organization of the labour force.

Without suggesting that those who enter the sex trade are not indeed often marginalized economically or damaged by early childhood victimization, it is noteworthy that the statistics vary in regards to the proportion of sex workers who fit this profile. In all cases, a substantial minority, and sometimes a majority, of respondents do not report childhood victimization or poverty prior to entering sex work, suggesting that there are other factors involved in leading individuals to the sex trade. As Shaver (1999: 159) noted in her research, neither the levels of education nor the poverty rates of her respondents set them apart from the Canadian population at large; in fact, the demographic data collected supported a view of sex workers as a heterogeneous population. Further, as Vanwesenbeeck (1994: 22) notes, not all persons who share a history of sexual trauma and abuse end up in the sex trade, and as much as trauma and negative childhood experiences may be a factor in turning away from a conventional straight life, the form of deviance that one may engage later in life depends on a number of factors.

Some of the other factors presented in the literature, albeit less frequently than the dominant perspectives noted above, include: social proximity and "drift" (Pheterson, 1986; O'Neill, 1996; Silbert and Pines, 1981), curiosity (Boggs, 1991; Benoit and Millar, 2001); values (Brock, 1998), student costs (Delacoste and Alexander, 1998); desire for material goods (Boggs, 1991), and the market for sexual services (Vanwesenbeeck, 1994).

2.3 Gender and the Sex Trade

Usually portrayed as a "female crime" (Lowman, 1991), most research on the sex trade has largely overlooked male sex workers, and in doing so, has all but ignored differences

between the gender divisions of the sex trade. While female sex workers continue to far outnumber males, several studies have cited a significant contingent of male workers. For example, a headcount of street workers conducted in 1989 in Calgary, Toronto and Halifax, found that 18 percent of visible street workers in Calgary were male, 25 percent were male in Toronto, and 33 percent were male in Halifax (Shaver, 1993). Some researchers have suggested that the costs associated with sex work are more pronounced for female sex workers, who typically suffer greater stigma and loss of social status, are arrested more often than male workers, and are more likely to bear the brunt of occupational hazards such as violent assault than males (Shaver, 1993). Although relatively little research has systematically investigated differences in rates of violence and earning among male and female sex workers, preliminary evidence has led some to theorize that "the differences between female and male prostitutes regarding job hazards and earning power suggest that most of the undesirable aspects of prostitution are linked to broader social problems rather than the commercialization of sex" (Shaver, 1993: 167). In other words, patterns in the gendered division of labour and socially constructed roles of women, relative to men, observed in the broader social context, are mirrored to some extent in the gendered division of labour experiences found within the sex trade. Differences based on gender form but one of the points of variation among sex workers; other points of difference include, but are not limited to, location of work, areas of specialty, workplace autonomy and worker characteristics. Some of the noted bases of intra-group difference are discussed in more detail in the next section.

2.4 Organization of the Sex Trade

While many researchers and the public at large continue to view the sex trade through dominant stereotypes, other research indicates that the sex trade is far more variable and complex, challenging the common assumptions of both the organization of the sex trade and the activities of the individuals involved. Recognizing the highly variable nature of sex work, many researchers are paying closer attention to the specific location and working conditions in which sexual labour take place:

> Sex workers all perform erotic labor, but their accounts of that experience vary dramatically from the "happy hooker" to the "sex worker survivor". The source of those differences may lie less in the "nature" of erotic labor than in the social location of the worker performing it and the conditions under which the work takes place (Chapkis, 1997, 98).

A great deal of research indicates that the sex trade is highly stratified according to venue. While it has been estimated that on-street workers in any major centre across North America represent roughly only 20 percent of the total population of sex workers (Campbell, 1991; Jackson and Highcrest, 1996), there nevertheless seems to be an inverse relationship between the public visibility of sex work and its social status (Lowman, 1991). Thus it should come as no surprise that street workers are usually regarded as representing the lowest stratum of the trade. However, the working conditions of on-street workers may not be as grim as is commonly portrayed. For instance, in a review of recent field studies conducted on street prostitution in Canada, Shaver (1993) found that many street workers worked independently, indicating that one of the purportedly most negative aspects of the street trade—the presence and influence of pimps—may be exaggerated. Nevertheless, the locations in which the on-street trade is conducted (for example, sometimes taking place in customer's cars, motel rooms, or even public places), are suggestive of a more vulnerable work context (Barnard, 1993). In

addition, as noted earlier, the public visibility of street workers makes them more vulnerable to arrest and the burden of a criminal record (Lowman, 1991; Shaver, 1993).

Sex workers working operating in indoor venues such as massage parlors or escort agencies, whose work largely remains hidden from pubic view, occupy a relatively higher social status. Indoor workers are less likely to be identified as sex workers by others, and as a result, are able to maintain a more respectable public image. While data on indoor sex workers is limited, it is believed that the rights of indoor workers are more extensive than that of their counterparts working in the more visible street trade. Some scholars suggest that indoor workers are generally able to command higher fees than street workers, and thus receive higher payment for their work (Boritch, 1997). As well, sex workers located in escort agencies or other indoor venues, are thought to be less vulnerable to arrest and victimization, and enjoy safer, more stable work conditions (Lowman and Fraser, 1995; Pyett and Warr, 1997; Jackson et. al., 1992; Lewis and Maticka-Tyndale, 1999a). However, many sex workers are unable to meet the higher standards associated with the indoor trade. As Lowman and Fraser (1995: 132) note, "for most of the women at the low price end of the street trade (a large proportion of whom are also involved in injection drug use) there are no viable off-street venues". Thus, while it is common for sex workers to move between various venues and work occupations within the sex trade, so-called higher status sex trade positions such as escort work may not be accessible to some individuals.

It has also been suggested that factors such as class, race/ethnicity and length of time in the trade can influence the degree of autonomy exercised by some workers. For example, in the United States, racial minorities are reported to be considered of lower status than Caucasian sex workers (Chapkis, 1997). A similar situation of ethnicity based discrimination has been

reported to effect the experiences of Aboriginal sex workers in Canada (Brock, 1998). Social status is said to "not only influence a worker's ability to screen out undesirable clients and refuse dangerous services, but also determine the ease with which a woman will be able to transition out of sex work into other forms of employment" (Chapkis, 1997: 100).

Anecdotal information and empirical research suggest that a large proportion of sex workers in the CRD are independently employed (Benoit and Millar, 2001). Although not a homogenous group, self-employed sex workers, often working out of their own homes, are able to exercise a great deal of control over the details of their work. These details include: price of labor, net earnings, pace of work, choice of clientele and activities performed (Benoit and Millar, 2001). Thus, self-employed sex workers are often able to retain more control over the details of their work, perhaps more so than workers who report to a supervisor in legitimate occupations and similar to other self-employed individuals. In general, because they tend to cater to clients who are better off, and often specialize in more diverse sexual requirements (for example, domination), these sex workers are often able to command substantial fees, and therefore are believed to earn significantly more than other groups of sex workers (Davidson, 1995). Many build up a regular clientele, which provides a more steady and reliable source of income than is associated with other forms of sex work. In addition, independent workers are believed to exercise a great deal of control over the details of the services they perform, making them less vulnerable than either on-street or escort and massage parlor workers to sexually transmitted infections (Davidson, 1995). Summarizing the more lucrative conditions enjoyed by "Desiree" a self-employed sex worker, Davidson (1995:5) notes:

> Unlike the majority of workers, Desiree has chosen, designed and owns the physical environment she works in. She plans and controls all aspects of her business; where and how to advertise, who to employ and what tasks to assign them, the pricing system, what services are and are not on offer, the hours and days of business.

Although mainly applied to conventional, and often professional, work environments, research regarding health in the work place has long stressed the importance of autonomy over one's labour to both workplace satisfaction and work related stress (Karasek, 1989). Worker autonomy and control over the conditions of work have also been described as relevant to service workers who often sacrifice their own feelings in order to ensure that the customer has a pleasurable experience (Hochschild, 1983; Leidner, 1993). This "estrangement of self" from the work role is aggravated by a lack of control over the conditions of work. Thus, there is reason to believe that autonomy exercised by self-employed sex workers may be significant to their health.

While on average there is decreased risk of client violence, and police and public harassment among indoor workers due to the fact that the work is being conducted in less publicly visible, but also less isolated environments, some research suggest that indoor workers may have less control over work conditions relative to independent street-based and home-based, self-employed workers (Benoit and Millar, 2001). Applying the research concerning workplace autonomy and the estrangement of self that can occur in service occupations to the marginalized work settings of the sex trade, the importance of autonomy becomes readily apparent; by entering into an employment relation with a third party such as agency owner or manager, a sex worker may lose some or all personal control over her own rate of work, price of labor, choice of clientele and activities performed (Phoenix, 1995). The consequences of this loss of autonomy many be compounded if the worker also internalizes or otherwise struggles with the negative social construction of sex work in his/her social community.

2.5 Social Stigma and Sex Work

There is little doubt that the commercial sale of sexual services is regarded as deviant in Canadian society and those who engage in such activities are negatively labeled. It is the act of selling sex that is seen as morally reprehensible, not the act of buying it (Brock, 1998). However as noted earlier, increased attention is being paid to clients of sex workers by community leaders and law enforcement personnel in an effort to curb the visible sex trade in Canada.

Living amidst the negative portrayal of sex work undoubtedly takes a toll in the well-being of persons involved in the sex trade. According to Goffman: "the standards [s]he has incorporated from the wider society equip him to be intimately alive to what others see as his failing, inevitably causing him [her], if only for moments, to agree that [s]he does indeed fall short of what [s]he really ought to be. Shame becomes a central possibility..." (1963: 7). Thus, the management of a stigmatized identity is also central to the question of health and well-being among sex workers; not only do workers have to confront negative social constructions of their identity but the these stereotypes are impact workplace health and safety by defining the nature of services and supports available to workers. Public condemnation puts sex workers in a place of being wary of not only the police and regulatory bodies, but also health and social service providers. At the same time, because the dominant social stereotypes do not represent the majority worker – indoor, non-street involved – the array of services and supports available only meet the needs of some individuals. Finally, the negative stigma of the sex trade also impacts personal relationships by making it unlikely, in many cases, that workers will receive support from family or friends who are not themselves involved in the sex trade and/or other socially marginalized activities. Indeed, as Goffman (1963: 95) notes, a very widely employed

strategy of the discreditable person is to handle his risks by dividing the world into a large group to whom [s]he tells nothing, and a small group to whom [s]he tells all. Maintaining social distance from others is one of the main strategies employed by stigmatized individuals who wish to "pass" as normal in social settings; of course, managing the stigmatized information both impedes social relationships and places a psychological burden on the stigmatized individual (ibid.)

2.6 Violence and Sex Work

Although violence is one of the dominant themes found in the literature on the sex trade and health, much of it is anecdotal and where empirical evidence is available, it is usually in the form of criminological statistics. There is relatively little detailed information on the health consequences of violence, or on how workers manage the stress associated the ever-present possibility of encountering a "bad date".

Street workers are considered to be the most at risk for assault, robbery and other forms of violence, so much so that some scholars have concluded that violence is the greatest health risk faced by those engaged in the sex trade (Farley and Barkan, 1998; Green and Goldberg, 1993; Lowman and Fraser, 1995; McKeganey and Barnard, 1996; Pyett and Warr, 1997; Vanwesenbeeck et. al., 1995). For instance, 98 percent of street workers interviewed in the Vancouver Downtown Eastside reported that they had been victims of violence as a result of a "bad date" with a client (Currie, 1995). Silbert and Pines (1982b) reported that 70 percent of their sample had experienced rape by customers and 65 percent had been physically assaulted. Other research indicates that the majority of sex workers, regardless of venue, have been the victim of violence on the job at least once in their careers (Plumridge and Abel, 2001; Maticka-

Tyndale et. al., 1999; Lewis and Maticka-Tyndale, 2000). However, Shaver (1993) cautions that violence should not be interpreted as inherent to sex work, since the risks are more likely gender-based, rather than work-based.

Two of the psychological health consequences associated with violence among sex workers include *dissociation* – the psychological process of placing distance between oneself and the traumatic experiences by closing off certain emotions and environmental stimuli (Farley and Kelly, 2002; Vanwesenbeeck, 1994), and Post Traumatic Stress Disorder, which is characterized by feelings of depression, anxiety and reoccurring states of panic (Farley et. al., 1998).

Research findings indicate that clients are most often the persons responsible for incidences of victimization and harassment against sex workers (Lowman and Fraser, 1995; McKeganey and Barnard, 1996); however, victimization at the hands of boyfriends/partners, other sex workers, the police and even the general public has also been reported. The perception that sex work is inherently risky and that sex workers are on some level responsible for their own victimization because they engage in socially and legally unsanctioned sexual activity discourages them from seeking the protective services of the police (Green and Goldberg, 1993; Lewis and Maticka-Tyndale 2000; Miller, 1993a). Some researchers contend that serial crimes against sex workers do not generate as much public concern as they do when they are perpetrated against other members of society (Alexander, 1998; Farley and Kelly, 2000). For example, rape may be viewed as failure to follow the contract of sex exchange but not as a violent sexual assault because prostitutes are viewed a having lost the right to say "no" (Farley and Kelly, 2000; Maticka-Tyndale and Lewis, 1999).

2.7 Mental Health

With the exception of the literature on child abuse and violence, the mental well being of sex workers has not been extensively investigated by sex trade scholars. Farley and Barkan (1998), report that 68 percent of the sex workers they interviewed met criteria for a clinical diagnosis of Post-Traumatic Stress Disorder. They concluded that the severity of Post-Traumatic Stress Disorder experienced by sex workers was significantly associated with childhood sexual and physical assault and sexual or physical assault while working in the sex trade (ibid.). Similarly, Vanwesenbeeck (1994) found that dissociation in people working as sex workers to be common and Alexander (1998) found depression to be high among sex workers. Research indicates that psychological distress and mental health conditions are in part the result of diminished access to social support, problems in personal romantic relationships, and the ongoing stress of managing a stigmatized identity (Alexander, 1998; Farley and Kelly, 2000), however there is much work to be done in specifying how mental health conditions such as depression, self esteem, anxiety and social support are associated with sex work – either as an antecedent to involvement or as a consequence of involvement.

2.8 Health Risk Behaviour - Safer Sex Practices, STI's and Drug and Alcohol Use

Without question, the bulk of the literature addressing health and the sex trade concerns sexually transmitted infections. Adherents to the health risk/social problem perspective have largely confined their analysis of health among sex workers to safer sex practices and the spread of HIV/AIDS and other infectious diseases. In the early years of the HIV epidemic, sex workers were viewed as one of the primary sources of heterosexual infection and as transmitters of HIV from the homosexual population to heterosexuals (Jackson et. al., 2002). The depiction

of sex workers as conduits of disease prompted a backlash by researchers, who argued that, as a group, sex workers had been scapegoated in the AIDS crisis, and there was little direct evidence to support the claims being made about the purported incidence of HIV among this population (Alexander, 1998; Downe, 2001a). Davies and Feldman (1997: 35) describe the difficulty of assessing the risks of HIV among sex workers:

> *"...it seems a dubious and unscientific undertaking to compare the rates of HIV positivity in populations that are culturally diverse, from samples that vary in representatives and in countries at different stages of the epidemic, as if the label prostitute were a universal category with specific physical potentials for infection rather than a socially and culturally bound and constrained set of social and sexual practices and relationships.*

Beyond the vagaries of sample characteristics from population to population and place to place, two additional factors confound the issue of sex trade work and risks of sexually transmitted infection: the presence of IV drug users who are involved in the sex trade and who are at increased risk due to personal drug use practices (Alexander, 1998; Campbell, 1991); and personal sexual practices outside the commercial context (Alexander, 1998; Jackson, 2002). Recent evidence on the rates of HIV positivity amongst sex workers in Europe and North America indicate that HIV infection in the population of non-intravenous drug using sex workers is generally low (Campbell, 1991; McKeganey and Barnard, 1992; Pyett and Warr, 1997; Scambler et. al., 1990; Vanwesenbeeck, 1993), but certain groups may be more at risk than others (Jackson et. al., 1992; Jackson and Highcrest, 1996). For example, it has been noted by several researchers that individuals who engage in injection drug use face a substantially greater risk of coming in contact with the HIV/AIDS virus and other blood-borne sexually transmitted infections such as Hepatitis C than those who do not use drugs intravenously (Campbell, 1991; de Graaf et. al., 1995; Pyett et. al., 1996). However, the interface of risks presented by the combination of injection drug use and sex work is a complicated matter and it

is problematic to assume that those who consume drugs intravenously are unilaterally more at risk than their counterparts who do not use substances this way. Indeed, at the root of the problem of blood borne infections is not intravenous drug use per se, but the lack of available resources for intravenous drug users and the hidden nature of illicit drug use, both of which inevitably lead to contexts of use where resources are scare and individuals resort to sharing syringes and other equipment.

There is some evidence to suggest that both HIV infection and unsafe sexual practices are higher among male sex workers than female sex workers, but again, critics point to problems of sample representativeness (Feldman and Davies, 1997), and the lack of sound epidemiological evidence to substantiate such a belief (Allman and Myers, 1999). In a study comparing the practices of a control group of homosexual men and a group of sex workers, Shaver and Newmeyer (1996) did not find significant differences in either sexual activities or the frequency of unsafe sexual practices between the two groups, although there was some suggestion that risk-taking varied by sexual identity. Several researchers have noted that the risks for contracting HIV or other infections may be greatest in personal relationships where workers are less likely to practice safer sex (Campbell, 1991; Green et. al., 1993; Jackson et. al., 2002; Pyett et. al., 1996). Similar to many others in intimate relationships, sex workers may not view their sexual relations with private partners as possible sources of HIV infection from which they need to protect themselves and may be inclined to abandon safer sex practices as the relationship develops and trust is established (McKeganey and Barnard, 1992). A further reason sex workers choose to not use condoms in private sexual relationships, is the need to differentiate their work from their private lives – in some cases, it may be their partners who feel strongly about this differentiation (Pyett, et. al., 1996; Jackson et. al., 2002); however the premise of

heightened risk in personal contexts rests on the presumption that sex workers have romantic partners who belong to higher risk groups with regard to contact with sexually transmitted diseases. The latter may well be the case, but further empirical evidence is required before any conclusions can be drawn.

In addition to the risk of HIV infection, sex work is also associated with greater incidence of STIs such as Gonorrhea, Chlamydia, and Syphilis, which are in turn related sexual health problems, including cervical cancer and pelvic inflammatory disease (Carr, 1995; Elizabeth Fry Society, 1985, Maticka-Tyndale et. al., 1999; Maticka-Tyndale and Lewis, 1999; Weeks et. al., 1998; Ward et. al., 1993). For instance, 32 percent of street prostitutes in London reported ever having had a sexually transmitted infection (Gossop et. al., 1995) and 20 percent of brothel workers in Australia reported having had an STI at some point in their career (Pyett et. al., 1996). Interestingly, Maticka-Tyndale et. al., (1999) found that 35 percent of female exotic dancers in Windsor, Ontario reported histories of STI's, even though exotic dancing does not in and of itself place workers at risk for STI's. They concluded that the risks of contracting STI's as a dancer were to be found in instances of unwanted touching, lap dancing, and among those workers who in addition to working as exotic dancers, also engaged in paid sexual services with clients (ibid.). In addition, of the aforementioned contexts of risk were argued to be, to a greater or lesser extent, susceptible to the influence of the work site management (ibid.).

Safer sex practices are considered to be the primary factor influencing the transmission of STI's. While much research has shown a high level of condom use in commercial sexual contacts overall (Alexander, 1998; Allman and Myers, 1999; Campbell, 1991; Carr, 1995; Davies and Feldman, 1997; Day and Ward, 1997; Maticka-Tyndale and Lewis, 1999; Ward and Day, 1997; Weeks et. al., 1998), several factors are believed to influence the frequency and

consistency of condom use. Research has shown that condom use may be abandoned or rendered ineffective in the following circumstances: condom failure, either unintentional or deliberately damaged by clients (McKeganey and Barnard, 1992; Scambler et. al., 1990); with regular clients who successfully negotiate special services that do not include safer sex (Vanwesenbeeck et. al., 1993; Jackson and Highcrest, 1996); when financial need is acute (as is often the case among the most marginalized workers), when the customer is willing to pay extra for unprotected sex (Jackson et. al., 1992; Scambler et. al., 1990; Scambler and Scambler, 1995) and, in situations in which condom use is beyond the worker's control, such as with violent customers or when third party control is a factor (Barnard, 1993; McKeganey and Barnard, 1992). Other, more contextual factors influencing safer sex practices include the policies of the work site, including the health standards enforced by management, the pace of work, the earning structure and levels of stress in the work environment, and the individual risk management style adopted by the worker (Maticka-Tyndale and Lewis, 1999; Vanwesenbeeck, 1994). Vanwesenbeeck (1994) found that female workers who disliked the work and had the greatest history of trauma in their lives were the most likely to engage in indiscriminate, non-safe intercourse and/or the most likely to be the victims of forced, unprotected sexual violence. Interestingly, female workers who demonstrated the highest levels of well-well being and thought of their work in professional and positive terms were the second most likely to engage in unsafe sexual intercourse, usually with regular clients or clients who are were perceived as attractive, and sometimes for their own pleasure. The group that was the least likely to engage in unsafe commercial intercourse were those whose health and well being might be described as average and whose attitude toward the work was business like, but neither strongly negative nor positive. Finally, young, inexperienced workers have also been reported to be more likely to

engage in unsafe sexual practices (Pyett and Warr, 1997).

The semi-legal and stigmatized context of the sex trade in Canada is also described as a barrier to safer sex practices since condoms can be treated as evidence of prohibited sexual exchange by the police when found on the person of street workers or within the staff areas of exotic entertainment clubs and agencies (Alexander, 1998). In addition, workers are less likely to report instances of unprotected sexual assault and have reason to avoid targeted prevention programs and resources, however well meaning or appropriate, because of the shame associated with identifying as a sex worker (Jackson et. al., 1992, 2002). Finally, the stigma of the sex trade results in isolation and dissociative defense mechanisms among sex workers, which in turn can contribute to risk by lessening the worker's investment in maintaining his/her own well-being (ibid; Vanwesenbeeck, 1994).

It has often been argued that the public licensing of sex workers presents an opportunity to reduce risks by instituting mandatory health screening, a practice that is exercised in parts of Australia, the United States and Europe. While mandatory health screening may have benefits with regard to the early detection and treatment of STI's, critics suggest that it is difficult to enforce and can result in a two-tier system between licensed and unlicensed workers, with the latter not sharing the same access to health care and at greater risk (Campbell, 1991). It has also been argued that the premise for mandatory testing is a desire to protect the public from contracting infections rather than to protect the health of sex workers. Mandatory testing may result in the paradoxical effect of reducing safer sex practices if clients perceive that licensed workers are free of infections (ibid.). In Ontario, Canada, Lewis and Maticka-Tyndale (2000) report that although licensing was intended to enhance the health of escorts in the municipalities that have licensing provisions, there are many drawbacks for workers, including

the use of the licensing information by police for the purpose of monitoring and sometimes harassing workers in order to make them leave the industry.

The topic of drug and alcohol use has already been raised at several junctures – as influencing safer sex practices, as precipitating involvement in the sex trade, and as an additional context of risk where blood borne infections may be acquired (among intravenous drug users in particular). Indeed, the topic of illicit drug use and "addiction" is central to the existing literature on the sex trade and health. However, just as licit and illicit drugs are a matter of socio-cultural interpretation, so to is the concept of drug addiction and the embodiment of addiction in "the addict" (Alexander, 2001; Campbell, 2000). In a manner almost parallel to how the sex trade is social constructed as a social, criminal, health problem, addiction is also constructed in contemporary society as a medical-legal-moral hybrid; on the one hand, "the addict" is constructed as victim of disease (and in the case of IV drug use, a public health concern), however, on the other hand, illicit drug users are also criminalized and constructed as morally inadequate. Illicit drug use is almost always depicted as pathological use, and heroin and crack cocaine in particular, are viewed as leading to only one kind of use: problematic. In a manner similar to sex trade scholars, scholars studying the social construction of illicit drug use have suggested that social stereotypes regarding illicit drug use are also infused with moral and medical rhetoric that may be more political than factual. For example, contrary to dominant stereotypes regarding the dangers of illicit drugs, it has been argued that illicit drugs can be used recreationally with little to no negative outcome for the user, and the impact of any drug is always the composite outcome of the psychological mind-set of the user, the social setting of use, and the historically and culturally specific meanings through which drug effects are interpreted (Zinburg, 1984 in Reinerman and Levine, 1997). Like the sex trade,

illicit drug use takes place within an environment of secrecy and shame and on the empirical literature is likely biased by an over representation of the most visible and marginalized individuals, who for reasons of poverty, homelessness, criminal justice and child welfare involvement, are afforded less privacy and social autonomy in their lives than other citizens (Boyd, 1999; Hepburn, 1993).

As might be expected, the existing literature on drug use and the sex trade almost exclusively pertains to women. Six main themes emerge at the intersection of the literature on the sex trade and drug use. First, existing research suggests that illicit drug and alcohol consumption is common among sex workers (Boritch, 1997; Volero et. al., 2001; Alexander, 1998). Second, the use of illicit drugs (and sometimes alcohol) is commonly depicted as an antecedent to entering the sex trade (Carr, 1995) and often in the context of abuse and victimization (Alexander, 1998). Third, once involved in sex work, drug use has been described as playing a functional role in helping workers to cope with the stress, unpredictability and less desirable aspects of their work (Carr, 1995; De Graaf et. al., 1995; Maticka-Tyndale and Lewis, 1999). The fourth theme concerns the segregation of sex workers with illicit drug problems to outdoor venues where visible signs of drug and alcohol use are tolerated (Alexander, 1998; Carr, 1995; Kail, 1995). Street work is also said to place illicit drug users at greater risk for criminal involvement (Kail et. al., 1995). The fifth theme, which may be better described as several themes, concerns the health status and health-related behaviour of sex workers who use illicit drugs. Researchers have reported that women who had a problematic dependence on (usually illicit) substances before they entered the sex trade tend to use condoms less and engage in higher risk activities (Alexander, 1998; Campbell, 1991; de Graaf et al.,1995; Weeks et. al.,1998). For example, clients offering greater financial rewards for unprotected sex have

been reported by many sex workers (Jackson et. al., 1992; McKeganey and Barnard, 1992, 1996; Morrison and Reuben, 1995; Vanwesenbeeck, 1994), and the temptation to accept economic inducements for unprotected sex is thought to be greater for those working to support an illicit drug dependency because of the high street value of some illicit drugs (Alexander, 1998; Campbell, 1991; Morrison and Rueben, 1995; Shuler et. al., 1995; Vanwesenbeeck et. al., 1993). Those who began substance misuse after entering the sex trade may have done so because of workplace stress, availability, and its functional role in reducing inhibitions; but they have been described as more likely to use condoms and practice other risk-reduction techniques relative to those who entered the sex trade to support an established substance habit (Alexander, 1998; Maticka-Tyndale et. al., 1999). Compared to female IV users outside the sex trade, female IV users *in* the sex trade are thought to be more likely to be involved in health risk behaviour (Kail et. al., 1995), and drug use has been described as a greater predictor of HIV for women, as it has been argued that they are more likely to share needles than males (Campbell, 1991; Kail et. al., 1995), in part, because they are more likely to require assistance with the injection process (Spittal, et. al., 2002), and may be more likely to be the second user when a syringe is shared.

Finally, those who frequently use illicit drugs are believed to have higher rates of hospital utilization and comparatively less access to general practitioners and family physicians (Morrison and Ruben, 1995; Stein et. al., 2000), making them a costly patient group within the health care system. It has also been suggested that those with illicit drug dependencies are more likely to experience negative treatment in health service contexts. Persons with children may avoid seeking services related to negative substance use because of concerns regarding the

involvement of child welfare by medical professionals (Boyd, 1999; Sandi Merriman House, 1996; Shuler, Gleberg & Davis, 1995; Weiner, 1996).

Studies actually measuring the actual prevalence of alcohol and drug use among sex workers are limited, and the findings seem to vary according to population accessed. Focusing on street-involved workers, Currie (1995) and McKeganey and Barnard (1996) estimated that the majority of their respondents were regular intravenous drug-users. However, Pyett's (1996) study of individuals working in an off-street venue (legalized brothel), found that only 27 percent reported ever injecting drugs, suggesting that the prevalence of illicit drug use varies according to venue.

2.9 Access to Appropriate Health Services

Given the preoccupation with health risks, one might expect a corresponding emphasis on access to health services in the literature on the sex trade; however, this topic is only addressed in a cursory manner, and typically focuses on barriers to service utilization when it is addressed. A number of barriers to service utilization have been identified, more often on a theoretical level, than through empirical measurement. For example, sex workers report a reluctance to engage with professional services for fear of discrimination (Snell, 1991). Even though some studies suggest that workers regularly access certain services including medical services, they often do not disclose their line of work to medical professionals (Benoit and Millar, 2001; Carr, 1995; Davies and Feldman, 1997; Scambler et. al.,1990). Although alternative medical clinics such as community needle exchanges and other services designed with the needs of street-involved clients in mind offer an important point of health care access for many sex workers, the downside of such services is that they are often staffed by non-

medical professionals, nurses, and only on occasion, physicians, which is a weakness insofar as it corresponds to limited availability of services that can only be delivered by physicians. In addition, alternative health service sites are often under-funded and may not be able to offer a great deal of continuity of care because if they are organized on a drop-in, "first come, first serve" basis. If sex trade workers are fortunate enough to have regular physicians but do not disclose their line of work, they may have increased continuity of care but their specific health needs may not be met—diagnosis and relevant treatment is less likely to occur without open communication (Maticka-Tyndale and Lewis, 1999; Scambler et. al.,1990). Reluctance to disclose involvement in the sex trade is justified to the extent that some physicians, like other members of the public, have strong personal and/or moral objections to sex trade work (Carr, 1995). Even within the medical field where professional ethics prohibit discrimination, there is a history of open condemnation of sex work (Carr, 1995).

Another barrier to health care access may be the behavioral norms expected from clients. The most marginalized and vulnerable sex trade workers (those with psychiatric conditions or presenting patterns of problem substance use) may not present as co-operative clients, resulting in communication difficulties with service providers who are not skilled in serving "challenging" populations (Weiner, 1996). Services to vulnerable populations, such as persons with unstable or no housing, must take into account the difficulty of keeping appointments and producing personal health care identification (Morrison and Rueben, 1995). In addition, many services require that the client be able to commit to appointments in the future, which in and of itself, is a formidable barrier to those whose lives are generally unstable (Sandi Merriman House, 1996; Weiner, 1996). On the other hand, because the street community is the most visible and obvious group requiring specialized health service, the few alternative services that

are available are designed with the above-noted needs in mind and often result in a service model that is neither attractive nor appropriate to indoor sex trade workers whose lives are more stable and health needs less acute (Maticka-Tyndale and Lewis, 1999).

Delivering appropriate health care means understanding the health beliefs and help seeking patterns of the target population (Stevenson, 1992). Although there is little Canadian data on the help seeking patterns of sex workers, an interesting study of sex workers in India by Evans and Lambert (1997), found that by focusing on agency and personal health beliefs, the help seeking patterns of their research population appeared both rational and purposeful. Evans and Lambert (1997) found that the health needs identified by workers were much broader than the obvious concern with sexual health screening; convenience and perceived efficacy of treatment were important considerations in seeking help as were the personal characteristics of physicians and effective doctor-patient communication (Evans, and Lambert, 1997; see also, Maticka-Tyndale and Lewis, 1999). In addition, the workers they interviewed demonstrated an acceptance of certain health risks as inevitable and had developed particular beliefs regarding health and illness that were peculiar to sex trade work and not necessarily in sync with broader cultural beliefs (ibid.). Thus, the likelihood that sex workers draw on subcultures of knowledge that are specific to their social environment when thinking about health is further reason for health providers and health researchers to look beyond the traditional biomedical framework to examine local definitions of health and the socio-cultural-economic contexts in which help seeking behaviour is carried out (Evans and Lambert, 1997).

In summary, the literature on the sex trade and health is dominated by a health risk perspective, and for the most part, tends to concentrate on topics such as STI's, safer sex practices, HIV/AIDS, violence, and illicit drug use, and the risks that lead to involvement in the sex trade in the first place. The social and legal context of the sex trade is also a dominant topic in the literature, with many researchers highlighting how the legal framework surrounding prostitution in Canada helps shape and reproduce contexts of risk by relegating sex trade activity to hidden locations and complicating access to social support. However, there are some important gaps left by the dominant focus on risks and socio-legal context in the literature on sex work and health. First, the range of health concerns identified as important to sex workers – safe, clean work sites, muscle strain, personal relationships, and self concept - have yet to be fully explored, although they are frequently touched upon (Alexander, 1998). There is some indication that mental health problems may be a concern among sex workers, particularly because of the negative stigma that surrounds the sex trade, but mental health has not been widely addressed, except where it is said to be compromised by violence encountered in the trade or where it has been speculated as contributing to risk behaviour. Finally, sex workers have been isolated in the literature as a specific population and little effort has been directed at comparing their situation with that of other sub-populations. In other words, the health of sex workers is often presumed to be determined, in large part, by their involvement in sex work; however this presumption cannot be substantiated without comparison and may indeed be overstated, especially since there seems to be a fair amount of agreement among scholars that persons entering the sex trade often do so in the context of poor access to social and economic resources. Poor social and economic conditions offer a competing, yet complementary explanation of poor health among the sex trade population, even irrespective of the risks most

directly associated with sex work such as STI's and violence. Thus, sociological studies on the socio-economic determinants of inequality in health comprise a complementary body of literature that can be considered alongside the literature on health and the sex trade. The literature produced by sociologists studying the social determinants of health focuses more generally on the social and economic resources that result in some populations having greater access to good health and satisfactory health care, while others are disadvantaged by poverty, poor access to social support, hazardous working conditions, and low levels of education. This literature contains many insights that are relevant to the situation of sex workers. The social determinants of health model adopted by sociologists studying disparities in health is a promising model through which some of the gaps noted above with regards to the literature on the health of sex workers can be investigated; it includes occupation as a central determinant of health, but also moves beyond occupation to explore how education, social support, family experiences, class and socio-cultural resources interface with one another and influence the health of individuals and populations. Before moving into a description of the research methodology, it is worth noting some of the significant insights brought by sociologists regarding health, health care access and socio-economic marginalization.

Chapter 3: Sociological Perspectives on Health and Health Care Access

3.1 Sociological Interpretations of the Social Determinants of Health

As noted earlier, Sociological studies of health and health care access tend to focus on the social factors that are influential in shaping health and access to health care. The primary social determinants of health that have been correlated with disease, disability or illness include: gender, ethnicity, social support, stress and socio-economic variables including work, income and education (Health Canada, 1999). It has been found that low income Canadians are more likely to be diagnosed with heart disease and mental health conditions, suffer greater incidence of chronic stress, and have shorter life expectancies compared to higher income groups (D'Arcy, 1998; Federal, Provincial and Territorial Advisory Committee on Population Health, 1996; Kawachi and Kennedy, 1999; Stolzman, 1988). Similarly, workers in jobs with high demand and low decision latitude have greater incidence of psychological distress and worker injury (Wilkins and Beaudet, 1998). Other occupational mental health risks such as lack of control, uncertainty, and conflict are associated with the onset of psychosomatic disorders and worker leave (Quick et. al., 1992). In addition, those who work in marginal or irregular jobs have access to fewer health and welfare benefits and other protective workplace regulations (Reskin and Padavic, 1994; Hodson and Sullivan, 2002).

Although the research points to clear patterns in the connection between socio-economic status and health in an almost deterministic manner, less is known about the specific mechanisms through which socio-economic status determines health in particular populations. Social conditions are thought to result in physical symptoms via biological pathways such as the immune system and stress responses (Evans et al., 1994); however the bio-psychological

mechanisms whereby social stimuli are converted to physical symptoms are not well-understood, at least not by sociologists whose more natural domain of inquiry includes the generation and regeneration of social relations and not the specific biological and psychological impact of particular social environments.

A central topic of debate among social scientists studying inequality in access to health is the structure/agency dualism. As Williams (2003: 135) notes, sociologists invoke social structure as a defense against biological reductionism and behavioural subjectivism in health; it places the study of power, however defined, at the heart of the sociology of health and illness. The resurgence of interest in social determinants of health has created space for a more specifically sociological contribution to interdisciplinary debate on the connections between structures, ideologies, polices, life courses, and their impact on health and well-being (ibid.). Fairly early on in the study of the social inequalities in health, the widely cited "Black Report" (Black et. al., 1985), a study of the differences in health status among the British working class, identified four possible types of explanation for class differences in health: measurement artifact, natural or social selection, materialist/structuralist explanations and cultural-behavioral explanations. While noting the difficulty of disentangling the elements and directions of causal processes, Black and his colleagues argued firmly that materialist/structuralist explanations were most promising as they were the only explanations that could simultaneously account for an observed overall improvement in health among populations in high income countries at the same time overall class differences in health maintained relatively the same. Marmot (2002) makes a similar point, concluding that economic disparity among the classes, rather than base population income, is the most important economic-related determinant of health. Thus, in the United States where the average income is high, but income disparity is also high, the health of

the lower classes follows the same patterns observed in countries with considerably lower average incomes among the elite and working classes. Linking the income-based gradient in health with social theory, scholars have suggested that disparities in relative income correspond with disparities in social capital – defined as the resources available through social connections and social relationships - between lower-income and higher-income classes (Kawachi et. al., 1997).

Although debates regarding the primacy of agency (behaviour) and structure (social context) continue in full force, health sociologists are marking out new territory at the intersection of these domains, based on the increasing availability of mature longitudinal data (Wilkinson, 1996). Newer models of social inequality in health circumvent the false antithesis of agency and structure by enveloping both under the rubric of the "social determinants of health", described as a more layered, pluralistic approach to modeling disparities in health (Williams, 2003).

As noted earlier, the social determinants of health include: socio-economic determinants (income, education and occupation), gender and other identity based-determinants, social relationships and psychosocial factors. However, despite the accumulation of data on the social determinants of health, some notably weak points remain in this body of work. First, the emphasis on "social risk factors" in epidemiology-oriented studies, have shifted the emphasis for action away from the social collective and toward the individual by treating "risks" as ontological givens enacted by individuals. As Shim (2002: 134) states, "epidemiology renders invisible the very social relations of power structuring material and psychic conditions and life chances that contribute to the stratification of health and illness. Epidemiological investigation of health risks has been criticized as methodologically sound, but theoretically weak

(Williamson, 2002). Second, the macro social determinants of health have eclipsed more subjective, or micro level explanations of why individuals behave one way or another in the context of wider social structures. In other words, there is a lack of persuasive theoretical or empirical literature connecting the beliefs and behaviours that are developed and regenerated in specific socio-cultural contexts with disparities in health outcomes among social classes? In order to break past the agency/structure dualism and develop a more rigorous theory of social inequality and health, health sociologists are advocating for greater attention to be paid to the recursive and co-dependent nature of individuals practices and collective lifestyles, to the lay knowledge deployed by individuals in the temporal and social locales of their lives (Williams, 2003). At any given point, class is only a broad indicator of a "probabilistic cascade of events" which needs to be seen in combination if the effects of social environment on health are to be understood (Bartely et. al., 1998: 11 in Williams, 2003: 138). The conception of a "probabilistic cascade" of events that loosely correspond to class location is alluring as it illustrates how social situations and health consequences are more likely to effect some members of society than others, can build up over time, exposing people to different kinds of risks and benefits at different points in the life cycle, and result in broad based class differences in health.

3.2 Social Determinants of Health Care Access

The majority of health services in Canada are designed to intervene in "illness" based on a bio-medical model of health (Segall and Chappell, 2000). The development of the Canadian health care system – often more aptly referred to as the "sick care system" – is complex but can be broadly reduced to two major developments: 1.) The development of the hospital system and related hospital insurance legislations; and 2.) The successful organizing and ascendancy of physicians as a professional group within the medical system. As a result of these developments, one can scarcely talk about access to health services without first establishing a context of need based on sickness, and second, addressing the relationship between patients and their physicians, especially since physicians control approximately 80% of health care costs, making service utilization provider-driven rather than consumer driven (Segall and Chappell, 2000; Evans, 1976 in Segall and Chappell, 2000).

Although physicians appear to have the most significant influence on the use of health care services, the Canadian assumption is that the *need,* rather than ability, drives the use of health care services because of the universal funding system. Thus, as one might expect based on the social determinants of health, lower income groups have greater health care needs and use more services (Broyles et. al., 1983).

"Predisposing factors" and "enabling conditions" mediate the relationship between sickness and seeking health services. Predisposing factors include demographic, socio-structural and attitudinal-belief variables, whereas enabling conditions include those conditions that facilitate use – such as having transportation (Segall and Chappell, 2000). Although sickness determines need, the point at which one identifies with the sick role and becomes motivated to seek treatment may be influenced by education, lay-beliefs about health and well-

being, and interactions within one's personal social network.

As definitions of good and poor health are to a lesser or greater extent socially constructed, one of the driving forces behind the provision of health care is the *medicalisation* of human behaviour and functioning. Sociologists have devoted considerable energy to understanding the social conditions under which behaviours and conditions are *medicalised*, a concept which "consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical definition to 'treat' it" (Conrad, 1992: 211; see also Zola, 1972). Recently, it has been argued that medical dominance, most often exercised by physicians, is on the decline and consumers of health care are exercising greater control over their health and health services. The supposed decline in medical dominance in public conceptions of health, help seeking behaviour, and patient provider-interactions is said to be the result of widespread public scepticism about the ability of medicine to solve health problems, increasing lay-knowledge regarding health (Blishen, 1991; Haug, 1988) and government efforts in countries such as Canada to control escalating physician-related costs by seeking less expensive methods of delivering health care (Coburn *et al*, 1983). However, the likelihood that the lower classes are able to participate in this movement of consumer control over health to the same extent that those in higher socio-economic classes are is doubtful.

Drawing on the work of Johnson (1972), Clarke (2000) outlines three crucial variables that determine the amount of social power held by a professional group: 1) the more esoteric the professional knowledge, and the less accessible to the lay public, the greater the power; 2) the greater the social distance between the professional and the client, the greater the power; 3) the greater the homogeneity of the professional group in contrast with the heterogeneity of the

client group, the greater the power. By all accounts health professionals, in particular physicians, hold more social power than socially marginalized patients such as sex workers. Thus, when physicians convey ideologic notions about desirable health behaviour, especially as these notions help shape patients' roles in the public and private spheres, medical encounters contribute to the broader hegemonic impact of dominant ideologies (Waitzken, 1998: 280). This is not encouraging if we consider the interaction between physicians and individuals belonging to disadvantaged and stigmatized social groups. Not only are they likely to ignore the social factors that shape the lives of socially and economically marginalized clients, since these do not hold prominence in the bio-medical model, but physicians are also culturally and economically removed from such experiences because they occupy one of highest echelons in the social hierarchy. Consequently, there is reason to assume that one of the barriers faced by sex workers accessing health care is the social distance between the patient and the service provider as well as the possibility that the physician will convey biases in the service context that mirror dominant social values and are disaffirming to the stigmatized client.

In summary, sociological insights on health and health care access suggest that the health and health care access of sex workers is also likely explained by their relative average position in the social hierarchy, by their social class. Thus, the education, income, social relationships and overall socio-cultural class location of sex workers are central determinants of health that likely interact with and reinforce their experience as sex workers.

Chapter 4: Methodology and Research Process

4.1 Conducting Research on the Sex Trade

Research on the sex trade requires consideration of the methodological challenges created by the context of social disapproval that surrounds the sex trade. Sex workers belong to what Heckathorn (1997, 2002) describes as a "hidden population". Hidden populations have two characteristics: first, no sampling frame exists, so the size and boundaries of the population are unknown; and second, there exist strong privacy concerns because membership involves stigmatized or illegal behaviour (ibid.). Hidden populations, such as sex workers, actively avoid identification and cannot be accessed through conventional means such as public records because they do not occupy a legitimate occupation in Canada and the conditions of the work vary from licensed and regulated to completely freelance and unregulated, except by the criminal code. Other populations that bear the characteristics of a "hidden population" include persons with HIV or other stigmatizing health conditions, illicit drug users, sex workers and groups of persons who engage in behaviours that are illegal or otherwise subject to social condemnation, including being the customer of a sex worker. Referring to similar characteristics, Heaman (2001) describes such populations as vulnerable; a term that she explains encompasses social minority status, lower socio-economic status, or other stigmatizing markers (cf. Demi and Warren, 1995). According to Heaman (2001), vulnerable populations are exposed to increased risk for health problems and should be considered a priority in health research. She also notes, however, that researching vulnerable populations usually entails barriers to research that include perceived inconvenience on the part of potential participants, negative attitudes toward research and researchers, and inadequate evidence that the research

will benefit participants (ibid; cf. Larson, 1994; Moore, 1997; Swanson and Ward, 1995). Bearing in mind Heaman's (2001) and Heckathorn's (1997, 2002) descriptions of "vulnerable" and "hidden" populations, and the challenges they note with regard to researching these populations, I describe some of the challenges and limitations encountered by the principal researchers while carrying out the research project on which this study is based. I also describe some strategies for minimizing the adverse impact such challenges can have on the research process before taking a closer look at the basic characteristics of the data set.

Without a sampling frame, or adequate existing research on the size and character of the sex trade population, it is virtually impossible to confidently determine the representativeness of research samples relative to the target population (Bagley and Young, 1987; Pyett et. al., 1996; Lewis and Maticka-Tyndale, 2000). Based on a methodological review of the existing literature, there is reason to assume that a great deal of the research is not representative of the sex trade population as a whole, although it may be representative of particular sub-populations. One fundamental problem in the literature is the varying conceptualizations of the sex trade. Research on sex trade populations includes studies of mainly outdoor, street workers (Pyett and Warr, 1997; Shaver, 1996), studies that encompass an array of sub-occupations within the sex trade, including outdoor workers and indoor workers (Benoit and Millar, 2001; Jackson, Highcrest and Coates, 1992; Vanwesenbeeck, 1994), and studies focusing on particular occupations within the sex industry such as exotic dancing (Maticka-Tyndale et. al.). While most sex trade scholars are careful to specify any apparent biases or exclusions in their research samples, some do not, which is problematic given the heterogeneity of the trade and a lack of reliable information on the different sectors that make up the sex trade as a whole. Further complicating efforts to neatly categorize the organization of the sex trade is the existing

evidence that movement across the sex industry by workers is quite common and the distinctions between different types of work may be permeable with some workers performing more than one service out of a single venue (Maticka-Tyndale and Lewis, 1999) and others working in more than one venue at a time and/or in more than one venue over time (Benoit and Millar, 2001). Although the sex trade is made-up of several sub-sectors, the organization of these sectors in relation to one another and the movement of workers across them is complex and not amenable to simple categorization.

A second difficulty in accessing diverse research samples is that some populations are more accessible than others because they work in visible locations such as the street, attend health and social service clinics, or are incarcerated in local detention facilities (Carr, 1995; Green, et. al., 1993; Heaman, 2001; Miller, 1995). While these visible points of access to hidden populations provide a valuable resource to researchers, they also introduce sample biases and weaken the external validity of the findings. For example, sex workers who access local health and social service sites are doing so in most instances because they have health and social problems for which they are seeking support. Although sex workers may access service sites proactively in order to maintain good health, in most cases, if a particular health service site is known to be servicing sex workers, it is usually because the site is offering a specialized service accessible to marginalized populations who have difficulty attending mainstream services (i.e. street based nursing clinic, STI Clinic). Thus, research projects that rely on the clientele of health and social service sites are likely to attract respondent samples whose health may be more problematic than workers who do not attend such services. In a likewise fashion, research projects that sample sex workers in detention facilities may be biased toward more marginalized or visible sex trade groups. Other recruitment methods may also undermine external validity by

introducing participation biases via incentives that attract more economically marginalized participants or advertising in particular venues known to be accessed by certain sub-populations of sex workers. The reputation of the research sponsors among the target population can also influence patterns of participation. More specific to the sex trade is the possibility that participation may be blocked by third parties, including pimps and workplace managers, who do not want to draw attention to the potentially illegal aspects of their businesses or unfavourable workplace practices. Some scholars have suggested that the most hidden aspects of the sex trade are the worksites of the most marginalized sex workers – minors, migrant women and those working for pimps – and these workers are unlikely to be reached by academic researchers. Of course, it is difficult to determine to what extent such circumstances present a gap in the research literature or a widespread public myth since most of the existing information about these sex trade venues is anecdotal.

In order to facilitate access to culturally and socially difficult-to-reach populations, many researchers are adopting more "participatory" or "experiential" research models (Johnson and Arfken, 1992; Lewis and Maticka-Tyndale, 1999b, Lillie-Blanton and Hofman, 1995; Plumridge et. al., 1997; Pyett and Warr, 1997; Silbert and Pines, 1981). While participatory models vary immensely, they generally involve a collaborative partnership between academic researchers and community members who are either indigenous to the target population or who are proximal to the target population. These individuals are believed to have privileged access to the research population because of their insider status relative to the target group, or in the case of those proximal to the target group (service providers, for example), because they are able to draw on their experience interacting with the target population in order to assess the usefulness of the research from their alternate, yet relevant perspective. In addition to the basic

requirement of establishing a research partnership, collaborative projects almost always entail some form of negotiation regarding the roles and expectations of each partner in the collaboration.

Lewis and Maticka-Tyndale (1999) summarize the range of research partnerships in their typology of *classic*, *collaborative* and *experiential* research models. The classic research model is described as a model in which the academic partner maintains control and primary influence over the research questions, research instrument, data collection and data analysis. Researchers may involve persons from the target population in a consultative role, but the project is primarily driven by the interests of the researcher (ibid.). The benefit of this model is that it is simple and more efficient from the perspective of the academic researcher because it avoids the time consuming activities of seeking out research partners, negotiating the objectives and processes of the research, and maintaining the research partnerships. The major drawback of this model is that it may be perceived as minimally inclusive of the views of sex workers and their advocates, and may therefore be regarded with skepticism or disdain by the target population, some of whom are likely to feel that their experiences are being exploited in order to further the academic portfolio of the researchers.

Collaborative research involves a more equitable partnership between researchers and members of the target population (or other stakeholders) and varies in terms of the roles assigned to the academic and non-academic partners. One of the central tenets of this model is that the researchers and members of the target population share some common research interests that are enhanced by the partnership model. If this is not the case, Lewis and Maticka-Tyndale suggest that one of the other research models may be more appropriate (ibid.). The strengths of the collaborative model lie in the benefits of a team approach to research – the research process

is informed by multiple perspectives, relationships of trust are developed that may be drawn upon in future research projects, access to the target population may be strengthened, and the findings have the potential to be relevant to a number of audiences inside and outside the academy. The main drawbacks with this approach is the time consuming nature of collaboration, negotiation and renegotiation among the various stakeholders in the research process and the potential that the research will in fact be undermined if differences in opinion and skill between the research partners become insurmountable. In such instances, the academic partners are more likely to bear the brunt of the failed research relationship if the project is funded according to collaboration-oriented project deliverables (ibid.).

The third model outlined by Lewis and Maticka-Tyndale is called the "sex worker as researcher model". This model is also often referred to as the "indigenous researcher" or "experiential researcher" model because it involves persons indigenous to the target population initiating and carrying out the research with the consultative assistant of academic researchers when needed. The objectives and process of the research remain with the indigenous researchers in much the same way the purpose and objectives are the primary domain of the academic in the classic model. The primary advantage of this model is that it is potentially more responsive to the research needs of sex workers and/or their community of stakeholders and advocates. However, research funding agencies are not as likely to fund projects in the absence of an academic researcher willing to take professional responsibility for the allocation of research funds, and indigenous groups may not possess either the expertise or time to carry out a quality research project (ibid.).

It is important to reiterate that each of these models has a place in research on the sex trade and whether one adopts one model over another is wholly a matter of the research

objectives, target audience, time frame, funding considerations and the availability of research partners. Moreover, the models as depicted are not mutually exclusive and might be better depicted as a continuum. On one side of the continuum, the academic researcher maintains complete authority and control over the research, whereas on the other, the indigenous researcher maintains complete control and authority. Of course, these models often carry an implicit assumption that the views and opinions of academic researchers, indigenous groups and community members stand in opposition to one another, when in fact, the perspectives of insiders (indigenous groups) and outsiders (academics and some community stakeholders) are themselves quite diverse. For example, while an experiential research model may be more likely to meet the needs of sex worker communities than a classical research model, this is not to say that research conducted by indigenous groups will necessarily reflect the opinions and knowledge of all members of the group. Likewise, research conducted by one academic will not meet the approval of all academics. Making a similar critique of claims to epistemic privilege based on insider and outsider status, Merton (1972) argued that a combination of views arising from multiple positions in relation to the research topic results in the most rigorous knowledge claims.

As will be discussed in greater detail below, the data set on which this project is based bears some of the characteristics of the collaborative model and some of the characteristics of the experiential model. The idea for the research was developed by a local social service organization staffed by former sex workers (Prostitutes Empowerment Education and Resource Society (PEERS). After filing a letter of intent with the BC Health Research Foundation, PEERS approached a local consultant and a researcher from the University of Victoria (Dr. Cecilia Benoit) to help develop the grant application. The grant application was successful, and

an advisory board of community stakeholders representing other service agencies, the provincial government, and the capital regional district was put together (Benoit and Millar, 2001). Indigenous research assistants, under the guidance of the academic partners and community consultants, carried out the data collection and some aspects of data management. This particular research collaboration entailed both benefits and drawbacks for the primary researchers (Benoit et. al, forthcoming). Some of the more notable benefits for the researchers included access to the research population and the opportunity to combine experiential and academic knowledge in designing the research instrument and carrying out the project. For the community partners, the opportunity to help design and carry out research that was relevant to the services they provide and to program funding applications was one of the most significant benefits of the partnership. For those who became indigenous research assistants, acquisition of important job skills, the opportunity earn a decent wage in a mainstream job, and a context in which to gain a different perspective on their personal experiences in the trade were significant benefits.

Despite the numerous benefits of collaboration, researchers have also noted some drawbacks to using indigenous interviewer assistants in research on marginalized populations. For example, interviews conducted by indigenous interviewers has been associated with interviewer bias and often involves extensive training of the assistants, which may or may not result in effective interviewing skills (Heckathorn, 1995). Although, the use of indigenous research assistants was by and large a positive experience, and certainly integral to the success of the research project on which this thesis is based, the researchers noted that additional time and resources were expended ensuring the indigenous research assistants were trained to

perform their roles as interviewers. Commenting on the process of training the indigenous research assistants who took part in the current project, Benoit et. al. (forthcoming) note:

> "Because those hired had little formal experience in conducting research, a considerable amount of time was required in order to train the interviewers in interview techniques. There was the possibility, for example, that the interviewers would not have the same sense of commitment to the rigors of conducting social research.

It has also been suggested that the same credentials that make indigenous assistants excellent at assisting with access to marginalized and hidden research populations also portend problems as these attributes may not be compatible with the norms of the more traditional work environment in which some academic research is carried out (Broadhead and Fox, 1990; Seidman, 1998; Sixsmith et. al., 2003). In addition, access to the research population can be just as easily be used to screen potential participants if indigenous assistants see reason to play a gate-keeping role between the research and the target population Also, where communities are small and the research issues sensitive, the use of indigenous research assistants can also create problems if participants fear that confidentiality may be breached (Sixsmith, 2003).

4.2 The Data Set

As noted earlier, 201 active and former, adult sex workers, located in a range of sex trade venues were interviewed for the project. A subset of the respondents, who were currently active in indoor venues or had left the sex trade (n=79), completed the open-ended questionnaire. Of the 201 respondents, 147 were active workers, and 54 were exited workers. 160 of the respondents identified as female and 36 as male. Five respondents identified as transgendered. The gender distribution of the respondents approximates other estimations found in Canada and provided a reasonable sample from which to examine gender differences.[9] In addition, persons of Aboriginal descent were overrepresented in the sample in comparison to

regional estimates of the Aboriginal population. This is not surprising as it follows patterns estimated by other Canadian researchers (Save the Children, 2001). The age range of the respondents was 17 to 60 years, with a mean age of 32 years. The workers represented a variety of sex trade sites, but given the difficulty of estimating the sex trade population and the paucity of confident estimations in the literature, it is unclear whether the non-random, purposive sample accessed by the research team was generally representative of the local sex trade population as a whole.

Respondents were recruited through a variety of means, including advertisements, existing social contacts, and by accessing the clientele of PEERS and Sandy Merriman House[10]. An honorarium of forty dollars was offered to participants who completed the study, which may have had an impact on the sample characteristics. On the one hand, it might be expected that the more economically-marginalized and hidden sex workers might have been more reluctant to participate in the study because of distrust, fear of exposure or third party abuse, on the other hand, the honorarium might have offset such deterrents by appealing to the financial need of exploited and/or substance dependent workers in need of money. While the value of incentives have been noted by many (Demi and Warren, 1995; Kelly and Cordell, 1996), researchers targeting vulnerable populations must balance ethical concerns regarding wanting to acknowledge the time and contribution of participants, but yet at the same time, take into account that financial incentives in the context of voluntary participation may be problematic when the targeted population is financially deprived.

Benoit and Millar's (2001) research was conducted by former sex workers who were trained as research assistants. As noted above, this strategy benefited the project in two principal ways: 1) it provided a valuable employment opportunity for the research assistants

who were developing employment skills, and 2) it brought some experiential expertise to the project, which the original researchers argued was beneficial both for the respondents who preferred to be interviewed by an experiential individuals, and for the researchers who benefit from having inside knowledge on the research team.

The research instrument was the collaborative outcome of the community-academic team. The broad range of research questions reflects an effort on the part of the research team to gather information about the lives of sex workers and to determine which perspective of sex work presented in the literature—the social problem perspective or the occupation perspective—was best able to explain their findings. The questionnaire included both closed-ended, survey style questions and semi-structured, open-ended questions.

Individuals who did not consider themselves as sex workers in the same vein as others, or individuals who otherwise do not wish to associate themselves with other sex workers may have also been reluctant to participate in the study. Nevertheless, given the difficulty of studying this population and the relative lack of similar data with which to compare it, the information provided by the respondents is an important contribution to the literature, regardless of whether or not it is thoroughly representative of its target population.

One of the benefits of the research design was its use of both closed ended measures of key variables of interest alongside qualitative interview questions. According to Davidson and Layder, "surveys can play a vital role in confirming more qualitative research, in highlighting gaps in knowledge or issues that require further investigation, and in revealing broader patterns that might be missed if researchers relied solely upon qualitative methods" (1994:, 115). Combining methods allows the researcher to discover the possibilities and overcome the limitations of each. As Critcher et. al., (1999:82) suggest, "in assessing the relative

contributions of qualitative and quantitative methods, it soon becomes apparent that each has the potential to compensate for the weaknesses of the other". Insights obtained from the qualitative portion of the interview schedule therefore added texture and detail to the quantitative data. It was hoped that triangulating in-depth, semi-structured interviews with close ended survey questions would improve measurement and provide a more detailed and descriptively rich picture of the experiences of sex workers in the CRD.

Advertisements were posted throughout the Capital Regional District in local agencies that provide services to current and former sex workers, at Camosun College and the University of Victoria, as well as in Monday Magazine and the Times Colonist at various points during the data collection period.

The first portion of the questionnaire dealt with demographic and background information: 1) demographic variables (including gender, age, ethnicity, sexual orientation, education, etc.); and 2) family background (including, living situation while growing up, relationships and experiences with mother and father/guardians, experiences of abuse and neglect, etc.). Following this, a series of questions on experiences in the sex trade were posed, including the circumstances the led to sex work, attempts to leave, types of sex work/venues worked in, relative control over work situation and benefits and drawbacks of the work. The questionnaire next addressed health issues, including experiences of violence/victimization while working in the trade, substance use, physical and sexual health, mental health, safer sex practices and the use of birth control. The questionnaire closed with questions on personal relationships and social support systems (See Appendix 1). The open-ended questions covered a range of topics including respondent views regarding the sex trade and health, experiences

accessing health care services, the characteristics of a good health service provider and additional questions regarding respondents' views of sex work.

4.3 Research Questions

Using data from the non-random sample of male and female sex workers described above, this thesis explores the following research questions.

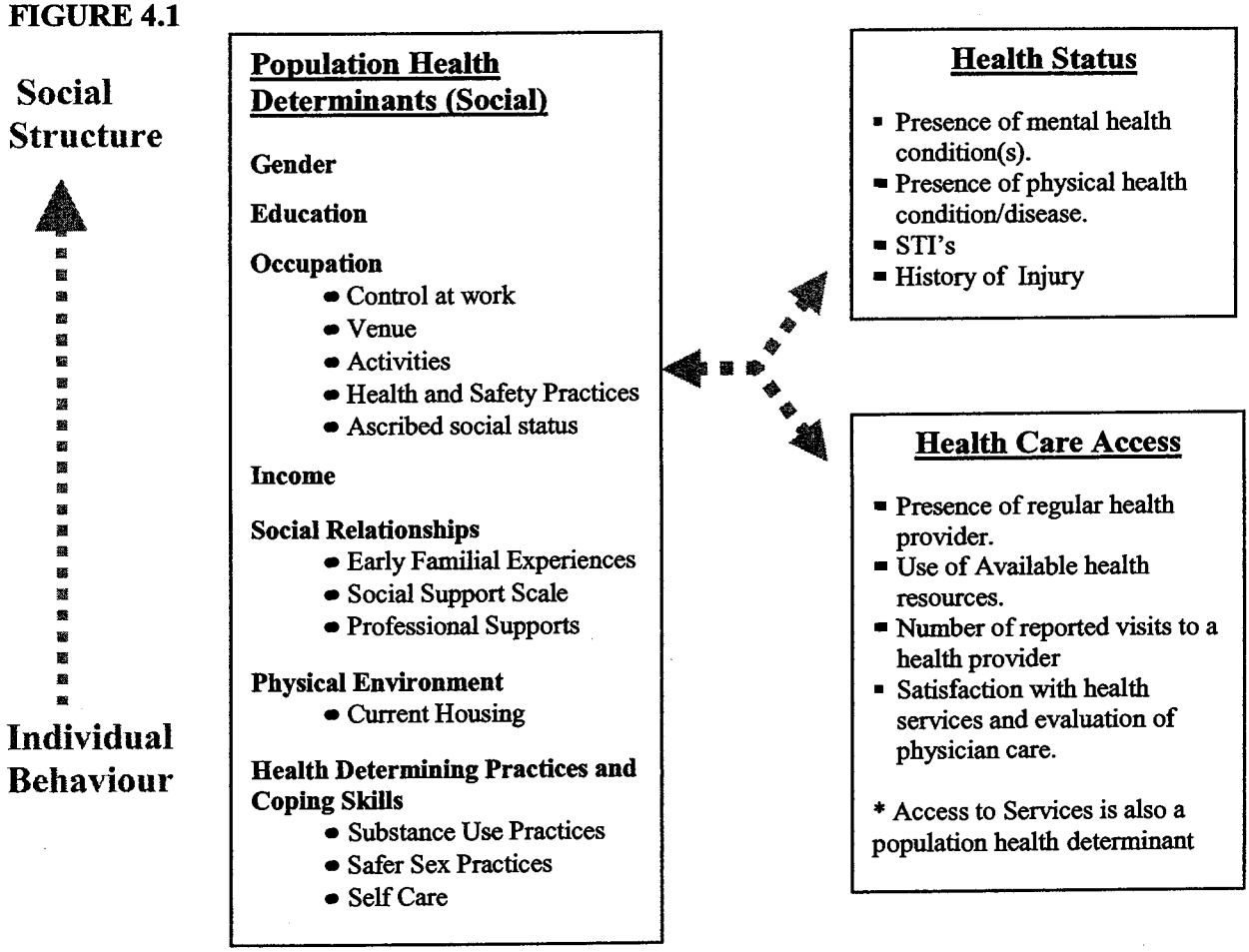
1. *How are sex workers positioned according to the social determinants of health? What are the implications of their social and economic status with regard to theorizing a causal model of health among this population?*

2. *What is the health status of sex workers according to select measures of health? What factors, if any, predict differences in health status among this population?*

3. *What kinds of health care do sex workers access? Are there groups of persons who are more likely to receive appropriate health care? What conditions predict a successful encounter with the health care system?*

A diagram of the variables to be investigated is presented below in Figure 4.1

FIGURE 4.1



4.4 Data Analysis

This upcoming analysis of empirical data uses combines a number of closed ended measures regarding social determinants of health, health status and health service utilization

with a number of open-ended questions from an existing data set study concerning health seeking behaviour, satisfaction with health services, interactions with health professionals, and ideas for improved health services to sex workers (Benoit and Millar, 2001). The quantitative analysis is limited to descriptive statistics and bivariate analysis using the Statistical Package for the Social Sciences Software Package (SPSS). While the bivariate analyses are not intended as confirmation of correlational relationships between the variables under investigation, they are nevertheless informative to the extent that they facilitate a general exploration of within group differences along the main variables of investigation – social determinants of health, health status and health care access. The qualitative analysis will supplement the bivariate and univariate statistics with illustrative text in the words of the research population as well as provide additional data not found in the closed-ended portion of the questionnaire. In particular, a number of open-ended questions regarding relationships with health personnel, main health concerns and health protecting strategies will be summarized according to dominant themes emerging from the interview text. The software NVIVO has been used for this task. While the NVIVO software does not perform analysis functions like SPSS, it contains both a useful search engine and a number of text organizing and coding functions, which are important when there are many transcripts to be reviewed. The coding of the interview data proceeded as follows: reading the interview transcripts in their entirety, identifying broad themes in each question until the point at which no new themes emerged, identifying sub-themes within each broad theme, and then reviewing the resultant theme structure to identify overarching themes repeated across separate questions and opportunities to collapse and reorganize themes within each question. If the interview schedule had been less structured and more phenomenological in its' design, it may have been appropriate to analyze the transcriptions more holistically in order to

capture the free-flowing associations commonly found in uninterrupted descriptions of one's experiences or views. However, in this case, the semi-structured nature of both questions and probes guided the respondent through a series of topics that were deemed relevant to the research objectives. While on the one hand the semi-structured interview guide allowed for a more discreet analysis of respondents' responses to particular questions, on the other hand, it may have curtailed the potential for the sort of iterative insight valued by proponents of unstructured interviewing techniques (Bryman, 2001). Nevertheless, one of the advantages of standardized questions is that they allow for comparison between respondents, and in some cases, the emergent themes were amenable to numeric aggregation, bearing in mind of course that numerical summaries of open-ended data may be biased by intra-coder variability and by ambivalent responses. Thus, in the few instances where numerical summaries of open-ended responses are provided, it is only for the purpose of depicting the dominance of certain themes relative to others in the data.

4.5 Augmenting the Data: Key Informant Focus Group

There are a few limitations to secondary analysis of an existing data set, but certainly they are not outweighed by the convenience of being able to focus on data analysis rather than on the labour intensive process of process of instrument design and data collection. One noteworthy limitation of secondary data analysis is that key variables may be absent from the data set and opportunities for data clarification have likely passed (Bryman, 2001). However, given the benefit of hindsight, researchers often gain insight on additional measures that should have been included or measures that could have been designed differently, even when they themselves carefully designed the data collection tool to optimally explore their topics of

interest. Understandably, these feelings are even more pronounced for the researcher who comes to the data with his/her own research agenda after the project is complete. In this case, although the existing data set contained extensive interview material, it was evident at the outset of planning that additional primary data collected after the initial analysis was complete would enhance the project by providing an opportunity to clarify and build upon the findings. To this end, a focus group was held with local health and social service providers who were familiar with the sex trade population because they provide services to them in their worksites[11]. At the time, it was thought that the experience of these individuals as health and social service providers (and, in the case of a few individuals, researchers with similar interests) offered a complementary view point to that of the interview respondents, and may even serve as a credibility check regarding both the plausibility of the findings and the value of the research to a non-academic oriented audiences (Davidson and Layder, 1994; Keggs, 1994; Kelly et. al., 1994; Singleton and Straits, 1999; Reinharz, 1992). In retrospect, it may have also been useful to conduct a similar focus group meeting with individuals active or formerly active in the sex trade as an additional investigation of the credibility of the findings and subsequent interpretation of the findings.

The focus group meeting was attended by physicians, nurses, mental health specialists, health outreach workers, and a select number of academic researchers with shared research interests. The focus group meeting began with a presentation of the findings regarding the social determinants of health, health status and health care access, moved into a focus group discussion, and then concluded with a short discussion regarding the development of a pamphlet containing: key research findings, information for sex workers about local health services and resources, and information for professionals regarding how to sensitively deliver appropriate

health consultation to persons involved in the sex trade. The planning, and subsequent carrying out, of the research meeting was a joint collaboration between myself, my academic supervisor, another student, and a staff member from PEERS. Beyond providing valuable feedback on the research, the focus group meeting stimulated useful exchange regarding directions for further research and seemed to be an effective research dissemination method. A number of participants expressed their appreciation for the opportunity to meet with other professionals whose particular health and social services are complementary to and often offered in conjunction with their own. Such meetings are often difficult to arrange in the often busy and bureaucratic environments found in the health and social services sectors.

The findings of the focus group meeting are discussed further in Chapter 8.

4.6 Limitations of this Research

This research project has some distinct limitations, some of which relate to the difficulties associated with researching hidden populations, while others are innate to secondary analysis of existing data. As discussed above, the hidden nature of the sex trade population and a lack of reliable knowledge regarding the make-up of the local sex trade industry render any sort of assessment regarding the representativeness of the research sample and findings an educated guess. Thus, one of the main limitations of this research is its lack of generalizability beyond the study population. The principal researchers gathered a purposive sample using a respondent and key informant driven sampling method. Such methods introduce the possibility of population biases due to connections between the original sample and the network of respondents accessed through them (Heckathorn, 1997). However, because the recruitment process included incentives for respondents and a variety of strategies including community

advertisements, key informant sampling and respondent driven sampling, the likelihood of reaching a more representative sample was increased (see Heckathorn, 1997). A secondary set of incentives for respondents recruited by other respondents may have been improved the process. These secondary referral incentives have been demonstrated to assist in accessing a wider, potentially more representative, network of respondents (ibid.). Nevertheless, the research sample studied here was believed to be diverse by the primary researchers.

A second limitation of the research is that it is primarily concerned with social determinants of health, health status and access to health services, but the data does not always lend itself to an extensive examination of these topics, even though a wide breadth of subject matter is covered. In addition, although some of the measures included in the study lent themselves nicely to comparison with the findings of research using similar measures, sometimes findings lack a decent point of comparison with other populations. Finally, the cross-sectional nature of the data precludes any assessment of causality. Keating and Hertzman (1999) note that population health research aims to explain heterogeneity in health status among population groups by finding related characteristics of the groups. However, they also warn of reverse causality, noting that one should always be aware that health could influence one's position in the social hierarchy, as well as the other way around; based on the existing literature, it is difficult to determine to what degree the health status of sex workers is linked to conditions encountered while working in the sex trade as opposed to conditions that were present prior to entering the trade such as health risks in the family of origin. Likewise, it is equally difficult to disentangle the impact of sex work on health from other factors present in the respondent's lives, such as their overall lower levels of socio-economic status.

Having summarized the background literature on the social determinants of health and health and the sex trade, and described the process of research, it is now time to turn to the research findings.

Chapter 5: Social Determinants of Sex Workers' Health

Pinpointing the pathways to particular health outcomes in a causal sense is complex, and as already noted, well beyond the scope of this research. However, in keeping with the emphasis placed on the social environment within the sociological theories of health, I begin the presentation of findings with the health determinants of the respondents. In doing so, I hope to emphasize the socio-cultural and socio-economic factors that likely play a role in determining health and well-being among the sex trade population. My rationale for doing is similar to Anderson (1995) and others who, while recognizing the complex array of reciprocal relationships between health and the social environment, argue that both the social determinants of health and the organization of the health care system are primary determinants of health behaviour in the sense that they *shape health status* and *predispose* one to use services. Following this logic, the presentation of findings will proceed as a narrative that begins by situating the sex industry and sex workers within their broader socio-economic and cultural context – both presently, and to some extent, historically. Such an argument is typically sociological, placing a certain degree of primacy on the material-structural environment relative to individual agency (Williams, 2003).

The social determinants of health can be broadly divided into endogenous factors – those specific to individuals – and exogenous factors – those specific to the socio-structural environment. Endogenous factors include aspects such as personal health beliefs and practices, coping skills, and self care, whereas exogenous factors include institutional environments such as the health care system, educational institutions, the labour market and the pervasive cultural beliefs that rationalize normative behaviour and guide the provision of social welfare programs. Although there is widespread agreement regarding the importance of social determinants of

health, specifying the relative importance of endogenous and exogenous factors relative to one another, as well as the biological pathways through which they interact on an individual's physical and psychological health, has proven more difficult, though nevertheless crucial if we are to understand the underlying reasons why some people in our society are healthy while others not (Segall and Chappell, 2000).

The analysis presented below begins with exogenous factors – social identity (race, gender and sexual orientation), measures of early childhood environment, education, occupation (income), housing, and social support – followed by select endogenous measures of health beliefs and health practices. The interspersing of qualitative data amongst both the endogenous and exogenous measures sheds some insight on how individual respondents rationalize or give meaning to their health and well-being in the context of their social-structural environment.

5.1 The Demographic Picture

The gender breakdown among the respondents supports the established view of the sex trade as a female dominated occupation. In this case, 79 percent of the respondents were female, whereas 18 percent of the respondents were male. A small number of respondents indicated that they were male-to-female transgendered. Although the latter is of great interest, and clearly more research is needed on the experiences of transgendered and transsexual sex workers, the small number in this sample does not allow for extensive investigation, except with regard to some of the open-ended interview data. Following the counsel of scholars who argue that a gendered perspective on the sex trade is one of the weaknesses in the literature because of the emphasis placed on the female subject, many of the findings presented below are presented according to gender (Weinberg et. al., 2000).

Although not strictly a social determinant of health (it is both biological and social), it is interesting to note that the median age of the respondents was older than what might be expected given the current emphasis on the sexual exploitation of young people and social stereotypes regarding the desirability of youthful beauty. The mean age of currently working female and male respondents was 33 and 32 years respectively, with an age range spanning 19 to 61yrs.

It is of great significance to note that while the prevalence of minorities among the respondent population was similar to that of the Victoria Capital Regional District overall, persons of Aboriginal heritage/race were overrepresented in the sample, particularly females (Benoit and Millar, 2001). The 2001 Aboriginal Peoples Survey found that 2.7% percent of the population in the CRD was Aboriginal, which is substantially lower than among the respondent population where 16.2 percent of females reported an aboriginal background and 8.3 percent of males reported an aboriginal background. (Community Profiles, Statistics Canada 2003). This finding supports other Canadian research indicating that aboriginal persons are disproportionately represented in the sex trade (Save the Children Canada, 1998).

Similarly, sexual minorities appear over-represented among the respondent population with 33.3 percent of females reporting either bisexual or homosexual status, and 69.4 percent of males reporting either bisexual or homosexual status. Although population figures on the occurrence of homosexuality and bisexuality are difficult to obtain, as a point of comparison, Alfred Kinsey (1948) found that 4 percent of males reported being exclusively homosexual and approximately 2 percent of females reported being exclusively homosexual. Although the prevalence of sexual minorities in the respondent population appears to differ from estimates of sexual minority status in the population as a whole, Shaver (1999) found similar rates of sexual

minority status among sex workers in San Francisco. One explanation for the over-representation of Aboriginals and apparent overrepresentation of sexual minorities in the sex trade population is the coalescing of economic and identity based exclusion from resources among discriminated social groups (Fraser, 1997). Similarly, the over-representation of females in the sex trade population is likely a reflection of the over-representation of women living below the poverty line in Canada (Morton et. al., 1995), which is itself tied into the gendered division of labour and disparities in wages between working females and males (Scott & Lochead, 1997), and the dominance of women in frontline service occupations, including the helping professions and lower-prestige, pink-collar service jobs (Benoit, 2000; Statistics Canada, 2002).

Table 1: Social-Demographic Profile

Gender			Age (Mean)	Aboriginal Status	Sexual Minority
Female	n=160	79%	33yrs	N=26 (16.2%)	n=53 (33.3%)
Male	n=36	18%	34yrs	N=3 (8.3%)	n=25 (69.4%)
M to F	n=5	3%	*	*	*

5.2 Early Childhood

Early family experiences have been linked to health outcomes that continue to unfold over the lifespan (Mustard and Frank, 1994). Poverty in particular has been associated with lower educational attainment (Hoddinott et. al., 2002) lower health status (Wilkins and Sherman, 1998), and greater incidence of childhood injury (CICH, 2000). In addition, the majority of families engaged in government sponsored child-protection programming are of lower socio-economic status (Gordon, 1988). Children living in government care have been found to have lower educational attainment, higher rates of criminal incarceration, and greater

difficulty transitioning to the labor force than their counterparts (Children's Commission, 2001). In the field of child psychology, poor development outcomes among children and youth in government care have been linked to disruption in bonding process during early development – commonly referred to as "attachment disorders" (Bowlby, 1975). Although such breaks may occur in families where parent-child interaction is abusive or undermined by parental depression or other illnesses, attachment disorders are most notoriously associated with foster care and adoption due to the phenomena knows as "foster care drift" – many transitions in caregivers over a short period of time (Steinhauer, 1998). The literature presented above is relevant to the findings regarding the early family experiences of the respondents in this study because it sheds light on how patterns in health and social functioning are set early in life. This is not to suggest that early childhood problems lead to a career in the sex trade; child abuse is neither a necessary nor sufficient antecedent to involvement in the sex trade, and while many sex workers in other studies as well as this one have reported negative childhood experiences, a substantial number of persons did not (Alexander, 1987). Rather, by examining early family experiences and other historical biographical data, the point is, in part, to draw attention to a fundamental problem in the literature on health and the sex trade: the health of sex workers is only partially influenced by involvement in the sex trade as it is also influenced by other conditions, many of which were present long before entering sex work.

Although the existing literature is clear in depicting a dysfunctional family of origin and early age of independence as common among the sex trade population, there is little empirical literature on the health effects of frequent transitions in caregivers in childhood for either the population as a whole or for persons involved in sex work. Table 2a demonstrates the gradual decrease in the number of respondents who were living with both biological parents during

childhood and early adolescence. To some extent, a gradual decrease in the number of children living with both biological parents is quite expected - in Canada it is estimated that 25 percent of children will witness the decoupling of their parents by age six (Province of Manitoba, 2003). Nevertheless, less than 70 percent of respondents in this study said that they spent their first year in an intact family unit, and by age 10, only 34 percent of respondents reported living with both biological parents. Close to half of the respondents reported only one or two care giving environments before the age of 19, while, just over half of the respondents reported three or more changes in care giving environments over their childhood. The respondent population also over-represents a history of government care relative to the general population. Whereas, it is estimated that 1-2 percent of children under the age of 19 live in permanent or temporary government care in the CRD (MCFD, 2003), the number of respondents living in government care steadily increased with age among the respondent population. Overall, 57.2 percent of the respondents reported having spent some time in government care at one point or another in their childhood, which is itself a strong indicator of early childhood trauma. Over half of these respondents reported they were dissatisfied with their care, which is further evidence of childhood dislocation and trauma.

Table 2a: Caregivers

Total N=201	Age 1	Age 5	Age 10	Age 15
Both Biological Parents	n=140 (69.7%)	n=91 (45.3%)	n=69 (34.3%)	n=41 (20.4%)
Mother Only	n=23 (11.4%)	n=39 (19.4%)	n=39 (19.4%)	n=19 (9.5%)
Father Only	n=1 (.5%)	n=6 (3%)	n=9 (4.5%)	n=9 (4.5%)
Bio/Step Comb	n=6 (3%)	n=23 (11%)	n=35 (17%)	n=19 (9.5%)
Other Relatives	n=3 (1.5%)	n=4 (2%)	n=4 (2%)	n=10 (5%)
Adoptive Parent	n=13 (6.5%)	n=24 (11.9%)	n=22 (10.9%)	n=14 (7%)
Government Care	n=13 (6.5%)	n=14 (7%)	n=20 (10.5%)	n=48 (24%)
Independent				n=37 (18.5%)

Table 2b: Transition in Caregivers during Childhood and Adolescence[13]

1 or 2	3 or 4	5 or 6	7 or more
n=84 (47.8%)	n=85 (42.3%)	n=25 (12.5%)	n=7 (3.5%)

Table 3a: Government Care

	Percentage of respondents who have been in government care.
Males	n=21 (58.3%)
Females	n=95 (57.5%)
Aboriginal	n=30 (73.3%)

Table 3b: Satisfaction with Government Care

Satisfied (very/somewhat)	Undecided	Dissatisfied (very/somewhat)
n=41 (36.3%)	N=12 (10.6%)	n=60 (53.1%)

Abuse has been linked with numerous negative long-term health outcomes including: difficulty in school, problems with law enforcement officials and substance use problems (WHO, 1999). As noted earlier, childhood abuse is commonly viewed as one of the more widespread antecedents to entering the sex trade (Badgley and Young, 1987; Silbert and Pines, 1981; Earls and David, 1990). The findings here generally support that view, although it is difficult to determine to what extent the figures reported in table 4 are different from or similar to the general population. This is because population data have not been widely gathered on the topic of abuse and measures vary from study to study. Much of the data on abuse that does exist is from populations who are receiving treatment or intervention, and as such, may not be representative of the population as a whole. The Canadian incidence study of child abuse and neglect found 21 cases of reported child abuse per 1000 children across Canada, and estimated that 67% were either substantiated or suspected child abuse (Trocme and Wolfe, 2001).

Notwithstanding the potential that these population figures may be limited by sample and varying measures, it appears that abusive circumstances are more common among the respondent population - 52.8 percent of males reported experiencing physical abuse (defined as being hit with an object or by the parent him/herself using various means such as kicking, slapping, an punching) and 47.3 percent reported experiencing emotional abuse (measured as the respondent's perception of "emotional torture", verbal belittling, confinement, or neglect). For females, familial sexual abuse was most common, with 55.3 percent indicating they had been victimized this way. Experiencing all three forms of abuse was also common among females. Overall, just over 11 percent of the respondents reported a background free of all measures of abuse. These figures are not dissimilar to other statistics reported in the sex trade literature. For example, as noted in Chapter 2, Canadian researchers report rates of childhood sexual abuse among sex workers that range from 28 percent (Shaver, 1993) to 73 percent (Badgley and Young, 1987). Similarly, Vanwesenbeeck (1994) found that more than four out of ten of the female sex workers in her study had a history of sexual or physical abuse (or both).

Table 4: Childhood Abuse

Reported Abuse by Parents or Caregivers [ever/some of the time?]	Males	Females
No Reported Abuse	N=4 (11.1%)	n=19 (11.9%)
Physical Abuse	N=19 (52.8%)	n=44 (27.5%)
Emotional Abuse	N=17 (47.3%)	n=54 (33.8%)
Sexual Abuse	N=12 (33.3%)	n=88 (55.3%)
All three forms of abuse	N=9 (25%)	n=62 (38.8%)

Given the circumstances above, it is not surprising that the 72 percent of respondents reported living on their own by age 18, and 42 percent reported living on their own by age 16.

5.3 Respondents' Educational Attainment

The level of educational attainment among respondents was mixed, but generally low in comparison to the general population. The median level of education was grade 10; less than 40 percent of the respondents had graduated from high school, a finding which is well below the national average of 67 percent graduation (Statistics Canada, 2001), but very similar to other reports of educational attainment among sex workers (Shaver, 1999). Looking at postsecondary education specifically, 28.8 percent of females and 22.2 percent of males reported having some form of post secondary training. By comparison, Statistics Canada reports that 36.8 percent of the population in the Victoria area has some post-secondary education (Community Profile, 2003). The differences in educational attainment between the respondent population and the general population, with respect to post secondary level, are not as drastic as one might expect, however, it is possible that upon closer examination that the post-secondary training of sex workers is concentrated in short diploma programs and trades school. However, it has been noted previously that some sex workers become involved in the sex trade in a transient manner in order to earn money for the costs of postsecondary education (Bruckert, 2002). As a point of interest, at the time of the interview, 14.4 percent of respondents indicated that they were enrolled in school and 13.9 percent indicated that they were enrolled in other training. As noted earlier, education is a strong predictor of population mortality and morbidity, and forms one of the cornerstones of the overall socio-economic gradient in health (Ross et. al., 1995). Thus, one would expect respondents with a higher level of education to be healthier.

Table 5: Highest Level of Education Attained

Gender	Less than Grade 10	Some High School (More than Grade 10 but less than Grade 12 completion).	Complete High School	Post Secondary
Female	42 (26.3%)	59 (36.9%)	59 (36.9%)	46 (28.8%)
Male	13 (37.1%)	8 (22.9%)	14 (40%)	8 (22.2%)

5.4 Occupational Characteristics

In stark contrast to other reports indicating that the majority of sex workers began working before the age of majority as sexually exploited youth (Save the Children, 2001; British Columbia, 2002), the median age of entering sex work was 18 years for females and 19 years for males. A Glasgow-based study of sex workers similarly found that mean age of entering the sex trade was 21 years of age (Green and Goldberg, 1993). Nevertheless, 38.8 percent of the respondents had turned their first "trick" by age 16 or earlier, indicating the childhood sexual exploitation is not an insignificant concern, even as much as it may not represent the experiences of the majority of those studied. There appears to be some relationship between educational attainment and age of entering the sex trade, with those possessing higher education entering the sex trade later; however, this finding cannot be regarded as conclusive.

Table 6: Age of Entry

	Mean/Median Age of Entry
Males	Mean = 21 yrs Median = 19yrs
Females	Mean = 20 yrs Median = 18yrs
Less than Grade 10	Mean = 18 yrs Median = 16yrs
Some High School	Mean = 20 yrs Median = 18yrs
Finished High School	Mean = 22 yrs Median = 19yrs

Respondents' most commonly cited reasons for entering the sex trade were economic duress, enticement or curiosity, drug and/or alcohol use, and forced involvement, respectively. While economic duress was quite expected, given the prominence of this topic in the literature (Brock, 1998), the frequency that enticement and curiosity were cited as precipitating factors was unexpected. A few scholars have suggested that enticement and curiosity more likely precipitate the entrance of women and men to seemingly higher status sex trade occupations such as those found in the exotic entertainment (Lewis, 1998). Drug and alcohol use was noted by several respondents, but less so than might be expected, given the dominance of this topic in the existing research literature (Green et. al., 1993; de Graaf et. al., 1995). As a point of comparison, Alexander (1998) reported that 60 percent of street-based sex workers in a Seattle-based study entered the sex trade for reasons related to drug and alcohol use, whereas only a minority of respondents in this study indicated that drug and alcohol use precipitated their entry to the sex trade. However, Alexander (1998) also suggests that drug and alcohol use is lower among indoor workers, which may explain the discrepancy in findings between her research population and the mixed-venue population included in this project. A substantial minority of respondents noted forced involvement but, nevertheless, was the fourth most common reason noted. However, as mentioned earlier, it is difficult to determine whether or not those who work against their will under the direction of a third party are underrepresented in the research sample.

Reasons for entering the sex trade also varied in frequency by gender. While the most common reason for entering the sex trade among females was economic duress, this was the least commonly cited reason among the male respondents. The most commonly cited reason for entering the sex trade among males was enticement and curiosity, followed by drug and alcohol

use. The high proportion of male sexual minorities in the respondent population is suggestive of a relationship between sexual minority status and entering the sex trade.

In sharp distinction to the findings concerning enticement and curiosity, more males than females also felt that their entry to the sex trade was forced or coerced, which is surprising, and difficult to interpret given data limitations. Judging by the descriptions offered by the male respondents regarding their entrance to the sex trade, two possible explanations for forced involvement stand out: 1) Sexual assault precipitated later involvement in the sex trade; 2) the costs of substance dependence led to sex trade involvement, which was viewed as forced, as there was little alternative for earning the money required to maintain the substance habit.

Table 7: Reasons for Entry

	Males	Females
Enticement/Curiousity	n=18 (50%)	n=27 (17%)
Economic Duress	n=5 (13.9%)	N=50 (31.4%)
Drugs and Alcohol	n=7 (19.4%)	n=27 (17%)
Forced Involvement/Assault	n=6 (16.7%)	N=19 (11.9%)

The variability in current or last work locations noted by respondents is further confirmation of the heterogeneity of the sex trade. As shown in table 8, work locations varied from motels and hotels, to agencies to street work, to home-based services as well as other work sites. In the original analysis of the data set used in this project, Benoit and Millar (2001) found that workers often worked in more than one type of venue over time, and it was not unusual to be working in more than one venue at a particular point in time. For males, the most common venue of work was the home, followed by outdoor (street) work. For females, the most common work sites were outdoor (street) work followed by agency work.

Table 8: Work Locations[14]

Location of Work	Males	Females
Agency	n=6 (16.7%)	n=47 (29.4%)
On-Street	n=10 (27.8%)	n=54 (33.8%)
Hotel/Motel	n=1 (2.8%)	n=11 (6.9%)
Bar/Strip Club/Peep Shows	n=4 (11.1%)	n=14 (18.8%)
Home	n=14 (38.9%)	n=29 (18.1%)
Massage Parlor	n=1 (2.8%)	n=5 (3.1%)

As noted earlier, alongside income (D'Arcy, 1996) and education (Ross et. al., 1995), working conditions are one of the more significant social determinants of health. In particular, the degrees of decision latitude and job demand in the workplace have been found to influence the number of job-related injuries and the amount of psychological distress among workers (Wilkins and Beaudet, 1998). It is significant then that respondents indicated that autonomy and safety at work varied by venue; those working under the direction of an agency manager were more likely to lose part of their income to overhead costs and other imposed fees and less likely to exercise full control over their work activities compared to those who worked independently (Benoit and Millar, 2001). Self-employed workers – both outdoor and home-based – were in a better position to choose both the conditions and pace or their work and control over earnings and take home pay (ibid.).

Home-based, independent workers also earned more than their counterparts. For example, the median income among those who described their work as full-time (or most of the time) was $35, 750 for home-based workers, 30, 000 for agency workers and $30 000 for outdoor (street) workers. When working full-time, males and females were found to earn roughly the same amount of income. Among those who work part-time, many hold jobs in the legitimate economy as well. When earnings for these respondents were combined, the median

income for females was $25,800 and $18,400 for males, which is surprising on the one hand as males typically earn more than females (Statistics Canada, 1999), yet expected on the other as other researchers have found that females earn more money than their male counterparts because they work more regularly and see more clients (Weinberg et. al, 1999). It is important to note that error in the findings regarding income is quite possible and may have been reduced by multiple measures of income as respondents were asked to provide their yearly income but were not asked other income indicators. Given that sex workers are very unlikely to receive written pay cheques or file yearly income taxes, yearly income may be a difficult figure to calculate in the context of a research interview. In addition, it is noteworthy that several respondents indicated that they were receiving disability benefits or BC Benefits (income assistance) while working in the sex trade so the figures reported below may not reflect the total monthly household income of respondents.

Table 9: Income from Sex Trade Activities

Gender	Part-time (Median) n=106	Full-time (Median) n=78	Combined with other sources of income (Median) n=40
Female	$10 000	$30 000	$25 800
Male	$7 500	$30 000	$18 400
Home	$10 000	$35 750	
Agency	$11 000	$30 000	
Street	$9 000	$30 000	

Outside of the earnings associated with sex work, respondents identified their ability to set the conditions of their work as one of the most positive aspects of the sex trade. The most negative aspects of the job were disliked or unattractive clients, bad dates, the labour itself and the shame and stigma associated with the work. Respondents almost uniformly agreed that the social perception of the sex trade was very negative.

Obviously everybody thinks of it in a negative way. Everyone thinks that you're criminals; that you're drug addicts or alcoholics. (Male, Age 29)

Sure, people handle it with a negative attitude. If you're giving away your body for sex, then nobody looks at it as a job. They look at you like a slut. (Male, Age 27)

Respondents noted several methods of dealing with the stigma and discrimination surrounding the sex trade ranging from keeping their sex trade work a secret, to confronting the negative stereotypes head on. As one respondent noted:

How I handle it [the stigma associated with the sex trade] is by just pointing out that we are people first and deserving of basic dignity and respect. I try to inform people who have a negative view. I try to shed some light on their ignorance or lack of information. (Male, Age 41)

Not all respondents demonstrated as much confidence in confronting negative stereotypes regarding their work. As one noted:

I feel like I've been judged because of it. I've been seen as less than white trash,[ ] like there's something wrong with me. It's really held me back from participating in the mainstream in some ways. To the outside world, it looks like I'm participating in it quite readily. However emotionally, I haven't been. I sort of go through the motions but there's a part of me that doesn't participate. I know it's because people would view me negatively if they knew. I know this because I've made the mistake of telling people in the past and had them treat me differently. I don't like it. (Female, Age 41)

Another respondent described outright attempts on the part of the public and clients to harm sex workers:

There are people that drive around in cars and throw beer bottles at you while you're working. People that come into agencies and batter women. Or people call an agency for service to hotels and some of those situations are pretty dangerous. A lot of the girls in the agencies and on the streets don't have any help from the police. That's a main safety concern. (Female, Age 18)

The negative perception associated with the work continued to impact the lives of workers long after they had left the trade (Millar, 2002). As on respondent noted:

> *...when I'm in public areas, [ ] I'm afraid that I might run into someone that I've had encounters with before in the sex trade. The individual might say something to me that might not be fitting for that scene, or someone might look at me wrongly. In a way I am kind of ashamed of it, but it was my only alternative [at that time]. (Female, Age 55)*

In sum, managing the negative perception of the sex trade and the sex worker identity was described as difficult, and in many cases, undermining to personal health and well-being, particularly because the stigma of the sex trade complicated access to social support and put sex workers in a positions where they had to managing the release of information about themselves on a daily basis and/or deal with the responses that ensued when others became aware of their sex trade involvement.

5. 5 Housing

Although the majority of respondents reported living in stable housing, this was not the case for a significant minority. As will be shown in succeeding chapters, persons without stable housing reported a somewhat higher incidence of certain illnesses. Any relationship between housing and the sex trade is likely representative of the larger relationship between relative or absolute homelessness and participation in illicit activities as a means of earning money. Employment is difficult to obtain when living transiently or without consistent shelter, particularly when additional barriers to employment are present – poor mental health, psychiatric conditions, physical health conditions or problem substance use (Eberle et. al., 2001). Sex work may represent a transient or longer-term solution to financial needs for those without housing and/or other barriers to gainful employment. As might be expected, respondents who reported unstable housing were also more likely to work on the street (See also Pyett and Warr, 1997). About half of the currently working street-based workers (56.5 percent)

reported unstable or very unstable housing, which is similar to Weiner's (1996) finding that approximately 60 percent of the street-based sex workers in her New York study did not have stable housing.

Table 10: Stability of Housing

Gender	Stable Housing	Unstable/Very Unstable
Females	N=124 (77.5%)	N=36 (22.5%)
Males	N=27 (75%)	N= 9 (25%)

5.6 Social Support

Two quantifiable measures of social support were included in the survey portion of the interview instrument: 1) A series of seven-likert scale measures of supportive personal relationships (Q121), and 2) A likert scale regarding the amount of social support received from various persons who were aware that the respondent was working in the sex trade (Q119). According to these measures, the majority of respondents reported supportive relationships in their lives. For example, the mean sum score when the series of questions regarding supportive relationships were compiled in a scale was 3, indicating that the majority of respondents disagreed with the questions regarding the absence of trusted confidants in their lives[15]. This score remained consistent when broken down by gender and problem substance use. The second set of questions concerning support received from persons who were aware of their sex trade activity generated some mixed results. Persons most likely to be aware of respondents' involvement in the sex trade included: outreach workers, relatives, romantic partners, health care workers, other sex trade workers, the police and friends. Persons least likely to be aware of respondents sex trade work included: mother, father, and social workers. Of the persons who were aware of the respondents' sex trade involvement, the most support was received from: outreach workers, romantic partners, and health care workers, respectively. Given the centrality

of the access to health care as one of the determinants of health, it is important to note that although health care workers were one of the more valued sources of support, 46.3 percent of respondents indicated that their health care worker was not aware of their involvement in the sex trade. Persons least likely to provide support when aware of the respondents' sex trade involvement included: police officers, social workers, mother and father. As a case in point, when considering what strategies he employed when confronted with a potentially dangerous work situation, one respondent noted: *"I never call the police - that's the last thing you do" (Male, Age 27).*

In sum, it is positive that the majority of respondents indicated that they had sources of social support in their lives. Nevertheless, there is some indication that sources of support may be predominantly confined to peers and often do not include family and professional supports .

> *Usually it's friends because there isn't a service that you can go out there talk to like an outreach. I can talk to my friends and say "This is what I did last night" and I tell them how it was and if it was good or not or if the person scared me or not. Everyone has their own stories about it and its good to have friends to share with. I've never been to a service about anything. I used to just know people in the sex trade industry. They would do their thing and then we would just all go to their place afterwards and sit around and drink hot chocolate and talk about work and what we're doing tomorrow. (Male, Age 27)*

Given the broader social stigma attached to sex trade work, it is even more crucial the sex trade workers have reliable sources of social support with whom they can talk about their work in order to cope with the pressures related to their work and the negative stereotypes associated with the sex trade. Thus, the above findings are both reassuring and a source of concern.

5.7 Select Health Behaviours and Occupation Related Health Beliefs

The data set contained several variables related to health behaviour and health beliefs, some of which are reported here and others, which will be reported on in the next chapter with the findings concerning health care access. Findings concerning health behaviour are derived from quantifiable variables concerning condom use and use of licit and illicit substances. Findings concerning health beliefs are derived from the open-ended interview data concerning main health concerns, health and safety concerns in the sex trade, and the impact of sex trade work on health.

Alcohol was the most common substance used by respondents; overall, close to three-quarters of sex workers reported regular or weekly consumption of alcohol. Males were more likely to daily consume alcohol (27.7 percent) than females (7.6 percent). With regard to alcohol consumption, respondents were no more likely to be regular alcohol consumers than those in the general population. According to the 1993 General Social Survey, 74.4 percent of Canadians aged 15 and older reported drinking over the last 12 months, averaging 4.4 drinks per week (Single et. al.,1994). A substantial minority of respondents were regular users of one or more illicit drugs, in most cases cocaine/crack or heroin. Females were more likely to frequently (daily) consume cocaine (16.6 percent) than males (2.8 percent). Similarly, females were more likely to frequently (daily) consume heroin (22.3 percent) than males (16.7 percent), which differs from other research where males have reported greater use of "hard" drugs such as heroin and cocaine (Shaver, 1996). Among those who reported consumption of heroin and cocaine, intravenous injection (IV) was the most popular method of consumption. About one quarter (27.7 percent) of males and about one third (36.8 percent) of females reported having consumed substances intravenously in the last six months, which is similar to Pyett and Warr's

(1997) finding that approximately one quarter of the brothel-based sex workers they accessed in Victoria, Australia were intravenous drug users. The combination of indoor and outdoor workers in this study may account for the slightly higher prevalence of intravenous drug use. It is also noteworthy that there was a range in frequencies of illicit drug use. For example, a sizable sub-sample of the respondents consumed cocaine and/or heroin on a less than daily basis but rather on a monthly, semi-monthly or weekly basis, which is noteworthy as both are traditionally viewed as problem drugs that invariably lead to physical dependency and ongoing use. Daily, or more than daily, substance use was highest among those who consumed marijuana, bearing in mind that the frequency of consuming prescription narcotics and other habit forming prescription drugs was not measured. Further, because it was assumed that the majority of respondents were tobacco smokers, tobacco use was not measured. Methamphetamine was not a popular drug among respondents; among those who reported methamphetamine use, males were the most likely to be regular consumers. It is the perception of local health care providers and outreach workers that consumption of methamphetamine has increased since the time of data collection and is a significant problem among young males and females (Phillips, 2002; Meeting Notes). Contrary to dominant stereotypes, current illicit drug use was reported by a minority of respondents overall. This finding may in part be explained by the inclusion of current and former sex trade workers in the respondent sample. However, when broken down by working status, a minority of currently working respondents report regular illicit substance use and even fewer former sex workers report illicit substance use: using cocaine as an example, at the time of interview, 47.6 percent of currently working respondents had consumed cocaine at least once in the last six months and 20.5 percent of retired workers had consumed cocaine at least once during the same time period. Presumably the latter finding

is indicative reflects that for some respondents leaving the sex trade was influenced by a desire to reduce or cease drug consumption (or vice versa). Looking at it from another angle, however, it is of interest that a sizeable minority of retired sex workers continued to use illicit substances even after leaving the sex trade, which may in fact be evidence that the presumed relationship between illicit substance use and the sex trade is overstated.

The overall prevalence of illicit drug use reported by the respondents in this study is similar to findings reported elsewhere. For example, Vanwesenbeeck (1994) found that a minority of Dutch sex workers reported using drugs and alcohol while working, and Shaver (1993) found that less than half sex workers in cities across Canada reported consumption of illicit drugs. Combined with the findings presented here, the above studies further corroborate the view that the relationship between illicit drug use and sex work is either overstated in some of the literature, or alternatively, reflects discrepancies in illicit drug use among different sex work populations. For example, Green and Goldberg (1993) found that over 80 percent of sex workers in a Glasgow-based study were injection drug users, however, their research population was accessed via a drop-in health clinic that was known to serve street-based female sex workers, which undoubtedly influenced their findings regarding the prevalence of illicit drug use.

Table 11: Drug and Alcohol Use

Substance	Never		Once or twice per month		Once or twice a week		Once or more than once a day		Intravenous Use in last six months	
	M	F	M	F	M	F	M	F	M	F
Alcohol	30.6%	25.5%	16.7%	45.2%	24.8%	21.6%	27.7%	7.6%	27.7%	36.8%
Cocaine	69.4%	56.7%	22.2%	15.3	5.6%	11.5%	2.8%	16.6%		
Heroin	66.7%	69.4%	5.6%	4.4%	11.1%	9%	16.7%	22.3%		
Methamphetamine	77.8%	97.5%	8.4%	2.5%	8.4%	0%	5.6%	0%		
Marijuana	41.7%	45.2%	13.9%	12.9%	5.6%	15.5%	38.9%	26.4%		

Prescription and over-the-counter drug use was quite high among the respondents, with 58 percent of females and 41 percent of males reporting that they were currently taking medication. This topic will be discussed further in chapter seven as a measure of health service utilization.

The use of condoms during commercial sexual exchanges is a profoundly important disease prevention practice. Given this, it is encouraging to find that safer sex practices were, for the most part, high among the respondent population, particularly among female respondents. This finding is similar to that of other researchers who have also found safer sex practices to be high among those working in the sex trade (Jackson et. al., 1992; McKeganey and Barnard, 1996). Males were considerably less likely to use a condom during hand sex and during oral sex. Shaver (1996) also found that males were less likely than females to report always using condom when providing oral sex. Intravenous drug users (most of whom are regular drug users) were not less likely to practice safer sex practices than their counterparts, as suggested in the some of the existing literature (Carr, 1995; DeGraaf et. al., 1995). Still, as shown in table 12, a sizable minority of respondents reported engaging in unsafe commercial sex, particularly when performing hand and oral sex. Interestingly, fewer former sex workers reported having always used condoms while working in the sex trade when compared with their currently working counterparts; this finding may in part be related to the more recent emphasis placed on safer sex practices and the concurrent establishment of outreach health prevention programs (Millar, 2001). The most commonly cited reasons, respectively, for not using condoms were "felt that the activity did not require it" (typically, when performing manual and oral sex), clients resistance to condoms, condom not available, dislike for condoms, and because the client was a regular.

In stark contrast to the commercial context, many respondents reported never using condoms in their private relationships. Males were twice as likely as females to report always using condoms in the private relationships, which is the converse of what was found in the commercial context. The most dominant reasons for choosing not to use condoms in the private context were that the respondent was in a monogamous relationship, both partners had been tested and each felt s/he was free of sexually transmitted infections, one or more of the partners did not like the feeling of condoms, and/or either the respondent or his partner were trying to become pregnant.

Table 12: Safer Sex Practices (Condom Use) (Currently Working Respondents)

Activity	Always		Most of the time		Half of the time		Some of the time		Never	
	M	F	M	F	M	F	M	F	M	F
Hand Sex (Commercial)	15.2%	47.1%	3%	6.5%	6.1%	7.7%	9.1%	10.3%	66.7%	28.4%
Oral Sex (Commercial)	51.4%	78.9%	14.3%	6.6%	8.6%	3.9%	8.6%	3.9%	17.1%	6.6%
Vaginal Sex (Commercial)	69%	85.3%	13.8%	6.7%	10.3%	2.0%	6.9%	2.7%	0%	3.3%
Anal Sex (Commercial)	87.5%	83.1%	3.1%	4.6%	0%	1.5%	9.4%	3.1%	0%	7.7%
Sex with Private Partner	40%	20.2%	5%	4.8%	0%	4.8%	5%	6.7%	50%	63.5%

In addition to a high incidence of safer sex practices, the open-ended interview data is suggestive of a population that is both health conscious and well aware of the risks associated with their work.

> *I'm very cautious [ ] I don't share anything with them [co-workers]. We've had a real scare lately of Hep C. [ ] Our environment is very clean as well; hopefully the clients will be as well. We try to be very cautious.*
> *(Female, Age 36)*

I think[my] main[health concern] is to stay safe and make sure that I don't catch HIV. Hopefully, [given] the way I'm doing things, it won't happen. It's basically about being safe. That's one of the things that's kept us in line. I just keep myself as healthy as possible. I guard myself so that way I don't get sick. I take Echinacea and herbal remedies and Chinese medicine just to keep myself younger and I go to the gym. (Male, Age 27)

Perhaps it is because of prevention practices that close to 40 percent of the respondents felt that working in the sex trade had not had an impact on their health. Of the 60 percent that reported the sex trade had an impact on the health, the majority considered the change to be negative, although a few felt their health had changed for the better.

Among those who noted the negative impact the sex trade on their health, the most common concerns were mental-emotional health – particularly self esteem and being able to form trusting relationships, health complications related to substance use, and fatigue.

Mentally, emotionally it affects everything. You become that person and it seeps into the rest of your life. If you are going to be in the sex trade you got to have the skills to separate the business from home and there's no way of knowing how to do that except for time. Trial and error. (Female, Age 23)

Overwhelmingly, respondents indicated that infectious diseases and the possibility of a bad date were the greatest concerns for persons working in the sex trade.

Mostly the STD's and you get exposed to a lot of colds and stuff like that. That's from being so close to people. You have got to look after your own health. You have to be getting enough sleep and take the proper vitamins. As long as you are using condoms all the time I really think it's not that bad.(Female, Age 40)

The one [main health and safety concern] is being hurt by the person that you're meeting. This goes for out calls. In calls are not so bad. The customers know that there are other people around and phones so that you can call the police. For outcalls, that's where it gets a little risky. Most of the time they're not going to be thinking bad thoughts. If something were going to play out, you never know, because you're at their place. Even though you have you're protection, you never know. I think that's the main risk. I think the next risk is the threat of diseases. (Male, Age 24)

When asked what they do when their safety is at risk, respondents indicated that they had to rely on their instincts, become aggressive or somehow escape the situation.

> *I defend myself. I don't back down. I've learned one thing and that's to become tougher. I've become tougher when it comes to defending myself. I don't carry weapons and had thought about carrying a knife. That would lead to getting into trouble. I don't get into that many altercations...I stand up for myself whether it be a biker or....I stand up for myself. (Female, Age 45)*

Their stories conveyed a distinct lack of organized resources available to protect their health and safety on the job.

In summary, the sex workers who took part in this study are not, as a whole, well positioned along the social determinants of population health. Although not conclusive, primarily because of the limitations associated with a non-random sample, the findings provided above foretell poor health status among the target population compared to the general population. The higher instances of family breakdown, institutional-based care in childhood and reported abuse on their own predict poorer health outcomes in adult life. The gender breakdown among the sample population is likely reflective of both gender norms concerning sexual desire and labour market options available to women with little by way of workplace experience/skills and formal education vis-à-vis men with similar levels of education and skills. Although the income earned in the sex trade is not high, relative to the general population, it is greater, or comparable to the income earned by Canadians with similar levels of skill and education, especially among women (Brock, 1998). For example, the average income of all female workers with less than high school education is Canada is $21,230 (Statistics Canada, http://www.statcan.ca/english/Pgdb/labor50a.htm). While the respondents may have had good

reasons for entering the sex trade in many instances, and regard it as a "job" that has both benefits and drawbacks, social opinion regarding sex work was perceived by the respondents as highly negative. Indeed, as the comments provided above convey, the respondents were personally aware of the stigma associated with the sex trade. Although, many had developed strategies to help cope with negative public opinion regarding their work – including being discreet, secretive, trusting their own experience and having a double self (one for work and another outside work) – there is little doubt that confronting negative social constructions of their identities was an ongoing task. In many cases, this contributed to a poor self-concept and most certainly undermined many respondents' access to social support. Locating social support is complicated by the stigma of the sex trade, particularly for those whose close friends, family and professional health contacts are not aware of their occupation. Nevertheless, the majority of respondents report access to confidantes and persons who lend support to them when they need it. From an occupational health and safety perspective, it is concerning that the respondents reported low support from police and social workers, since both might normally be sources of support to citizens in need. In addition to coping with the stigma of the sex trade, substantial minorities of the respondents represent other stigmatized and marginalized identities in Canadian society – illicit drug users, sexual minorities, Aboriginal/Metis ethnicities, and those living in poverty. Finally, the health beliefs and health behaviour of sex workers provide reason to be both optimistic and apprehensive regarding their overall health status. On the one hand, the majority of respondents practice safer sex practices as a rule in the work environment and appear to be keenly aware of the health risks associated with their work. On the other, some respondents engage in risky sexual practices at work and the majority of respondents engage in unsafe sexual practices in their private relationships. In contrast to other studies (Alexander,

1998; Campbell, 1991; Morrison and Rueben, 1995; Shuler, et. al., 1995; Vanwesenbeeck et. al., 1993), the findings of this study suggest that regular illicit drug users are not significantly more prone to unsafe sexual practices[16]. However, persons who use illicit drugs intravenously, and to some degree, persons consuming large quantities of alcohol, tobacco and other substances, may be more at risk for health complications associated with their quantity and method of substance use as well as the further stigmatization that accompanies having a genitive substance problem and being involved in the sex trade.

Having investigated the positioning of sex trade workers with regards to some of the most influential social determinants of health, what remains to be explored is the actual health status of sex workers and, in light of their reported health status, their access to health services and experiences accessing the health care system.

Chapter 6: Physical and Mental Health Status Indicators

The findings presented in the previous chapter, regarding the overall status of the respondents with respect to key population health determinants, foreshadow health problems, particularly among those who reported little access to the social and economic resources – social support, education, income and positive early family relationships - that mediate the relationship between the social environment and health outcomes. Thus, it should come as no surprise that many of the sex workers who took part in this research reported negative health experiences, both in and out of the sex trade context and only a minority of respondents reported no health concerns or difficulties accessing health services.

Findings according to a few health status indicators are presented below, including the prevalence of injuries, history of infectious diseases, and presence of mental health conditions. These indicators do not comprise a comprehensive examination of health status, but, nonetheless, span both the physical and mental domains of health and well being, inside and outside the work context, and therefore, provide include a diverse enough array of indicators to both comment and build upon the existing literature. The preliminary indications of negative health conditions among the research population speak to the need for access to appropriate health services, including services aimed at improving mental health and well being.

6.1 History of Occupation-Related Injuries

The closed ended portion of the research instrument contained three questions regarding injuries incurred in the sex trade, and the subsequent use of health services. While it was tempting to present the findings regarding injuries sustained at work with the earlier findings regarding occupational conditions (Ch. 5), I have chosen to present the injury data alongside

other health status indicators because of the oft-cited relationship between injuries, morbidity and mortality, all of which are commonly used as measures of population health status (Segall and Chappell, 2000). One of the limitations of the injury measures presented below is that they exclude injuries sustained at work for which medical treatment was not sought or for which other social service treatment, such as crisis counselling, was sought. In light of this, some additional data regarding abuse by clients and managers is presented as it provides general evidence of the prevalence of physical injuries at work, specifically those related to violent assault. Still, one must bear in mind that the data presented below reflects incidence of injury in the context of the sex trade and thus excludes other potentially health-impacting injuries such as complications related to substance use, injuries sustained in the context of personal and familiar relationships and/or traffic related injuries.

As shown in Table 13, female sex workers reported an overall higher incidence of workplace injuries, including injuries requiring hospitalization, than males: 38.1 percent of the females and 27.8 percent of the males reported being hospitalized because of injuries incurred in the sex trade. Presumably, injuries resulting in hospitalization are more severe than injuries for which ambulatory care was sought. However, given that sex trade work occurs after business hours, and that hospital emergency departments are typically the only sites where one can seek health care during these hours, it is possible that the figures regarding hospitalization also include temporary emergency care. The differences in workplace injury among indoor and outdoor workers and active and retired workers were also notable with respect to the hospitalization measure: 41.2 percent of those who reported they were not working at the time of the interview and 32.8 percent of those who were currently working reported being hospitalized for injuries incurred at work.

As noted in the literature, outdoor work – the practice of soliciting customers in public places – is commonly regarded as more dangerous than indoor sex work for a number of reasons. As Lowman (1991) has observed, the legal sanctions surrounding public solicitation and the public disapproval of sex work, pushes many outdoor workers to less visible public locations and forces a quick exchange between the worker and client, after which the worker typically enters the client's vehicle. The practice of having a "spotter" is one of the main precautions used by sex workers against ill-intentioned clients, but this too is complicated by outdoor settings because persons in the company of sex workers may be subject to the laws concerning living off the avails of prostitution if their presence is interpreted as collusion in the public vending of sexual services. In short, street-based sex work is typically viewed as more dangerous, and the findings presented in Table 13 bear this out: 41 percent of the respondents who indicated that their present or last venue of work was outdoors had been hospitalized for injuries incurred in the sex trade, whereas 33.3 percent of indoor workers had been hospitalized for the same reason. In a large study (N=303) of sex workers in Australia, Plumridge and Abel (2001) also found that outdoor sex workers were more vulnerable to violence than indoor workers. Despite the greater incidence of injury among outdoor workers, indoor workers are by no means immune to injuries in the workplace. However, as noted earlier, the sex workers included in this study demonstrated a great deal of mobility in their work, which in many cases included transitions between outdoor and indoor work venues; therefore, it cannot be assumed that the injuries reported occurred in the last or current location of work reported by respondents at the time of the interview.

Table 13: Workplace Injury

Question ("Yes" response)	Gender (N=196)		Present/Last Work Location (N=201)		Current Work (N=201)	
	Female N=160	Male N=36	Indoor N=123	Outdoor N=78	Working N=116	Retired N=85
Have you ever been hospitalized for injuries incurred in the sex trade?	38.1% n=61	27.8% n=10	33.3% n=38	41% n=35	32.8% n=41	41.2% n=2
Have you ever visited a doctor's office for injuries incurred in the sex trade?	30% n=48	33.3% n=10				
Have you ever visited a health care workers for injuries incurred in the sex trade?	26.3% n=42	19.4% n=10				

The statistics regarding medical treatment and workplace injury may not be the best overall indication of the prevalence of injury among sex workers. Rather, the prevalence of physical assault by clients and managers may be a more general indication of risk of violence-related injury in the workplace. Proportionally speaking, over one third of males and females who have a history of working for a pimp or manager/boss, experienced physical abuse at the hands of that person(s). Although the stereotype of a physically abusive pimp is widespread, there is little literature on the relationship between sex workers and their employers and managers, even though the experience of working for a business manager or boss in the context of an escort, erotic massage, or other type of indoor sex service business is not uncommon. The prevalence of reported abuse by managers supports the elsewhere-established view that one of the benefits of working independently, whether indoor or outdoor, is the freedom from exploitation and abuse by third parties such as managers and business owners (Benoit and Millar, 2001).

The figures in Table 14 regarding physical and sexual violence at the hands of clients indicate that a substantial minority of sex workers reported physical abuse by a client: 33.5 percent of females and 33.3 percent of males reported being physically assaulted in this manner. It is not surprising, then, that when asked about the main health and safety concerns in the sex trade, respondents overwhelmingly identified an ever-persistent fear of encountering a violent client as one of their main concerns. As discussed earlier, the ability to protect oneself from violent clients is shaped by both local and federal laws regarding solicitation, living off the avails of prostitution, and operating a "bawdy house". These laws undermine the capacity of sex workers to work in visible locations in the company of others and complicate their access to police services when clients are violent, or otherwise do not honour the conditions of the informal verbal sex service contract. Compared to the incidence of physical abuse by clients, the incidence of sexual violence was low: 17.1 percent of females reported being sexually assaulted by a client and 11.1 percent of males reported being harmed this way. Although there are multiple ways to interpret this finding, one potentially uplifting observation is that the majority of respondents had not experienced physical and sexual assault at the hands of a client at the time of the interview. Thus, despite the complications posed by the criminal code and the negative social construction of sex workers in Canadian society, it seems that many respondents were successful with their strategies for ensuring personal safety at work, and the majority of clients are not violent toward the sex workers whose services they purchase. This finding departs from other studies such as those by Vanwesenbeeck (1994) and Plumridge and Abel (2001) where it was found that the majority of sex trade respondents had experienced workplace violence. Nevertheless, even though a minority of respondents reported experiencing workplace violence in this study, it cannot be overlooked that violence is a regular occurrence in

the sex trade, and according to the findings presented here, female workers are more likely to be the victims of sexual violence.

> *I've been told because of what happened to me the other night that I shouldn't even be going out there and working. It's like "Well how else am I going to make money?" You know welfare isn't going to help me out every time I need money so I've got to go to work. A girls got to do what a girls got to do. (Female, Age 22)*

Overall, the findings concerning injury in the workplace identify an urgent need to pay greater attention to improving the safety of those who work in the sex trade with respect to exposure to violence and other injurious conditions. Although several sex trade-oriented social service organizations across Canada maintain information on "bad dates" for the purposes keeping sex workers aware of ill-intentioned clients, maintaining the safety of those working in the sex trade has not been addressed in an organized fashion by government-sponsored social service programs and community task forces. These bodies typically address issues of health and safety by seeking to control the sex trade and provide support to those who wish to leave this line or work. Although these objectives, and the resultant programs, are often well intentioned, they are an inadequate response for those who wish to continue their involvement in the sex trade.

Table 14: Abuse at Work

Presence of:	**Female N=124**	**Male N=19**
Physical Abuse by Manager/Pimp	39.5% n=49	36.8% n=7
Rape/Sexual Violence by Manager/Pimp	17.7% n=22	10.5% n=2
* Smaller N value for above items reflects subset of respondents who have worked for an yer/pimp		
	Female N=160	**Male N=36**
Physical Abuse by Client	33.5% n=53	33.3% n=12
Rape/Sexual Violence by Client	17.1% n=27	11.1% n=4

The findings presented above, regarding the somewhat greater incidence of injury among those retired from/not currently working in sex trade, mark the beginning of a theme that will be repeated along several of the health status indicators presented in this chapter. There are multiple possible explanations for the similar or greater presence of health problems among retired workers. The first consideration is that of *time*. The median age of retired workers was 34yrs, whereas the median age of those currently working was 32yrs. Thus, the greater incidence of hospitalization due to workplace injury could in part be an effect of time elapsed, both chronologically and in terms of overall time spent in the sex trade. There is little evidence to support this explanation, however, since the mean number of years spent in the sex trade was similar among active and retired workers, and was in fact slightly higher among those who reported that they were currently working at the time of the interview. The distribution of those reporting a history of outdoor and indoor work location was also similar among active and retired workers, so work location may not be a strong explanation for the difference in health status between the two groups. Proportionally speaking, females were a little more likely to reported retired status. However, the differences were not great, so gender is also a weak explanation for any differences found among active and retired workers. A final explanation is that retired workers chose to leave the sex trade, in part, because of negative health experiences in the sex trade and/or deteriorating health status. Though far from conclusive, this final explanation may apply to a number of the measures presented below that indicate that the health of retired workers is in some cases worse than that of their actively working counterparts. One respondent described leaving the sex trade as a matter of health preservation:

> *I had a drug overdose and that is when I decided I needed to leave the sex trade or it was going to kill me, drugs were going to kill me. (Female, Age 33)*

Another respondent described a more gradual sense of deteriorating health as a contributing factor in her decision to leave the sex trade:

> *I started seeing myself age when I looked in the mirror. I was using twenty pounds of moisturizer after putting on my makeup. I started looking [old], mostly in the eyes. I would look at myself in the eyes and say, "Gee, you've had a rough life haven't you?" My posture was really bad unless I was in heels. I kept my head down unless I was hooking because I hated myself. (Male to Female, Age 41)*

The process of leaving the sex trade often entails additional health-impacting stressors, including reconstructing one's sense of self after leaving the sex work role, challenges entering the mainstream labour force, and missing economic and other fringe benefits associated with sex work and the sex work community (Millar, 2001). As one respondent describes:

> *Oh yeah. I went through major depression [after leaving sex work]. I went from being with these people that made me feel wanted and beautiful to having to stay at home and not be able to do anything I wanted and being alone [and] not having people to talk with. When you're working, your day is filled. Getting used to not having any money, that was a big phase. In half an hour I could go and have a hundred bucks. It's a matter of controlling yourself and saying, "let's find something else to do". My self-esteem was down for a while. Now it's just starting to build back up again. (Female, Age 24)*

6.2 Contagious Infections and other Health Problems

The findings presented in Table 15 largely concern the presence of contagious infections among the respondent population, and in the case of pelvic inflammatory disease and cervical cancer, the potential complications associated with untreated and/or repeat sexual transmitted infections. Migraine headaches have been included in this table because they are by nature a physical health experience, but are also often a symptom of other health problems, such as head injury, stress, allergies, nerve problems, and changes in serotonin levels in the brain (BC Health Guide, 2001). Thus, the prevalence of migraines, or the occurrence of headaches more

generally, can be regarded as an indicator of other health complications among a particular population.

As show in Table 15, female respondents report a greater incidence of infections in almost all cases, with the exception of HIV seropositivity, where proportionally speaking, male respondents had a greater incidence of infection; however, the numbers reported were so small that it may be misleading to try to interpret gender differences. Overall though, the finding that very few respondents reported HIV infection is surprising, particularly in the context of the overwhelming number of studies that cite HIV infection as one of the primary risks associated with the sex trade. As noted earlier, many researchers have argued that sex workers have been scapegoated in the HIV/AIDS crisis (Alexander, 1998; Brock, 1998). Notwithstanding the possibility that HIV infection was underreported by the respondents and the inherent limitations of the non-random research sample, the findings of this project also support the view that the risks of acquiring HIV have been overemphasized in the literature on the sex trade and health. This finding is not completely unprecedented, as similar rates of HIV infection have been found in other high-income countries (Campbell, 1991; Pyett and Warr, 1997). For example, in Australia, the prevalence of HIV among sex workers is said to be approximately 1 percent (Joint United Nation Program on HIV/AIDS, 2002). It is also noteworthy that the majority of respondents in this study who identified as HIV positive, attributed their infection to circumstances outside of their sex work: namely, intravenous drug use and sex with a private unprotected partner (Benoit and Millar, 2001), which also supports findings reported elsewhere that sex workers with HIV often acquire the virus outside of the commercial sex trade, perhaps as a result of their own intravenous drug use or from sex with an intravenous drug user

(Campbell 1991). Thus, sex trade involvement may not be an independent risk of HIV infection (ibid.).

As shown in Table 15, blood borne infections, particularly Hepatitis C (HCV) were not uncommon among the research population. However, when persons reporting a history of intravenous drug use (IDU) are separated from persons who have not consumed illicit substances intravenously, it becomes apparent that the risk of contracting HCV is much greater among IDUs. This finding is consistent with recent reports that the majority (53 percent) of intravenous drug users in the CRD report HCV infection (Capital Health Region, 2000)[17]. HCV is most readily transmitted through blood-to-blood contact, and most typically as the result of sharing syringes and other equipment used in conjunction with syringes (BC Health Guide, 1999). HCV is less likely to be acquired through sexual contact; therefore, those who reported no recent history of intravenous drug use, but reported HCV infection were likely to be either previously intravenous drug users or they form part of the 10 percent of cases of HCV where the source of infection remains unknown (BC Health Guide, 1999). The higher prevalence of HCV infection among female respondents is likely a function of the greater proportion of females who reported intravenous drug use relative to their male counterparts; however, on the other hand, as noted earlier, females are more likely to require assistance consuming drugs intravenously (Spittal et. al, 2002). Requiring injection assistance is associated with needle sharing and acquiring HIV, but could also explain higher rates of HCV among females.

Sexually transmitted infections, specifically Chlamydia, Gonorrhea, Herpes and Syphilis were also common among the research population. Just over half of the respondents (54.2 percent) reported having an STI while working in the sex trade. Female workers reported a higher prevalence of STI's in all cases, with the exception of Herpes, which appeared to be

more common among males. As a point of comparison, Weiner (1996) found 58.2 percent of female, street-based sex workers in New York reported a history of STI's while working. Similarly, in a Ontario-based study of exotic dancers, 35% of respondents reported a history of STI's, even though dancing is presumed to be less risky than other forms of sex work with respect to acquiring sexually transmitted infections (Maticka-Tyndale et. al. 1999).

The higher prevalence of STI's among females in this study is consistent with population statistics concerning the prevalence of these infections among men and women generally (Statistics Canada, 2000). As a point of comparison with the general population, in 1995, the prevalence rates of Gonorrhea, Chlamydia, and Syphilis for both genders was 17.9, 127 and .05 cases per 100, 000 individuals, respectively (Health Canada, 1995). When compared with the incidence of STI's among the research population, the rate among the general population appears to be significantly lower. As noted earlier, both cervical cancer and pelvic inflammatory disease (PID) are secondary complications of untreated STI's. The presence of Human papillomavirus (HPV), sexual risk behaviour (defined as multiple partners and early sexual activity), and smoking are the most commonly cited risk factors with respect to cervical cancer (Health Canada, 1995). Thus, given the rate of STI's among the respondent population and the high number of sexual encounters had by sex workers, there is good reason to expect that the rate of cervical cancer and PID will also be higher among female sex workers in comparison to females of the same age in the general population. As reported in Table 15, a small minority of female sex workers reported the presence of cervical cancer (6.3 percent). By comparison, the rate of cervical cancer among Canadian women across the provinces was reported to range from 7 to 11 cases per 100, 000 between 1994 and 1998 (CIHI, 2003). The incidence of PID - an infection of the upper reproductive organs that may lead to reproductive

complications - was 4.4 percent among the respondent population. While there are no population statistics for PID, it is estimated that 10 percent of women will experience PID at least once over their lifetime (Health Canada, 1995). A direct comparison of the prevalence of cervical cancer and pelvic inflammatory disease amongst the general population of Canadian females and the respondent population is not appropriate to the extent that differences in age distribution and method of measurement may render any direct comparison meaningless. Nevertheless, the findings presented here can be viewed as tenuous indication of poorer sexual health status among the female respondents, relative to the general population of Canadian women, and speak to the necessity of regular and satisfactory access to sexual health screening for sex workers.

Finally, 28.8 percent of females and 22.8 percent of males reported migraine headaches. As a point of comparison, population-based data indicates that approximately 11 percent of females experience migraine headaches and even fewer males report this health problem (Statistics Canada, 2000). Once again, the findings concerning the prevalence of chronic headaches suggest that the overall health status of sex workers is not good.

Table 15: Self Reported Presence of Infectious Diseases and other Select Health Conditions

Physical Health Condition	Gender N=201		History of Intravenous Drug Use (Last six months) N=201 * IDU = History if Intravenous Drug Use		Current Work Status N=201	
	Female N=160	Male N=36	IDU N=69	No IDU N=132	Working N=116	Retired N=85
Hepatitis A	1.3% 2	0%				
Hepatitis B	8.8% 14	5.6% 2	13% 9	4.5% 6		
Hepatitis C	35.8% 57	27.8% 10	59.4% 41	19.6% 26	33.4% 39	32.9% 28
HIV Seropos.	3.5% 5	5.6% 2	7.2 % 5	1.5% 2	2.6% 3	4.7% 4
Chlamydia	40% 64	22.2% 8			37.9% 44	34.1% 29
Gonorrhea	36.9% 59	22.2% 8			29.3% 34	40% 34
Syphilis	24.4% 39	16.7% 6			17.2% 20	30.6% 26
Herpes	8.9% 14	16.7% 6			7% 8	14.3% 12
Pelvic Inflammatory Disease	4.4% 7					
Cervical Cancer	6.3%10					
Migraine Headaches	28.8% 46	22.8% 8				

6.3 Mental Health Conditions

The mental health status among the respondent population presents further cause for concern with regard to overall health status. Approximately half of the respondents reported depression, and a significant minority of respondents reported feelings of anxiety, flashbacks and sleep disorders. Although, there are few studies of the incidence of depression among sex workers, a Dutch study found that 75-80 percent of sex workers experienced feelings of depression and other negative emotional states, which is evidence that the high rates of

depression reported by the respondents here is not entirely unprecedented in the literature (Vanwesenbeeck, 1995). However, in stark contrast to findings presented here, Romans et. al. (2000) found little difference in mental health status between a sample of 29 sex workers in new Zealand and a sample of comparably aged women who were not involved in sex work. However, it is noteworthy that the sample of sex workers (N=29) differed substantially in size from the comparison group (N=680), which likely limited the strength of the comparative findings.

As shown in Table 16, the high incidence of depression was consistent across both genders and across both working and retired sex workers participating in the study. In fact, as has been the case along a number of the health indicators reported here, retired respondents appear worse off in many instances than their working counterparts. As discussed earlier, any conclusions regarding why this may be the case are difficult to establish due to limitations of the data. Nevertheless, as noted earlier, it is possible that health problems are a contributing factor for some respondents' decision to leave or take a break from sex work, which would result in a greater concentration of poor health among non-working respondents (See also Vanwesenbeeck, 1995). As noted in Chapter 5, many, though certainly not all, of the respondents who had left the sex trade did so in conjunction with a decision to reduce or cease the use of illicit drugs. It has been observed that for many, the decision to address problem substance use also often entails addressing the health problems and adverse social conditions that lead many to use substances in the first place (Alexander, 2001). Thus, for these individuals the process of leaving the sex trade, in combination with changing substance use patterns, may result in a greater awareness of other health concerns, which ultimately may have an effect on self-reported mental health status. Similarly, the challenges faced outside the sex

trade, including in many cases, reduced earnings, may result in feelings of stress and reduced mental health, even though other aspects of leaving the sex trade may be regarded as positive. Vanwesenbeeck (1995) also reported that actively working sex workers were healthier than retired respondents, a finding that she suggested may be related (among other things) to retired workers legitimizing their retirement by acknowledging the negative health consequences of sex work.

When compared to the general population, the prevalence of mental conditions reported by the respondent population is high. For example, findings from the National Population Health Survey (1998/1999) indicate that that 5.7 percent of females and 2.9 percent males experience depression over a one year period (CIHI, 2003), which is significantly lower then the incidence of depression reported by the respondents overall. Yet it should be noted that the National Population Health Survey uses a series of depression screening measures to establish the rate of depression among the population and the findings presented here are based on a single, self-report depression measure that does not allow for the separation of episodic depression from chronic depression or for any distinctions between major and minor depressive episodes. Notwithstanding this, there is little reason to suspect that depression and other mental health problems would not be higher among the respondent population, given that the social risk factors associated with depression (such as inadequate access to social support, inadequate income, low self esteem, stress, violence, childhood trauma, and chronic health problems) are generally high among the study population (CIHI, 2003). On a positive note, just under 14 percent of the respondents who indicated that they were depressed or had a history of depression, had not received clinical diagnoses. It is presumed that the majority of these diagnoses occurred in health and social service settings where support for mental health

problems was also available. By contrast, according to population-based statistics, it is estimated that less than half of women with major depression have sought help (CIHI, 2003).

Other reported mental health problems among the respondent population also support the view that the mental health status of sex workers is markedly different from that of the general population. For example, although it is difficult to obtain reliable estimates of attempted suicide, 108 females per 100, 000 and 70 males per 100, 000 in Canada will be hospitalized because of attempted suicide each year. By comparison, 9.4 percent of females and 13.7 percent of males in the respondent population reported having attempted suicide. However, this figure likely also includes instances of attempted suicide that did not result in hospital treatment.

It is not uncommon for mental health concerns such as depression, eating disorders, and anxiety disorders to exist co-morbidly. Thus, it is not surprising that the majority of respondents reported having at least of the conditions measured and more often, more than one mental health condition.

The importance of mental health to overall health has been the topic of much recent research. For example depression has been linked with increased cardiovascular problems (CIHI, 2003), and population health researchers are increasingly exploring mental-emotional health and stress responses as the pathway through which the social and economic environment results in disparities in health between lower, middle and upper classes (Evans et. al., 1994).

Table 16: Self Reported Presence of Mental Health Conditions

Mental Health Condition	Gender		Current Work Status	
	Female N=160	**Male** N=36	**Working** N=116	**Retired** N=85
Depression	50% 80	50% 18	50% 58	51.8% 44
Anxiety/Panic Attacks	46.9% 75	36.1% 13	40.5% 47	50.6% 43
Attempted Suicide	9.4% 15	13.9% 5	16.3% 16	5.9% 5
Flashbacks	31.9% 51	27.8% 10	26.1% 31	38.8% 33
Self Harm	3.8% 6	11.4% 4	26.7%	4.8% 4
Eating Disorders	11.9% 19	8.3% 3	6.9% 8	20% 17
Sleep Disorders	36.9% 59	30.6% 11	31.0% 36	43.5% 37

In the interest of exploring differences in mental health status among the research population, a scale was constructed using the nine mental health measures[18] [19]. Following this, the mean score for a number of subgroups was compiled for the purpose of exploring intra-population differences in mental health status. This exercise yielded some interesting results, that point to further areas of research regarding differences in health among sex workers, even though the results cannot be regarded as conclusive or statistically significant. While the mean scores on the mental health scale were similar across gender, education level, and age of entry to the sex trade, a difference in mean score was notable based on First Nations/Metis Status, current age, history of childhood abuse, history of government care, outdoor work location, and retired work status. Specifically, the latter, beginning with history of abuse, had greater mental health scale scores, indicating that their mental health was worse than their counterparts. For example, those reporting a history of severe childhood abuse (including a combination of sexual abuse and physical abuse) had a mean score of 3.7 whereas those who did not share this history had a mean score of 1.3. Outdoor workers reported a slightly higher level of mental health concerns. A similar finding was reported by Vanwesenbeeck (1995) who found that outdoor

workers and workers in unorganized settings experienced greater incidence of psychosomatic complaints.

Table 17: Mental Health Scale (Compare Means)

Gender N=199		Current Age Group N=199		Aboriginal Status N=199		Education Level N=198	
Female N=159	Male N=35	</=35yrs N=109	>35yrs N=90	Yes N=30	No N=169	Less than High School N=120	High School N=78
2.5	2.4	2.2	2.8	1.7	2.7	2.4	2.5

Presence of Childhood Abuse (one or more of physical/sexual) N=90		History of Government Care N=199	
Yes N=70	No N=30	Yes N=114	No N=84
3.7	1.3	2.6	2.4

Age of Entry to the Sex Trade N=199		History of Work Location N=199		Current Work Status N=199	
<19yrs N=108	=/>19yrs N=91	Indoor N=122	Outdoor N=77	Active N=115	Retired N=84
2.5	2.4	2.3	2.7	2.2	2.9

6.4 Respondent Views Regarding the Impact of the Sex Trade on Their Health

Although the findings presented above may be viewed as tentative evidence (due to sample limitations) of the lower health status of sex workers compared to the general population, they do not, for the most part, substantiate any claim that involvement in the sex trade is the root of the problem, particularly since the respondents who had left the sex trade reported similar, and in some cases, greater incidence of health problems. While high incidence

of STIs and workplace injury are obviously directly related to sex work, other health problems, such as mental health conditions and contagious infections, may or may not be directly attributable to sex trade activity and sex workers may locate the origins of their health problems elsewhere.

Given this, it is interesting that the respondents were divided with regard to their assessment of the impact of the sex trade on their health. Overall, 56.2 percent of the respondents said that working in the sex trade had affected their health and 43.8 percent of the respondents felt that working in the sex trade had not affected their health. Furthermore, among those that felt the sex trade had impacted their health, a small number felt that their health had improved as a result of their sex trade involvement. As one respondent noted:

> *[Working in the sex trade] brought me to the realization that I need to be safer in life with everything. Even when I go on regular dates, I don't kiss. I don't kiss on the first date, I don't even kiss on the second date. I really don't kiss that much at all any more because you never know what could be carried in the mouth. If you meet someone at the bar, they could be out running around with everybody. With me, I know I'm running around, but I'm doing it with protection. I'm not catching these funky things. (Male, Age 22)*

Another respondent felt that she was sick less often after entering the sex trade because it helped her to gain a greater awareness of health problems and how to avoid them:

> *Yes, [working in the sex trade has affected my health]; it's actually made me healthier because I'm more careful now and more aware. So I actually get sick less now than I used to (Female, Age 29).*

Outside of the few instances of reported positive effects, the majority of respondents who reported that their health *had* been affected as a result of their sex trade involvement felt that the effects were negative. Respondents noted a number of areas where their health had been affected, but the most prominent experiences noted were feelings of fatigue, acquiring

contagious infections, a diminished sense of self-esteem, and problems in their personal sexual lives. As one respondent noted:

> *Oh ya, its affected me because [ ] along with working in the trade I used dope and I contracted Hep C and just my physical health - I've been tired, beaten, and just exhausted. (Female, Age 26)*

Other respondents described the toll of having to dissociate from their experiences in the sex trade:

> *I guess there's a part of me that's really aware of how I dissociated myself from my body and how I was able to do it for that many years and think of it as no big deal. Even still, I think of it as no big deal. I think it didn't hurt me very much, but it did. It's made me aware of [ ] how I could just shut down. It's also made me realize there's some issues that I haven't even looked at which are the things which led me [to the sex trade] in the first place. (Female, Age 41)*

> *Mentally, emotionally it effects everything. You [ ] become that person and it seeps into the rest of your life. If you are going to be in the sex trade you got to have the skills to separate the business from home and there's no way of knowing how to do that except for time. Trial and error. (Female, Age 23)*

The harmful effects of having to conceal one's involvement in the sex trade, or be one person in the sex trade and another outside the sex trade, was noted by several respondents and linked with lowered self worth and a constant fear of being "found out", even after leaving the sex trade. Another respondent described difficulties in interpersonal social relationships:

> *I would say my mental health [has been affected]. The ability to build strong bonds and relationships [has been affected]. Overall, physical health, no, [that has not been affected] . Mentally, there are a lot of problems I face daily. There's a problem with closeness and compassion. I have huge trust issues. [ ] I've seen a lot of the bad things [ ] happen in the world. I very rarely get a glimpse of the good things. I guess you just have to keep your head up. (Male, Age 26)*

Also relevant to the theme of mental and emotional health was the finding that several respondents described difficulty in their personal sexual relationships as a result of their sex trade involvement :

> *Sexually, with my partner things have been...I don't know. I just don't feel like it. I feel like I've done enough of it. Sometimes, of course, I'm normal and have times where I feel like it, but not like I used to before I did the sex trade. I was much more active before the sex trade. I was "into it", but now I could take it or leave it. It seems to be more of a chore than it's worth sometimes. That's how I feel about that. It just degrade[ing] making love, really. It made it like, well...I didn't really mean much to men. (Female, Age 30)*

Pyett and Warr (1997), similarly found that difficulty in romantic relationships outside the sex trade was one of the negative side-effects of working in the sex trade.

In summary, the findings regarding the prevalence of STI's and violence in the workplace provide further confirmation that these topics are relevant to considering the health of sex workers. However, the range of mental health concerns reported by many respondents points to an area of health problems among sex workers that has received comparatively little attention relative to issues of physical health. The range of health concerns reported by the respondents supports the need for researchers to examine health using a more comprehensive model than what is typically associated with the health risk model, particularly since close to half of the respondents felt that working in the sex trade had not negatively affected their health. It must also be remembered, that in the absence of a comparison group, or longitudinal data, it is difficult to determine to what extent the sex trade itself causes poor health.

Chapter 7: Access to Health Services

Although access to health care is regarded as a social determinant of health in the population health model (Hamilton and Bhatti, 1996), I have chosen to address it separately for two reasons: First, by presenting the findings concerning the respondents' poor standing with regard to social determinants of health and the prevalence of physical and mental health concerns, I hoped to provide a context of need from to evaluate whether or not the respondents reported adequate access to health services; second, the stigma surrounding the sex trade and low social status ascribed to sex workers portend complications accessing public services. Even though the Canadian health care system is intended to be universally accessible, it is established knowledge that certain populations, including those with lower socio-economic status, are less likely to access *appropriate* service than others (Weiss and Longquist, 1997). In Canada, health services may be theoretically available to sex workers, but whether or not the services available are satisfactory and/or effective is largely unaddressed within the literature on the sex trade and health.

The prevalence of STI's and mental health conditions among the population might be interpreted, if nothing else, as confirming a need for access to prevention and health promotion information, even for those who reported good health at the time of the interview. Further, clients themselves pose a risk to sex workers, and the organization of the sex trade in Canada is such that workers cannot rely on common workplace health and safety standards or employment legislation to protect their interests – quite the opposite. It is not uncommon for sex workers to bear the burden of insisting upon safer sex practices in the workplace and organizing their own health protection measures; thus, sex workers often act health educators in the workplace to both clients and peers, which is further reason for workers to have access to health education

and health prevention supports. A final reason to consider health care access especially important among sex workers, is the seemingly high rates of reported health problems such as depression, chronic disease, complications related to substance use, and health risks in their work and personal environments. Keeping this general context of need in mind, I would like to turn to some findings concerning health service utilization and appropriate access.

7.1 Service Utilization and Access to Health Resources

As might be expected, given the publicly funded health care system available in Canada, the vast majority of respondents (94.5 percent) indicated that they had a personal health number, and of the few who reported not having a current BC personal health number, several indicated that they were still able to access health clinics.

The median number of visits by respondents to a health professional in the last year was 10, which seems high, although it is not appropriate to draw conclusions based on this figure given the broad nature of the measure and the absence of directly comparable statistics. However, as a general point of reference, Statistics Canada found that 68 percent of females and 51 percent of males aged 12 years and over have visited a health professional on two or more occasions (Statistics Canada, 2000) whereas 96 percent of the respondents in this study had visited a health professional on two or more occasions. In the same report, it was noted that family physicians (general practice) were most often contacted (ibid.). Some notable differences in contact with health professionals were found among the respondents. As shown in table 18, the median number of health visits was higher among females, outdoor workers, intravenous drug users, those reporting depression and other mental health conditions and those with chronic diseases such as HIV and HCV. The median number of visits reported by aboriginal

respondents was considerably lower than non-aboriginal respondents. The finding of higher service utilization among females relative to males is consistent with what has been reported elsewhere (Statistics Canada, 2000). Since Methadone use and presence of HCV is more common among those reporting intravenous drug use, the greater median number of visits among this subpopulation is likely a reflection of the greater contact with health professionals associated with methadone use[20] and the complications that can arise from chronic infections. Also, equally interesting is that the median number of visits reported by current and retired sex workers was no different. Finally, also shown in Table 18, the median number of health visits increased with poorer mental health. The same was true with respect to physical health conditions – the more reported, the greater median number of health professional contacts.

Table 18: Median Number of Visits with a Health Professional by Sub-Population

Male N=35	Female N=160	Aboriginal N= 30	Methadone Use N=23	HCV N=67	HIV N=7	Currently Working N=116	Retired N= 84
6	10	5	24	12	24	10	10
No Mental Health Condition N=40	One Mental Health Condition N=37	Two Mental Health Conditions N=32	Three Mental Health Conditions N=30	Four Mental Health Conditions N=24	Outdoor Workers N=78	Indoor Workers N=122	Recent Intravenous Drug Use N=69
4.5	5	11	10	15	12	8	12

Given the higher rate of reported STI's, regular health screening among the population is, without question, a crucial health prevention resource. Thus, it was encouraging to find that 67.9 percent of the female respondents reported having had a pap smear on at least a yearly basis. Even more encouraging was that 75.6 percent of the female respondents who reported that they were currently working reported a pap smear on at least a yearly basis. By comparison, 59 percent of women in the Canadian population report having had a pap test in the

last year (Statistics Canada, 1999). In the general population, the percentage of persons who report having had a pap smear increases with level of education (Statistics Canada, 1999). Given that the respondents, on average, reported a low level of education, it is even more remarkable that so may had had a recent pap smear exam.

In light of the rate of STI's and blood borne infections among the group, it is also important that access to resources such as condoms and syringes be available in order to prevent transmission of infections. Overall, 83.6 percent of respondents reported having access to free condoms. The points of access included outreach health services (most notably the local needle exchange), social service agencies and physicians clinics. The majority of respondents who indicated that they did not have access to free condoms were not working at the time of the interview. In only one case did a respondent indicate that condoms were available at a place of work, which is interesting since one would hope that condoms and other protective health resources were made available to workers by managers and employers in business settings; however, on the contrary, it may be the case that some employers are not concerned about the health of workers, and perhaps even more plausible, is that stores of condoms are avoided in the workplace because, as noted earlier, condoms can interpreted by the police as evidence of prostitution related crimes. In any event, the fact that the workplace was notoriously absent in the respondent comments regarding access to free condoms is a notable health and safety concern, particularly since employers and manager can be very influential in setting the standards of health and safety in a given worksite. All of the respondents who reported using substances intravenously knew where they could get free needles or exchange needles, as did the majority of respondents who had not consumed substances intravenously. Several respondents indicated that they purchased their own syringes at drug stores and pharmacies and

a couple of respondents indicated that they were able to obtain clean syringes from friends. It was not asked, however, how often and under what circumstances the respondents who reported intravenous drug use had shared syringes.

Drawing on data from the Canadian Community Health Survey, Statistics Canada has noted that less than half (32 percent) of persons reporting mental health problems or substance dependency, seek treatment and approximately one fifth (21 percent) report an unmet service need with regard to substance dependency and mental health (The Daily, 09/03/2003). The three most commonly chosen reasons for not seeking service included: preferring to manage needs without formal service, not getting around to seeking service, and being concerned about what others would think and/or being afraid to ask for help (ibid.). However, among those who did seek service, over 80 percent were satisfied with the service they received (ibid.).

Among the respondents who reported depression, only 18.8 percent had not received treatment, which seems lower than is the case among the general population as reported above. It is not known if the services received were regarded as satisfactory. Similarly, among those who indicated a desire to decrease or cease the use of particular substances, 60 percent had received treatment. There may be many reasons for not seeking service, however it is likely that among these, some of the reasons have to do with the stigma of problem substance use and/or the limited availability of substance-related treatment in British Columbia.

Even though it is not known if the services accessed were perceived as effective by the respondents, it is encouraging that the majority of persons reporting stigmatizing conditions such as mental health conditions and problem substance use, had sought help for their health concerns, especially since the combination with stigmatizing health conditions and being involved in the sex trade is more reason to avoid seeking service.

Another common measure of health service utilization is the use of prescription drugs. Approximately 56.2 percent of respondents reported taking medications, which is similar to estimates for the Canadian population where it has been found that 42 percent of persons report taking medications (Statistics Canada, 1999) and just over half of females (51 percent) report taking medication (Statistics Canada, 2002). However, among the general population, over-the-counter painkillers are the most common medications used (ibid), but among the respondents, prescription drugs appeared to be more commonly used. Common prescriptions included Selective Serotonin Uptake Inhibitors, Sedative Hypnotics and Methadone, birth control pills anti-asthmatics and prescriptions for chronic infections. Use of painkillers was not uncommon, but in many cases, prescription doses of painkillers were noted rather than over-the-counter doses. This finding is consistent with others that show that persons with lower levels of income use more medication, including multiple medications (Statistics Canada, 1999), and it fits with the seemingly higher prevalence of mental health conditions reported by the respondents.

A final measure of health service utilization is the use of alternative therapies. In 1996-1997, 8 percent of women reported using alternative therapies. Only a subset of the respondents in this study were asked about their use of alternative therapies and therefore overall use among the respondents as a whole cannot be determined. However, of those that were asked about the use of alternative therapies, several respondents indicated that they did use an alternative therapy, most typically massage, chiropractic treatments, homeopathic remedies and vitamin supplements. The significance of this finding is that is does not fit within the health risk model of sex work, but rather demonstrates that sex workers can be health conscious, using their power as consumers to make choices about accessing both medical and non-medical health resources.

7.2 Appropriate Access to Health Services and Prevention Resources

According to the findings presented above, health service utilization is, in many cases, high among the respondent population; however, this does not mean that the services accessed are effective or satisfactory. Indeed, as has been reported elsewhere, sex workers face considerable barriers to accessing appropriate health services, including discrimination in the service context and reluctance to make health professionals aware of their sex trade involvement (Carr, 1995; Scambler and Scambler, 1995). For example Romans et. al. (2001) found that one third of physicians' respondents did not know of their involvement in the sex trade.

One indicator of appropriate access to health services is "continuity of care" - a multifaceted concept that includes both relational and informational continuity of service (Freeman and Sheppard, 2000). Continuity of care is not always desirable from the perspective of the patient as there may be some instances where a one-off, anonymous service context is desirable, however in the case of the respondent population it is assumed that continuity of care is one of the factors that can facilitate the development of provider-patient relationship in which a respondent might feel comfortable speaking about health needs related to the sex trade or other personal health topics. Given this, it is noteworthy that 57.2 percent of respondents reported that they had a preferred clinic and 61.2 percent of respondents reported that they had a preferred worker. On the one hand, one would hope that all respondents would have a relationship with a particular health provider, however given limited access to family physicians and the prevalence and ease of use of drop-in health clinics in the Capital Regional District, not having a preferred provider may not be unusual among some populations, and the services provided at drop-in clinics may be adequate for some. As one respondent commented:

> *There have been doctors that at the walk-in clinics that were actually respectful. Making sure that everything was okay and just checking in on you. You go in to see them and they make sure that everything's been okay up until then. Really nice about it and inquisitive. They're not always like that though (Male, Age 40).*

Speaking of the benefits of continuity of care, one respondent commented that her satisfactory access to health services was due to having an ongoing relationship with "*the same health care person who delivered the children, knows everything that I've been through and [is] very supportive"(Female, Age 24).* Another respondent noted the benefits of finding a doctor with whom he could develop a relationship:

> *I've had several doctors that didn't treat me like a person, like on a personal level. For the first part of my life I had a lot of different doctors because I was in so many different places all the time. I never really got used to one doctor and I had to keep switching.[ ] As soon as I stayed in a place for long enough to develop a relationship with a doctor and have him see me more as who I was as a person and not just somebody who was going to be there for a short time, then I got treated with a little respect. I'm sharp enough to change doctors if I'm not pleased, so I know how to do that now. (Male, Age 40)*

One benefit of developing a relationship with a particular health provider is that the patient will feel comfortable sharing information that is relevant to care, as the following comment illustrates:

> *Well I just recently told my doctor. I can't remember when but I hid it from her for a long time thinking that she wouldn't be too happy, but she was happy because I was happy. I told her because I was scared or whatever but... because of all the bladder infections that I have been getting from work, I had to tell. I had to be honest about what I'm doing and this is probably the reason why I'm getting all these bladder infections. (Female, Age 28)*

Overall, the experiences that respondents described with physicians were mixed: some respondents had only positive things to say, many respondents had both positive and negative experiences, and a minority of respondents had only had negative encounters with physicians.

Of those reporting negative experiences, perceived and enacted discrimination was a dominant factor, as was the respondents' perceptions that the environment was rushed and the provider lacked empathy or an understanding of their concerns. As one respondent commented:

> *The reason that I'm not (satisfied) is that I don't feel that my doctor is educated in substance abuse issues. I would never talk to her about my prostitution ever. [ ] I've never been satisfied with any doctor that I've ever had because none of them seem to be educated in my issues, which are substance abuse and prostitution.(Female, Age 41)*

Conversely, another respondent commented on how finding a physician she perceived as understanding her needs made all the difference to her feelings of trust and service satisfaction:

> *There's two doctors that I've seen that I don't want to be with because I felt that confidentiality was a big thing. I didn't really think that they respected my lifestyle and my wishes. Through trial and error I've found a great doctor. She's really cool and she really understands and she's on a street level. (Male, Age 26)*

Unfortunately, experiences of discrimination were not uncommon in the service context. Speaking about her experience accessing the emergency ward at the hospital, one respondent commented:

> *"... at the hospital they didn't respect me at all. "Oh, you're a prostitute, that's what you're doing in here" and "what did you expect" and other negative things were said to me. (Female, Age 18)*

Not only is emergency care largely inappropriate for those presenting health problems related to illicit drug use in terms of program funding, but individuals accessing emergency care for reasons related to substance use are not likely to be treated well in this environment, since it is reserved for acute medical issues, and staff will not follow-up with appointments to review conditions or participate in preventative or risk–reduction care (Morrison and Ruben, 1995; Sandi Merriman House, 1996).

For respondents who were also illicit drug users, discrimination in the physician service context was common. One respondent noted that even in the context of a long-term relationship she felt discriminated against when she developed substance dependence:

> *I had a doctor for thirty-six years, so I looked at him like my father too. He never knew that I was in the sex trade and I never told him. I was too ashamed. So, he didn't know. But I did get drug addicted. So with that, he didn't treat me with respect. He treated me like a lesser person. (Female, Age 43).*

Commenting on her earlier experiences, accessing physicians while involved in the sex trade, one retired respondent reported:

> *In the past its like a lot of them didn't want to deal with me because I had... you know I'd been working and I had been using and I had abscesses and stuff like that and they just... they treated me like I was a piece of shit. (Female, Age 26)*

Another felt that her sex trade involvement and receipt of income assistance, prompted her physicians to withhold prescriptions she felt she needed:

> *There was one doctor that I had [who] would hesitate to prescribe certain things such as Ativan because he knew what my profession was. He was just a little uptight about things and didn't want to give me what I needed. I don't know if that was because he knew what I did with my life, or if it was because I was on social assistance.(Male to Female, Age 28)*

Another respondent described her feelings of being treated as a "throw away", prior to finding a physician who she perceived as helpful:

> *The one I have now is just wonderful. He is the only one that ha[s] ever helped me. Until now they have all said that I was a hopeless case that I wouldn't make it. I was bawling my eyes out, begging them to help me and they said "your not ready yet, you'll never make it out, you one of the people who's not going to make it, so lets just forget about you". Sort of like kicking someone underneath a rock and I don't think that anybody deserves that. (Female, Age 30).*

Finally, a few respondents felt that their physicians treated them as less intelligent:

I've just noticed with doctors in general they treat me like I don't have... like I'm stupid, that they cant be bothered explaining what their doing or...and that was way before I started dancing,[so] I don't think that has anything to do with it. I think it would probably increase if they knew I was a dancer [ ]. I cant imagine how much more insulting it could get. (Female, Age 28)

Given the comments above, it is not surprising that when asked about the qualities most desired in a health provider, respondents overwhelmingly indicated that knowledge of their particular health needs, non-judgmental and caring were the qualities/attributes desired most. As one respondent put it:

Someone that you could actually go in, sit down and say, "this is what I am". And not have to worry about them putting on the gloves just to talk to you. I look after myself. Before I started I went to the library to do research about STD's, to figure out what's safe, what's not safe. [ ] I understand that they have concerns, but I'm not contagious just sitting there. (Female, Age 40)

Somebody who is compassionate and does not have false interpretations of [me] – like if you're a prostitute and going to see a doctor, then you must have all sorts of things wrong with you. (Female, Age 18)

I would just like to see a doctor out there who will not judge and look more at the whole picture of what is going on with the woman or the man that they are looking at. There's a lot more than just what they're doing for a living. (Female, Age 36)

Perhaps because of the prevalence of mental health concerns and feelings of discrimination and isolation in the sex trade, many respondents described their desire to develop a relationship with a physician that involved time to communicate about issues regarding the sex trade and well-being. For example, when asked about what she desired in a health provider, one respondent commented:

Maybe having an understanding about the sex trade and what's involved [to address] some of the fears that women have about going into a clinic or going to see their doctor. [ ] They don't really talk to you. They just sit you down, they write a prescription, do their thing and just ignore you. I would like to be able to talk, even if it's about the sex trade. At least they [could be] open to it; Not really looking down on you; I think that would be a big one. (Female, Age 27).

During a research dissemination and follow-up focus group meeting with local health providers, a local physician concurred with the finding that patients do not receive substantial interaction in traditional settings, noting that physicians generally subscribe to a "five minutes per patient rule". As someone who has both a private practice and works in an alternative health care setting, her feeling was that one of the benefits of alternative health care settings is that there is more flexibility to orientate service delivery to the needs of the target population. It is not surprising then that several respondents commented on their positive experiences accessing local alternative health clinics such as the local needle exchange:

> *They're awesome, they're so great and just nice and they really, really care. [ ] Everything is available. Condoms are there, and needles, there's everything. (Female, Age 28)*

> *"The street nurse when I didn't feel comfortable going to the doctor because I didn't feel comfortable building a relationship with my doctor and I felt the street nurses had the most compassion for people in our kind of work trade. They're completely non-judgmental." (Female, Age 22)*

> *I've gone to the needle exchange and there are nurses there. I've gotten shots from them and HIV [and], Hep C tests from them. I find them quite helpful. They supply condoms and they're good people to talk to. Much more [understanding than doctors]. (Male, Age 34)*

However, not all respondents felt comfortable accessing services designed for a more street-entrenched population. As one respondent commented, an alternative service for escort workers who were not visibly in poor health in the manner some street involved individuals or intravenous drug users are, is required:

> *The only thing I would say is that instead of us having to go down to the needle exchange to get our STD testing if they had a different place for people, I don't want to say "like us" because that's kind of snobby but, like not junkies and stuff. [ ]You have to go down to the needle exchange right now, and to me that's a very threatening place because of my life style... When I see people dropping off needles, like right in front of me and getting new ones it just makes me feel really uncomfortable. I think they should give us our own [service environment]. I'm not saying have leather couches and stuff but leave that as the needle exchange and have a separate place for escort workers who aren't there to exchange needles and stuff. That bothers me.(Female, Age 29).*

Another commented on the need to have access to physicians who were willing (and presumably appropriately trained) to serve sex workers:

> *Somebody who actually listens to you and doesn't just try to push pills on you. Somebody that you could talk to. I would try to tell doctors that I was an escort, but they just give[me] a send off and I don't think that it's right. I think that there should be[ ] doctors that advertise that they take sex workers. (Female, Age 40)*

In sum, even though utilization of health services was seemingly high, respondents reported a great variety of experiences accessing health care services, many of which were negative. Females, and those with service needs related to substance use (particularly intravenous drug use), were most likely to report negative experiences. Finding a health care provider with whom one could strike a positive relationship was paramount to satisfaction with care, however this task amounted to a process of trial and error for many. Although the local alternative health service sites were regarded positively by many respondents and seemed to cater to service needs that might be difficult to reveal in a traditional health context because of the stigma associated with them, others were not inclined to access these services because they did not seem themselves within the target clientele. Thus, it would likely be of benefit to workers to have some awareness of which physicians in private practices and drop-in clinics are knowledgeable about health and the sex trade in order to diversify the availability of sex-trade-

friendly health service options – it was noted by one of the participants in the research dissemination meeting that such as strategy had proved useful in another city.

Chapter 8: Discussion and Conclusion

The purpose of this thesis was to investigate the health and access to health services of persons working in the sex trade from a sociological perspective, taking into account the social determinants of health found in the population health framework and empirical indicators of social status, health status and health care access. In doing so, it was also my intentions were twofold: 1) To move beyond a model of risk behaviour when measuring health and health care access among sex workers; 2) To punctuate the findings regarding health and health care access with the tacit knowledge of sex workers in order to highlight the health beliefs that form part of the connection between social location, behaviour and health outcomes. Having outlined some of the main findings, it is time to revisit the initial objectives and research questions presented at the outset of the thesis and to summarize the main findings.

8.1 Summary of Findings: Social Determinants of Health, Health Status and Access to Health Services

As a group, sex workers were poorly positioned according to significant social determinants of health, although there was considerable variation within the group. Incidence of dislocation and abuse in the family was far from uncommon and over half of the respondents had spent time in government care, a figure that clearly sets the respondents apart from the population as a whole. Although it is difficult to draw any conclusions, the incidence of abuse among the respondents population seemed high and presents cause for concern given the abundance of literature currently emphasizing the pivotal role of early childhood experiences on lifelong health outcomes. Rather than view childhood trauma as an antecedent to the sex trade, negative early childhood experiences can be seen as one of the conditions that influence early

identity development, educational achievement, emotional wellness, patterns of social interaction and personal coping mechanisms; the latter may in turn impact adult relationships and labour force opportunities, which are more likely to be directly related to entering the sex trade than abuse is. In other words, it is plausible that childhood experiences are only indirectly related to entering the sex trade via their influence on other social determinants of health, and abuse is by no means a prerequisite since some individuals reported having a positive early childhood experience prior to entering the sex trade. Thus, while the findings presented here regarding prevalence of childhood trauma support the findings reported in "social problem"-oriented sex trade literature, the interpretation of these findings is complicated by the application of a lifespan perspective on the social determinants of health. The findings on early childhood experiences would have been strengthened by additional data on caregiver health, particularly because health and social support to parents has been identified as a critical point of intervention in reducing the incidence of abuse and neglect among children (Trocme and Wolfe, 2001). Education among most respondents was low; however, a significant minority of respondents had graduated from high school and participated in post-secondary education, again demonstrating the variability of experiences found within the trade. Although some stereotypes suggest that sex workers make good incomes, and indeed, sex workers themselves, cite money as one of the main benefits of the sex trade, the findings here indicate that the average income in the sex trade is modest. Yet, given the level of education among the respondents, it is not likely that they would earn greater incomes in mainstream occupations, and in many cases, they would earn less and have less freedom to determine the conditions of their labour. Although many respondents reported access to social support in personal relationships, the stigma of sex work often complicated relationships with one or more of: family, romantic partners, and professional

supports. Finally, an overrepresentation of marginalized identities was found amongst the respondents – sexual minorities, females, persons with aboriginal heritage - suggesting that sex trade involvement is entangled with other forms of marginalization and stigma. Indeed, further exploration of the additive impact of the various stigmas that come to play among sub-groups of sex workers who represent multiple stigmatized identities may add to the small, but growing body of literature documenting the impact of stigma on health and access to health services. For example, how do the stigmas of being an illicit drug user, sex worker, aboriginal, or the stigma of having a blood borne infection interact and become more or less salient in particular social contexts. It is presumed that persons whose lives encompass several stigmas face greater hardship. Certainly, it was the case in this study that being an aboriginal, an illicit drug user (particularly intravenous), and being one gender or another affected health experiences.

In sum, as a group, the respondents were poorly positioned along the social determinants of health. Based on the incidence of childhood dislocation as evidenced by government care and modest levels of income and education alone, one can reasonably assume that the health of the those who enter the sex trade is in many cases compromised, irrespective of their involvement in the sex trade. The complications of working in the informal economy such as lack of safeguards for employee health and minimal to no access to the public authorities that oversee the welfare of others types of workers, may further undermine health. Yet, women and men continue to engage in this type of work because it affords a fair amount of latitude over the conditions of one's labour and can result in quick earning in times of need or when other employment is not available. Thus, the sex trade might be viewed as both a risk to one's health and also a benefit when the alternatives, such as not having income to provide for one's basic needs, are perceived as worse Because of the complicated manner in which social determinants

of health interact over time, discerning the impact of sex work vis-à-vis other health impacting conditions is difficult, primarily because it is impossible given the design and scope of this project to disentangle the impact of socio-economic marginalization from the sex trade. Nevertheless, it can reasonably be assumed that, above and beyond socio-economic marginalization, the organization of sex work undermines the health of workers' because of the ever-present threat of maltreatment and the psychological stress associated with managing a stigmatized identity. Indeed, how workers experience and cope with stress, both at home and at work, may be a promising area for further research that has the potential to further elucidate the connection between access to social resources, personal behaviour, and health outcomes.

As has been previously reported, safer sex practices in the workplace appeared to be high among the respondents, including those who reported one or more of illicit drug use and mental health concerns. The latter findings depart from some of the existing literature where workers who are vulnerable due to poor mental health and substance dependent are reported to more readily engage in unsafe sexual practices than their counterparts (Campbell, 1991), but fits with other literature where no association has been found between illicit drug use and unsafe sex (Gossop and Powis, 1995). Incidentally, those reporting unstable housing did not appear to be any more likely to practice unsafe sex than their counterparts with stable housing. In fact, when asked their motivation for overlooking safer sex practices, respondents' beliefs regarding health risk, client wishes, and the respondent's own desires were most often cited. These findings fit with the model established by Vanwesenbeeck (1994) in which sex workers feelings about the job, rather than relative level or vulnerability, are an important predictor of safer sex practices.

Health Status

Given the findings regarding the social determinants of health and the social context of the sex trade, it was not surprising to find that many respondents reported health concerns – most notably STI's, HCV (mostly among those with a history of intravenous drug use), and mental health problems, including depression, anxiety, sleeping problems, difficulties in romantic relationships and diminished self concept. Many of these health concerns were as prevalent among retired workers as they were among currently working individuals, and there were no clear patterns regarding the level of education or income on health, which was unexpected given the importance of these variables in the population health model. It is possible that there was not enough variation within the respondent population for differences based on income and education to strongly present themselves, which is further reason to considers the benefits of comparative research designs wherein sex work populations are compared with other populations. However, as has been reported elsewhere (Vanwesenbeeck, 1994) negative early family experiences and working outdoors seemed to be associated with poorer health, and the presence of blood-borne infections was clearly associated with a history of intravenous drug use (Campbell, 1991).

While any conclusions regarding the health status of sex workers relative to other populations may be inappropriate given the non-random convenience sample accessed, it does appear that their health status is in many ways compromised relative to other groups, particularly with regard to experiences of violence on the job, mental health, and presence of sexually transmitted infections. The fact the most respondents reported using condoms in their commercial sexual exchanges, yet many report a history of STI's (often repetitive infection) suggests that condom use in the commercial sex trade is not a strong predictor of risk of

acquiring an STI among sex workers. This finding seems paradoxical, but may be explained by the combination of unsafe sex practices in private relationships and the vulnerability of females to acquiring sexually transmitted diseases, despite safer sex practices.

It was also observed that persons working independently were exposed to less violence from managers and employers, earned more money, and were able to exercise more control over the conditions of their labour. Working in an indoor location mediated the risks associated with "bad dates". Females and persons working in outdoor locations experience greater workplace injury, particularly injuries associated with violence. Finally, in many cases, being retired from the sex trade was associated with greater incidence of health problems.

Access to Health Services

By all accounts, health service utilization appeared high among the respondent population, which is fitting given the incidence of health concerns reported, and encouraging, given the distinct possibility that health services might be avoided by this population due to fear of reproach from service providers. Even though the respondents reported using local health services, there were many concerns presented regarding the relational aspects of the service encounter. Thus, as has been noted by others, utilization of health services and help-seeking behaviour is a limited indicator of health care access (Stevenson, 1992). In the research dissemination meeting, two points of caution were noted by a physician and a nurse, respectively, with regard to the service utilization data: 1) Some of the seemingly positive relationships with health providers reported by the respondents may not have been based on provider having knowledge of sex trade involvement; 2) Respondents who reported using the alternative clinics such as the needle exchange, access these services regularly for routine needs, which could, in part, account for the seemingly high median number of visits reported by the

respondents. The later is significant is it speaks the efficiency of some service models over others for respondents who have regular, routine health care needs. As one of the physicians who attended the research dissemination and focus group meeting noted: "the key to this population is nursing - What ways should nursing care be upgraded and should it be an mobile service?" One of the implications of this observation is that physician care is neither preferable nor cost efficient when nurses may be better equipped to manage routine health needs and/or deliver health services on an outreach basis, thereby reducing the costs associated with hospital-based or clinic-based care.

Another observation arising from the research dissemination and follow-up focus group meeting was that respondents are, in many cases, not aware of their rights as clients of the health care system. It was suggested that greater awareness of client rights may well result in sex workers feeling more empowered to negotiate more satisfactory health services. For example, it was suggested that bringing an advocate or personal friend to the health service site can be a powerful method for ensuring that the client feels supported in the service context and the provider is respectful in the service context. In addition to greater education for the respondent population regarding client rights, it was also suggested that local providers would benefit from some education material regarding how to deliver sensitive services to populations presenting stigmatizing health concerns such as those related to sex work and illicit drug use.

Persons who were problem substance users reported greater difficulty having the service needs met in traditional service contexts and stories of discrimination stood out among this population. In addition, females were more likely to report poorer access to physician care, but this may be related to females having greater health needs and/or expectations of care relative to males. Persons with higher education were not more likely to report better experiences

accessing health care. In fact it appeared that access to satisfactory health services was more a function of finding a provider that one related to on a relational level than to the social standing of the sex workers. Again, there may not have been enough variation in the experiences of the respondents for education to stand out as an independent predictor of positive health care access, particularly since, as a group, the respondents' current or historical sex trade involvement was likely a powerful enough experience to subsume other conditions that might otherwise be expected to lead to differences in health care access.

8.2 Implications of the Findings for Policy and Programming

The research findings contain some general implications for health policy and programming. First, the range of health concerns reported by respondents in combination with their apparent willingness to both employ health protection strategies at work and to access health services when ill, suggest that the health risk behaviour model has limited explanatory power with regards to accounting for the health experiences of sex workers or setting the direction for improved services, especially since the health problems reported by workers, are in many cases rooted in social and economic conditions in combination with individual behaviour. Thus, the population health model has more potential for explaining the health of sex workers, offering a more ecological view of health that takes into consideration the social and legal context in which individual health behaviour is carried out and the array of conditions that shape health status at different points in the lifespan. One of the implications of this model is that health intervention can take place at several levels of society and individual experience: personal skills, health services, community action, public policy, and supportive environments

(See Figure 1, p 14). Considering each of these areas in turn, some options for promoting health among sex workers are presented based on the findings of this study.

There are several areas of personal skills that could be targeted for development among the sex trade populations. As noted earlier, increasing awareness of client rights may assist sex workers to exercise more "consumer control" in the health service environment. In addition, health prevention resources targeting sex workers should include information on an array of health concerns, including mental health concerns, health and wellness promotion strategies and information relevant to health and safety at work. In the case of the latter, some information for workers new to the business may be of use regarding topics such as: the organization of sex trade businesses including the array of contract, independent and employee arrangements (Stella, 2003), how to manage the legal framework that surrounds one's particular work environment, strategies for maintaining safety and personal autonomy in the workplace, and how to access professional and public services for maximum satisfaction. Such information is best designed and delivered by individuals who are either currently working or have a history of working in the sex trade in consultation with persons representing other relevant professions – lawyers, police officers, health professionals etc. Additional information regarding the health service options most relevant to the reported health needs of sex workers–mental health, birth control, STI's, -may also help improve sex workers' skills in accessing health services, particularly in the case of mental health services which have anecdotally been described as very difficult to access in the research site. With regard to mental health services, psycho educational, group delivery models are both a potentially effective and cost efficient method for delivering needed health related information.

As noted earlier, opportunities to develop service skills and exposure to educational resources are necessary to teach health providers how to deliver appropriate services to person presenting health needs related to sex work and/or illicit substance use. It cannot be assumed that health providers have training in these topics, and as several respondents noted, their access to health appropriate health care was impeded by the lack of knowledge they felt the service provider had regarding their specific health concerns. In addition, as Alexander (1998) suggested, an occupational health and safety clinic for sex workers that incorporates primary health services alongside specific occupation-related services may also be of benefit. Such as services could target particular groups of sex workers or integrate services to the community with services specific to sex workers, depending on whether specificity of service or anonymity of service is the greater priority.

With regard to public policy, the population health model and the findings presented earlier suggest that both population wide social policies and sex trade specific policies (specifically, criminal code legislation) are relevant to improving working conditions and general health among sex workers and marginalized individuals more generally. The findings here lend support to claims being made by health sociologists that education, child care, employment programming, housing, and income assistance/redistribution programs are central to improving the health of populations. Further, as has been reported elsewhere, the focus on hospital and physician services in the Canadian health care system may be both cost inefficient and inappropriate for proactively addressing health among populations such as sex workers, since it is best equipped to intervene in sickness and disease, rather than address the negative health outcomes brought about by social and economic marginalization. Further, decriminalization of sex trade activities combined with greater access to public supports and

safety services have the potential to support health and safety among the sex trade. Finally, research on the sex trade and sex work has the potential to contribute more accurate knowledge of the sex trade among the public when it is effectively disseminated, which is important given the pivotal role of public opinion in social welfare policy and political responses to the sex trade.

8.3 Directions for Future Research

By broadening the range of possible health determinants to include factors outside, prior to, and post sex trade involvement, this project has complicated assumptions regarding the impact of the sex trade on health. However, as noted earlier, this was also limited with respect to research design and topics covered. First, as has been noted on several occasions, it is very difficult, if not impossible, to assess the representativeness of research on hidden populations. While it is expected that the context of sex work is neither static nor uniform from place to place, even with respect to its time and place, there may be significant biases in the population sampled for this project and thus the findings cannot be regarded as generalizable. There may very well be sub-groups of local workers who are under represented in this research and other research on the sex trade. Additional exploratory studies targeting seemingly under represented subgroups of workers – home-based independents, fetish, specialists, males, to name a new - have the potential to generate new knowledge that can be integrated with existing information about the multi-faceted nature of the sex trade. Further, the replication or repetition of basic measures across multiple Canadian cities would likely provide insight on how health may be shaped by the specific socio-political culture of a location and the local availability of relevant health services. Research designs that incorporate comparison groups from outside the sex

trade are also promising as a direction for future research. For example, while it is assumed that sex work is a highly risky occupation, comparisons with other groups of workers has the potential to elucidate greater specificity regarding just how much or how little the risks associated with sex work are different from risks found in other occupations. For example, workers in occupations that pose the risk of physical injury (such as security work or trades) and occupations that require the worker to perform personal service on/for another (home care aid, esthetician, masseuse) could provide a suitable reference point for assessing the relative health risks of sex work vis-à-vis other types of work. Further research is also required on indicators of health and health care access, using measures that allow for comparison with other groups of workers or the population more generally. For example, one could build upon the research presented here by further investigating issues of personal health concept and health seeking behaviour; this line of investigation has the potential to close the gap in knowledge regarding why decisions and behaviours are executed in a given social context, resulting in particular health outcomes. In addition, by replacing health status self-report measures with health status screening scales, the degree and frequency of illness can be examined, and the basis for intra-group differences, more fully explored. For example, in this study it was found that just over half of the respondents experienced depression, but experiences of depression can be episodic, chronic, severe and mild. Similarly, a sizeable minority of respondents had been admitted to the hospital for injuries incurred in the sex trade, but the nature of these injuries was not known. It is assumed that more specificity in the measures on health status and health care access might lead to more variance in the data, which would in turn provide a greater platform for examining the correlates of intra-group difference. Finally, research regarding respondents' health care access should be triangulated with complementary data from health care providers. During the

research dissemination meeting, it was noted by a couple of local health service providers that their colleagues are not trained, in many cases, to deliver appropriate services to persons involved in the sex trade or those presenting stigmatizing health concerns; without adequate training health providers are unlikely to be able to ask the questions relevant to the provision of appropriate care. It was also noted by a provider in a street-based alternative health clinic, that many of the clients who come to the clinic are seeking social-emotional support in the service context and are unable to effectively access mental health support, while another noted that not all providers possess the desire or capacity to deliver services to stigmatized populations and expressed an interest in knowing more about the qualities held in common by providers who are successful serving marginalized populations. Beyond the providers themselves, the organization of health care services accessed and the effect of different service models on the patient-provider encounter, is also relevant to furthering knowledge on maximizing access to appropriate health services by stigmatized populations.

In order to address some of these gaps, a doctoral research proposal is currently being developed and submitted for funding regarding the impact of stigma on sex workers and their service providers. The proposed research will build on an existing research project[21] being carried out by my academic supervisor, and will include a combination of data from the umbrella project and data collected those who service sex workers in the research locations. The umbrella project within which my doctoral research will be conducted has several novel research design features. First, in addition to gathering data on sex workers' health and access to health services both on and off the job, two additional groups of workers – hairstylists and food and beverage servers – will also be studied in order to highlight the unique and shared occupational health and safety concerns among different types of lower income workers, all of

whom work in the service industry and earn part of their income through tips and the provision of customer service. The comparative design will provide a reference point for examining the conditions that make sex work a unique occupational experience and for assessing the impact of stigma on sex workers vis-à-vis other lower income service workers. The aforementioned research will be carried out in two locations: Victoria, Canada and San Francisco, USA. The incorporation of two research sites, presenting two models of health care, will also allow the researchers to examine the effects of universal and private health care models on sex workers' access to health services, while, at the same time, provide an opportunity for me to examine the experiences of health service providers who come into contact with sex trade populations in each research location.

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[1] Except where noted otherwise, this thesis concerns sex trade activities engaged in for the purpose of earning an income. The ideas presented here are less relevant to situations where sex trade activities are engaged in for payment in kind. Although the distinction between exploitative and consenting sex trade activity is murky at best, payment in kind is typically associated with exploitative forms of sex trade activity, most notably the phenomena known as "survival sex", which involves individuals engaging in sex activity for the provision of daily necessities such as food, shelter and substances, and/or to avoid punishment.

[2] See the Canadian Criminal Code Sections 210 through 213, 163, 174, and 167 through 173. Broadly speaking, the following are legislated as illegal activities: public solicitation or communication for the purpose of selling sexual services, operating a bawdy house, and living off the avails of prostitution. In practice, it has been noted by many sex trade researchers and criminologists, that the application of these laws varies from city to city across Canada (Lowman, 1999; Shaver, 1994)

[3]Bassel et. al., 1997; Kail, 1995; Morrison and Ruben, 1995

[4] In some lower income countries, particularly those on the African continent, the incidence of AIDS/HIV is high among a number of segments of the population, including those involved in sex trade activity. In countries such as Canadian estimates of the prevalence of HIV continue to be approximate given the lack of representative data on this population.

5 Benoit and Millar, 2001.

6. See Farley and Kelly (2002), http://www.prostitutionresearch.com/review.html,

[7] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946; signed on 22 July, 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April, 1948.

[9] This is important because less is known about male sex workers because the female subject is often taken for granted much of the sex trade literature (Allman and Myers, 1999).

[10] A local emergency shelter that primarily serves women who are street involved.

[11] The research meeting with local health and social service professionals was funded by the Sara Spencer Foundation.

[13] These figures do not include transitions in caregivers within the government care system, which are reported to be frequent.

[14] These figures represent the current work situations of respondents active in the sex industry and the last place of work for respondents who have left the sex industry.
[15] Before creating the scale, Questions 121a through 121g were recoded so that positive and negative responses were coded the same across all the measures.
[16] Two respondents indicated that their drug and alcohol use led to unsafe sexual practices.
[17] Studies of intravenous drug users suffer the same weaknesses with respect to research sampling as other hidden populations such as sex workers. Consequently, studies of intravenous drug users are typically non-random, and often focus on more visible populations, who, not unlike visible sex workers, may be more marginalized and suffer greater health problems than other members of their population.
[18] The two additional mental health measures included in the scale but not reported in Table 16 include: 1. history of "Emotional Trauma"; and 2.presence of "Mental Illness". Although a significant minority of respondents answered positively to the presence of these conditions, they were not reported alongside the other health measures because, in the first instance, emotional trauma is arguably a measure of risk to mental health and not in and of itself a measure of mental health, and in the second instance, it is difficult to discern whether or not the presence of a "mental illness" is a repeat measure of other mental health problems listed in the table or a measure of additional mental health problems not included amongst the other measures. However neither of these issues precludes the inclusion of these items in a mental health scale.
[19] Cronbach's Alpha (.7318)
[20] Methadone prescriptions are typically dispensed on a daily basis, except where the granting of "carrying privileges allow the consumer to possess four days worth of methadone. As a result of this dispensing pattern, methadone users have considerable contact with physicians and pharmacists.
[21] The main research has been funded by the Canadian Institutes of Health Research and is being carried out under the direction of Dr. Cecilia Benoit and colleagues. My proposed dissertation research will incorporate relevant data from the umbrella studies led by Dr. Cecilia Benoit and build on this data with independent research on health providers. The title of the Canadian project is Interactive Service Workers Occupational Health and Safety and Access to Health Services (2002-05). Principal Investigator: Cecilia Benoit, PhD. Co-Investigators: Mikael Jansson, PhD, Bonnie Leadbeater, PhD, and Bill McCarthy, PhD. The title of the US project is Work, Health and Health Care Access in the U.S. and Canada. Principal Investigators: Cecilia Benoit, PhD., and Bill McCarthy, Ph.D. Co-Investigators: Mikael Jansson, PhD, and Bonnie Leadbeater, PhD, Funded by the Canadian Institutes of Health Research. (2003-06).

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Dispelling Myths and Understanding Realities: Working Conditions, Health Status, and Exiting Experiences of Sex Workers

Appendix 4: Research Instrument

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October 2001

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Case #:_____
Date:_____
Start:_____
End:_____
Interviewer:_____
Data Entry Person:_____

SEX TRADE WORKER QUESTIONNAIRE AND INTERVIEW

Thank you for taking the time to participate in this study. Through this research I hope to better understand the working conditions and health concerns of sex trade workers in the Greater Victoria Area and develop ways to help them.

The information that you give me will be combined with that of other sex trade workers and put into a report. This report will be shared with sex trade workers themselves, outreach workers, and governmental agencies addressing the issue of prostitution.

I realize that some of the questions being asked are personal and may be hard for you to answer. If you need to talk to someone about this further, arrangements can be made for you to see a counsellor free of charge.

Q1.What is your gender?

1. Female
2. Male
3. Transgendered M2F
4. Transgendered F2M

Q2. In what year were you born? _____

Q3. In what country/region were you born?

1. Canada
2. USA
3. UK
4. Europe
5. Central/South America
6. Asia
7. Africa
8. Oceania

Q4. Were you born in Victoria?

1. Yes
2. No

Q5. In what province were you born?

1. British Columbia
2. Alberta
3. Saskatchewan
4. Manitoba
5. Ontario
6. Quebec
7. New Brunswick
8. Nova Scotia
9. Newfoundland
10. NWT
11. Yukon

Q6. If you were not born in Canada, what year did you arrive? Year ____ (missing value=88).

Q7a. Did you spend the first ten years of life living in a very large/large city (e.g., Toronto, Vancouver, Ottawa-Hull, Calgary)?
1. Yes
2. No

Q7b. Did you spend the first ten years of life living in a medium/small sized city
(e.g.,Victoria, Winnipeg, London, Halifax, Kamloops, Nanaimo)?
1. Yes
2. No

Q7c. Did you spend the first ten years of life living in a very small city/large town(e.g., Campbell River, Stratford, Sidney, Parksville, Terrace, Lethbridge)?
1. Yes
2. No

Q7d. Did you spend the first ten years of life living in a small/very small town
(e.g., Duncan, Battleford, Hope, Sooke, Bella Coola, Grand Bend, Trinity)?
1. Yes
2. No

Q7e. Did you spend the first ten years of life living in a rural/farming community?
1. Yes
2. No

Q8a. Did you spend the **next** ten years of your life (after age 10 to age 20) in a very large/large city (e.g., Toronto, Vancouver, Ottawa-Hull, Calgary)?
1. Yes
2. No

Q8b. Did you spend the next ten years of your life (after age 10 to age 20) in a medium/small sized city (e.g., Victoria, Winnipeg, London, Halifax, Kamloops, Nanaimo)?
1. Yes
2. No

Q8c. Did you spend the next ten years of your life (after age 10 to age 20) in a very small city/large town (e.g., Campbell River, Stratford, Sidney, Parksville, Terrace, Lethbridge)?
1. Yes
2. No

Q8d. Did you spend the next ten years of your life (after age 10 to age 20) in a small/very small town (e.g., Duncan, Battleford, Hope, Sooke, Bella Coola, Grand Bend, Trinity)?
1. Yes
2. No

Q8e. Did you spend the next ten years of your life (after age 10 to age 20) in a rural/farming community?
1. Yes
2. No

Q9. Did you move frequently from location to location before age 10?
1. Yes
2. No

Q10. Did you move frequently from location to location in the next ten years of your life (after age 10 to age 20)?
1. Yes
2. No

Q11. How long have you been living in Victoria? Years_____
(N/A=88).

Q12a. The employment equity act define visible minorities as persons, other than Aboriginal people who are "non Caucasian in race or non-white in colour." Are you a visible minority member according to this definition?
1. Yes
2. No

Q12b. If yes, which group do you place yourself in?

1. Chinese	5. Filipino	8. Japanese
2. South Asian	6. South East Asian	9. Korean
3. Black	7. Latin American	10. Other
4. Arab/West Asian		88. N/A

Q13a. If Native, do place yourself in any of the following groups?

1. First Nation
2. Aboriginal
3. Metis
4. Indian
5. Other

Q13b. If from one of these groups, which nation are you from?

1. Cherokee
2. Cree
3. Gwichin
4. Metis
5. Ojibway
6. Squamish
7. Shuswap
8. Other
9. Don't Know

Q13c. If from any of these Native groups, have you ever lived on a reserve?

1. Yes
2. No

Q13d. If yes to Q13c, are you currently living on a reserve?

1. Yes
2. No

Q14a. What is the first language you learned and still understand?

1. English
2. French
3. Native language
4. Japanese
5. Chinese
6. Spanish
7. Other

Q14b. Do you speak any other language?

1. Yes
2. No

Q14c. Which other language do you speak?

1. English
2. French
3. Native language
4. Japanese
5. Chinese
6. Spanish
7. Other

Q14d. Do you speak a third language?

1. Yes
2. No

Q15a. What is your sexual orientation?

1. Homosexual
2. Heterosexual
3. Bisexual
4. Two-spirited
5. Queer
6. Other

Q15b. If other, what is your sexual orientation? _____

Q16. Do you have a partner/lover?

1. Yes
2. No

Q17. If yes, how many months have you been with your partner/lover? (Zero indicates less than one month) _____ (N/A=88).

Q18. How would you rate the quality of your relationship with your partner/lover?

1. Very good
2. Up and down
3. Abusive (could be physically, emotionally, psychologically)

The following is a list of various types of family situations. Check those in which you lived for a month or more, and circle your age when you started and stopped living there.

Q19a 1.Both biological parents	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
2.mother only	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
3.father only	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
4.mother and step-father	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
5.mother and friend/partner	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
6.father and step-mother	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
7.father and friend/partner	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
8.stepmother only	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
9.stepfather only	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
10.W/sibling only	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
11.Foster-parents	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
12.Other relatives	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
13.Group home	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
14.Adoptive Parent	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
15.Child Welfare	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
16.Combined formal care	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
17.Partner and children	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
18.Alone w/children	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
19.By oneself	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
20.W/partner only	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60

19b (continued) Other arrangement (please explain and include age)

_____

_____

_____

_____

Answer the following for the male guardian(s) with whom you lived the longest while at home.

Q20. Did he (your father, step-father, mother's boyfriend, etc.) work outside the home?

1. Yes
2. No

Q21. (If yes) Did he work full-time or part-time?

1. Full-time
2. Part-time
3. Occasionally

Q22. (If yes) What was his usual occupation? _____

Q23. In months, what was the longest stretch of time that he did not work outside of the home?_____

Q24. Did he ever study for a degree or a diploma while you lived at home?

1. Yes
2. No

Thinking back in your childhood, tell me how often did YOUR FATHER (step-father, etc.) do the following?

FATHER	Never	Rarely	Sometimes	Usually	Always	N/A
Q25a. Cuddle you when you were hurt or feeling down	1	2	3	4	5	88
Q25b. Throw something at you	1	2	3	4	5	88
Q25c. Read to you	1	2	3	4	5	88

Q25d. Slap, kick, bite or hit you with a fist	1	2	3	4	5	88
Q25e. Take you to the park	1	2	3	4	5	88
Q25f. Hit you with object(s)	1	2	3	4	5	88
Q25fa. What was/were the object(s)?						
Q25g. Take you on outings	1	2	3	4	5	88
Q25h. Confine you to a room/other enclosure	1	2	3	4	5	88
Q25i. Speak kindly of you to others	1	2	3	4	5	88
Q25j. Belittle you	1	2	3	4	5	88
Q25k. Help you with your homework	1	2	3	4	5	88
Q25l. Ignore you	1	2	3	4	5	88
Q25m. Praise you for your achievements	1	2	3	4	5	88
Q25n. Torture you emotionally	1	2	3	4	5	88
Q25o. Other	1	2	3	4	5	88
Q25oa. If yes, please explain						

Answer the following for the female guardian(s) with whom you lived the longest while at home.

Q26. Did she (your mother, step-mother, father's girl-friend, etc.) work outside the home?

1. Yes
2. No

Q27. (If yes) Did she work full-time or part-time?

1. Full-time _____
2. Part-time _____
3. Occasionally _____

Q28. If yes, what was her usual occupation?

_____

Q29. In months, what was the longest stretch of time that she did NOT work outside of the home? _____

Q30. Did she ever study for a degree or a diploma while you lived at home?

1. Yes
2. No

Thinking back in your childhood, tell me how often did YOUR MOTHER (step-mother, etc.) do the following?

Mother	Never	Rarely	Sometimes	Usually	Always	N/A
Q31a. Cuddle you when you were hurt or feeling down	1	2	3	4	5	88
Q31b. Throw something at you	1	2	3	4	5	88
Q31c. Read to you	1	2	3	4	5	88
Q31d. Slap, kick, bite or hit you with a fist	1	2	3	4	5	88
Q31e. Take you to the park	1	2	3	4	5	88
Q31f. Hit you with object(s)	1	2	3	4	5	88
Q31fa. What was/were the object(s)?						
Q31g. Take you on outings	1	2	3	4	5	88
Q31h. Confine you to a room/other enclosure	1	2	3	4	5	88
Q31i. Speak kindly of you to others	1	2	3	4	5	88
Q31j. Belittle you	1	2	3	4	5	88
Q31k. Help you with your homework	1	2	3	4	5	88
Q31l. Ignore you	1	2	3	4	5	88
Q31m. Praise you for your achievements	1	2	3	4	5	88
Q31n. Torture you emotionally	1	2	3	4	5	88
Q31o. Other	1	2	3	4	5	88
Q31oa. If yes, please explain						

Q32a. When you were at home, did one of your guardians (mother, step-mother, father, step-father, etc.) or other family members ever have sex with you (including touching or attempting to touch you sexually)?

1. Yes
2. No

Q32b. If yes, please name who: _____

Q33. If yes to Q32a, how many times:
1. 0-5
2. 5-10
3. More than 10
4. Ongoing

Q34. How old were you when this first happened (as best you can remember)? _____

35. How old were you when this last happened (as best you can remember)? _____

Q36. Have you ever been in care? "In care" means in care of the Ministry of Children and Families (formerly the Ministry of Social Services) -- e.g., ward of the state, in group or foster home/institution.
1. Yes
2. No
3. Don't know

Q37. If you have been or are in care, what type of care were/are you in?
1. Permanent
2. Temporary
3. Don't know

Q38. (If yes) How would you rate the care you were in/are in?
1. Very satisfied
2. Somewhat satisfied
3. Undecided
4. Somewhat dissatisfied
5. Dissatisfied

What is your current living situation? Tick all that apply.

Q39a. Rent house or apartment	1. Yes	2. No
Q39b. At home (with guardian)	1. Yes	2. No
Q39c. Squat	1. Yes	2. No
Q39d. Motel	1. Yes	2. No
Q39e. Street	1. Yes	2. No
Q39f. Hostel	1. Yes	2. No

Q39g. Shelter/transition house	1. Yes	2. No
Q39h. Group home	1. Yes	2. No
Q39i. Bath house	1. Yes	2. No
Q39j. Foster home	1. Yes	2. No
Q39k. Hotel	1. Yes	2. No
Q39l. With trick	1. Yes	2. No
Q39m. Trick pad	1. Yes	2. No
Q39n. Other	1. Yes	2. No

Q39na. If other please specify: _____

Q40. How much do you pay per month for your living situation? $_____

Q41a. Do you pay for your rent in kind (Eg., taking care of one or more children, keeping house, gardening, sex, etc.)?
1. Yes
2. No

Q41b. If yes, how so? _____

Q42. Are you currently in school?
1. Yes
2. No

Q43. If you are a student, do you attend:
1. Full-time
2. Part-time
3. Occasionally

Q44. Are you currently receiving any other kind of training?
1. Yes
2. No

Q45. If yes, do you attend:
1. Full-time
2. Part-time
3. Occasionally

Q46. What was the last grade you completed? Grade _____

Q47. Do you have any other formal education/training other than high school?
1. Yes
2. No

Q48. If yes, what type of education/training do you have?
1. Post-secondary education
2. Alternative school
3. Workshops
4. Job Training
5. Apprenticeship
6. Other

Q49a. Are you currently in a job other than the sex trade in which you receive a salary or wage?
1. Yes
2. No

Q49b. If no, have you ever worked for pay outside the sex trade?
1. Yes
2. No

Q50a. If yes, please name the job(s)_____

Q50b. If yes, are you working full-time, part-time or occasionally?
1. Full-time _____
2. Part-time _____
3. Occasionally _____

Q51. How many jobs outside of the sex trade do you currently hold?
_____

Q52. How many hours a week do you work for pay on average (excluding the sex trade)? _____

Q53a. How much money are you earning in an average week from these non-sex trade jobs where you receive a salary or wage? $_____

If not presently working outside the sex trade, how long has it been since you had a square/mainstream job?
Q53ba. Months less than a year_____ Q53bb. Years in total _____

Q54. Are you currently working in the sex trade?
1. Yes
2. No

If not, how long has it been since you have worked in the sex trade?
Q55a. Months less than a year _____
Q55b. Years in total _____
Q56a. How would you describe the frequency of your sex trade work (presently or when you were formerly active):
1. Infrequent
2. Part-time
3. Full-time

In total, approximately how many months/years have you worked/been working in the sex trade?
Q56b. Months less than a year_____ Q56c.Years in total _____

57a. How old were you when you turned your first trick? _____

57b. What were the circumstances that first led you into the sex trade?
_____
_____.

Did you learn about the sex trade from any of the following?

Q58a.	Parent/guardian	1. Yes	2. No
	Q58aa. If yes, who? _____)		
Q58b.	Relative	1. Yes	2. No
	(Q58ba. If yes, who? _____)		
Q58c.	Friend	1. Yes	2. No
Q58d.	Classmate	1. Yes	2. No
Q58e.	Boyfriend/Girlfriend	1. Yes	2. No
Q58f.	Neighbour	1. Yes	2. No

Q58g.	Dealer	1. Yes	2. No
Q58h.	Stranger	1. Yes	2. No
Q58i.	Pimp/Madam/Manager	1. Yes	2. No
Q58j.	Newspaper want ads	1. Yes	2. No
Q58k.	Other	1. Yes	2. No

Q58ka. If other please specify _____

Q59. How far did you have to travel to go to your first sex trade job?
_____km

Check the type(s) of sex trade work in which you have been/are still engaged in for pay (in money or in kind --Eg., clothes, food, cigarettes, drugs, alcohol, etc.)?

Q60aa Phone Sex Indoor	1. Yes	2. No
Q60ab Phone Sex Independent/Private	1. Yes	2. No
Q60ac Phone Sex Other	1. Yes	2. No

Q60ac1 If other, Please explain_____

Q60ba Prostitution Indoor	1. Yes	2. No
Q60bb Prostitution Outdoor	1. Yes	2. No
Q60bc Prostitution Independent/Private	1. Yes	2. No
Q60bd Prostitution Incalls/Your place of work	1. Yes	2. No
Q60be Prostitution Outcalls/Their place	1. Yes	2. No
Q60bf Prostitution Other	1. Yes	2. No

Q60bf1 If other, Please explain_____

Q60ca Stripping Indoor	1. Yes	2. No
Q60cb Stripping Independent/Private	1. Yes	2. No
Q60cc Stripping Incalls/Your place of work	1. Yes	2. No
Q60cd Stripping Outcalls/Their place	1. Yes	2. No
Q60ce Stripping Other	1. Yes	2. No

Q60ce1 If other, Please explain_____

Q60da Massage Indoor	1. Yes	2. No
Q60db Massage Independent/Private	1. Yes	2. No
Q60dc Massage Incalls/Your place of work	1. Yes	2. No

Q60dd Massage Outcalls/Their place 1. Yes 2. No
Q60de Massage Other 1. Yes 2. No
Q60de1 If other, Please explain_____

Q60ea Modelling Indoor 1. Yes 2. No
Q60eb Modelling Outdoor 1. Yes 2. No
Q60ec Modelling Independent/Private 1. Yes 2. No
Q60ed Modelling Incalls/Your place of work 1. Yes 2. No
Q60ee Modelling Outcalls/Their place 1. Yes 2. No
Q60ef Modelling Other 1. Yes 2. No
Q60ef1 If other, Please explain_____

Q60fa Movies Indoor 1. Yes 2. No
Q60fb Movies Outdoor 1. Yes 2. No
Q60fc Movies Independent/Private 1. Yes 2. No
Q60fd Movies Incalls/Your place of work 1. Yes 2. No
Q60fe Movies Outcalls/Their place 1. Yes 2. No
Q60ff Movies Other 1. Yes 2. No
Q60ff1 If other, Please explain_____

Q60ga Other Indoor 1. Yes 2. No
Q60ga1 Please name the other activity_____
Q60gb Other Outdoor 1. Yes 2. No
Q60gb1 Please name the other activity_____
Q60gc Other Independent/Private 1. Yes 2. No
Q60gc1 Please name the other activity_____
Q60gd Other Incalls/Your place of work 1. Yes 2. No
Q6gd1 Please name the other activity_____
Q60ge Other Outcalls/Their place 1. Yes 2. No
Q60ge1 Please name the other activity_____
Q60gf Other Other 1. Yes 2. No
Q60gf1 If other, Please explain_____

Q61. Has your personal control over your sex trade activities increased, decreased or stayed about the same across your sex trade career?
1. Increased
2. Decreased
3. Stayed about the same.
4. Don't know.

I would like to know a little about your sex trade jobs. Please answer the following set of questions for any one of your sex trade jobs:

Q62a. Please the type of venue?
1. Agency
2. Street
3.Hotel/Motel
4. Bar/Strip club/Peep show
5. Home
6. Massage parlour

Q62ab. Please name the activity?
1. Prostitution
2. Massage
3. Escort
4. Stripping
5. Domination/Submission
6. Modelling
7. Movies
8. Phone sex
9. Stags

Q62b. How much control do you have over the money you earn in your sex trade activities?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q62c. How much control do you have over having sex with more than one John at one time?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q62d. How much control do you have over the number of clients per work shift?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q62e. How much control do you have over the place where you perform your sex trade activities?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q62f. How much control do you have over the sex activities you perform with clients?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

More specifically, do you have control over or have the right to decide whether you perform or use the following:

Q62g.	S-M	1. Yes	2. No
Q62h.	Kissing on the mouth	1. Yes	2. No
Q62i.	Cuddling/embracing	1. Yes	2. No
Q62j.	Sleeping with client	1. Yes	2. No
Q62k.	French/blow job/fellatio	1. Yes	2. No
Q62l.	Greek/Anal sex	1. Yes	2. No
Q62m.	Bi-calls	1. Yes	2. No
Q62n.	Going down on you	1. Yes	2. No
Q62o.	Submission	1. Yes	2. No
Q62p.	Use condoms	1. Yes	2. No
Q62q.	Other(s)	1. Yes	2. No

Q62qa. If other, please specify_____

Q62r. How much control do you have over with whom you work/your co-workers?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q62s. How much control do you have over the hours you work in the sex trade?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q62t. How much control do you have over taking time off or holidays from you sex activities?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q62u. How much control do you have in saying "no" to sex with a John?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q62v. How much control do you have in saying "no" to sex with co-worker(s)?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q62w. How much control do you have in saying "no" to sex with your pimp/madam/boss?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

I would like to know a little about a different sex trade job that you have/had:

Q63a. Please the type of venue?
1. Agency
2. Street
3.Hotel/Motel
4. Bar/Strip club/Peep show
5. Home
6. Massage parlour

Q63ab. Please name the activity?
1. Prostitution
2. Massage
3. Escort
4. Stripping
5. Domination/Submission
6. Modelling
7. Movies
8. Phone sex
9. Stags

Q63b. How much control do you have over the money you earn in your sex trade activities?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q63c. How much control do you have over having sex with more than one John at one time?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q63d. How much control do you have over the number of clients per work shift?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q63e. How much control do you have over the place where you perform your sex trade activities?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q63f. How much control do you have over the sex activities you perform with clients?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

More specifically, do you have control over or have the right to decide whether you perform or use the following:

Q63g.	S-M	1. Yes	2. No
Q63h.	Kissing on the mouth	1. Yes	2. No
Q63i.	Cuddling/embracing	1. Yes	2. No
Q63j.	Sleeping with client	1. Yes	2. No
Q63k.	French/blow job/fellatio	1. Yes	2. No

Q63l.	Greek/Anal sex	1. Yes	2. No
Q63m.	Bi-calls	1. Yes	2. No
Q63n.	Going down on you	1. Yes	2. No
Q63o.	Submission	1. Yes	2. No
Q63p.	Use condoms	1. Yes	2. No
Q63q.	Other(s)	1. Yes	2. No

Q63qa. If other, please specify_____

Q63r. How much control do you have over with whom you work/your co-workers?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q63s. How much control do you have over the hours you work in the sex trade?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q63t. How much control do you have over taking time off or holidays from you sex activities?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q63u. How much control do you have in saying "no" to sex with a John?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q63v. How much control do you have in saying "no" to sex with co-worker(s)?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q63w. How much control do you have in saying "no" to sex with your pimp/madam/boss?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Finally, I would like to know a little about another sex trade job that you have/had:

Q64a. Please the type of venue?
1. Agency
2. Street
3.Hotel/Motel
4. Bar/Strip club/Peep show
5. Home
6. Massage parlour

Q64ab. Please name the activity?
1. Prostitution
2. Massage
3. Escort
4. Stripping
5. Domination/Submission
6. Modelling
7. Movies
8. Phone sex
9. Stags

Q64b. How much control do you have over the money you earn in your sex trade activities?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q64c. How much control do you have over having sex with more than one John at one time?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q64d. How much control do you have over the number of clients per work shift?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q64e. How much control do you have over the place where you perform your sex trade activities?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q64f. How much control do you have over the sex activities you perform with clients?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

More specifically, do you have control over or have the right to decide whether you perform or use the following:

Q64g.	*S-M*	*1. Yes*	*2. No*
Q64h.	*Kissing on the mouth*	*1. Yes*	*2. No*
Q64i.	*Cuddling/embracing*	*1. Yes*	*2. No*
Q64j.	*Sleeping with client*	*1. Yes*	*2. No*

Q64k.	*French/blow job/fellatio*	*1. Yes*	*2. No*
Q64l.	*Greek/Anal sex*	*1. Yes*	*2. No*
Q64m.	*Bi-calls*	*1. Yes*	*2. No*
Q64n.	*Going down on you*	*1. Yes*	*2. No*
Q64o.	*Submission*	*1. Yes*	*2. No*
Q64p.	*Use condoms*	*1. Yes*	*2. No*
Q64q.	*Other(s)*	*1. Yes*	*2. No*

*Q64qa. If other, please specify*_____

Q64r. How much control do you have over <u>with whom</u> you work/your co-workers?

1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q64s. How much control do you have over <u>the hours you work</u> in the sex trade?

1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q64t. How much control do you have over taking <u>time off</u> or holidays from you sex activities?

1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q64u. How much control do you have in saying "no" to sex with a John?

1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q64v. How much control do you have in saying "no" to sex with co-worker(s)?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q64w. How much control do you have in saying "no" to sex with your pimp/madam/boss?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q65. How much control do you have in saying "no" to sex in your personal life (outside of the sex trade)?
1. Full control
2. A lot of control
3. Some control
4. Very little control
5. No control

Q66a. Overall, who controls your sex trade activities at present?
1. Yourself/independent
2. You and your partner in the sex trade
3. Your boyfriend/girlfriend
4. Your pimp
5. Your madame
6. Your dealer
7. Your guardian
8. Other

*Q66b. If other please specify*_____

*Q67. Suppose that you make 100 dollars in the sex trade. How much of this do <u>you</u> keep? $*_____

The money that you keep for yourself was spent on (can check more than one):

Q68a. Rent	*1. Yes*	*2. No*
Q68b. food	*1. Yes*	*2. No*
Q68c. clothes	*1. Yes*	*2. No*

Q68d. entertainment	*1. Yes*	*2. No*
Q68e. drugs	*1. Yes*	*2. No*
Q68f. children/family	*1. Yes*	*2. No*
Q68g. partner	*1. Yes*	*2. No*
Q68h. other	*1. Yes*	*2. No*

*Q68ha. If other, please specify*_____

*Q69. Approximately how much money did you earn in the last 12 months from your work in the sex trade? $*_____

*Q70. If also in a square job, approximately how much money did you earn in total in the last 12 months? $*_____

Q71. What is the best thing about your job in the sex trade?

_____

_____

Q72. What is the worst thing about your job in the sex trade?

_____

_____

Q73. Have you ever quit the sex trade?
1. Yes
2. No

Q74. If yes, approximately how many times have you quit the sex trade?
Number of times: _____

Q75. If yes, why did you quit the sex trade?

_____

Q76. If you have quit and later returned to the sex trade, why did you return to the sex trade?

_____

_____

Thinking back over your career in the sex trade, tell me how often, for the most part, did a PIMP/MADAM/MANAGER do the following?

PIMP/MADAM/MANAGER	*Never*	*Rarely*	*Sometimes*	*Usually*	*Always*
Q77a. Cuddle you when you were hurt or feeling down	*1*	*2*	*3*	*4*	*5*
Q77b. Throw something at you	*1*	*2*	*3*	*4*	*5*

Q77c. Slap, kick, bite or hit you with a fist	*1*	*2*	*3*	*4*	*5*
Q77d. Hit you with object(s)	*1*	*2*	*3*	*4*	*5*
Q77da. What was/were the object(s)?					
Q77e. Confine you to a room/other enclosure	*1*	*2*	*3*	*4*	*5*
Q77f. Belittle you	*1*	*2*	*3*	*4*	*5*
Q77g. Ignore you	*1*	*2*	*3*	*4*	*5*
Q77h. Torture you emotionally	*1*	*2*	*3*	*4*	*5*
Q77i. Other	*1*	*2*	*3*	*4*	*5*
Q77ia. Please explain					
Q77j. Beat you up	*1*	*2*	*3*	*4*	*5*
Q77k. Rape you/sexually abuse you	*1*	*2*	*3*	*4*	*5*

Thinking back over your career in the sex trade, tell me how often, for the most part, did a JOHN do the following?

JOHN	*Never*	*Rarely*	*Sometimes*	*Usually*	*Always*
Q78a. Cuddle you when you were hurt or feeling down	*1*	*2*	*3*	*4*	*5*
Q78b. Throw something at you	*1*	*2*	*3*	*4*	*5*
Q78c. Slap, kick, bite or hit you with a fist	*1*	*2*	*3*	*4*	*5*
Q78d. Hit you with object(s)	*1*	*2*	*3*	*4*	*5*
Q78da. What was/were the object(s)?					
Q78e. Confine you to a room/other enclosure	*1*	*2*	*3*	*4*	*5*
Q78f. Belittle you	*1*	*2*	*3*	*4*	*5*
Q78g. Ignore you	*1*	*2*	*3*	*4*	*5*
Q78h. Torture you emotionally	*1*	*2*	*3*	*4*	*5*
Q78i. Other	*1*	*2*	*3*	*4*	*5*
Q78ia. Please explain					
Q78j. Beat you up	*1*	*2*	*3*	*4*	*5*
Q78k. Rape you/sexually abuse you	*1*	*2*	*3*	*4*	*5*

Thinking back over your career in the sex trade, tell me how often, for the most part, did a POLICE OFFICER do the following?

POLICE OFFICER	*Never*	*Rarely*	*Sometimes*	*Usually*	*Always*
Q79a. Cuddle you when you were hurt or feeling down	*1*	*2*	*3*	*4*	*5*
Q79b. Throw something at you	*1*	*2*	*3*	*4*	*5*
Q79c. Slap, kick, bite or hit you with a fist	*1*	*2*	*3*	*4*	*5*
Q79d. Hit you with object(s)	*1*	*2*	*3*	*4*	*5*
Q79da. What was/were the object(s)?					

Q79e. Confine you to a room/other enclosure	*1*	*2*	*3*	*4*	*5*
Q79f. Belittle you	*1*	*2*	*3*	*4*	*5*
Q79g. Ignore you	*1*	*2*	*3*	*4*	*5*
Q79h. Torture you emotionally	*1*	*2*	*3*	*4*	*5*
Q79i. Other	*1*	*2*	*3*	*4*	*5*
Q79ia. Please explain					
Q79j. Beat you up	*1*	*2*	*3*	*4*	*5*
Q79k. Rape you/sexually abuse you	*1*	*2*	*3*	*4*	*5*

Over the last 6 months, how frequently have you used the following substances?

	Never	***Once a Month***	***twice a Month***	***once a week***	***twice a week***	***once a day***	***more than one a day***
	0	*1*	*2*	*3*	*4*	*5*	*6*
Q80a. Alcohol							
Q80b. Cocaine/crack							
Q80c. Heroin							
Q80d. Marijuana							
Q80e. Crystal meth/speed							
Q80f. Other							

Q80fa. If other, please specify:_____

Over the last 6 months, have you done the following activities using these substances?

Q81a <u>SNIFFING</u>

1. Cocaine/Crack
2. Heroin
3. Glue
4. Other
5. Have not sniffed in the last six months

Q81b Additional substances sniffed in the last six months:

_____

Q82a SHOOTING
1. Cocaine/Crack
2. Heroin
3. Other
4. Have not shot up in the last six months

Q82b Additional substances shot in the last six months:
_____

Q83a SMOKING
1. Cocaine/Crack
2. Heroin
3. Marijuana
4. Other
5. Have not smoked in the last six months

Q83b Additional substances smoked in the last six months:
_____

Q84a SKIN POPPING
1. Cocaine/Crack
2. Heroin
3. Other
4. Have not skin popped in the last six months

Q84b Additional substances skinned popped in the last six months:
_____

Q85a SW for swallowing
1. Alcohol
2. Cocaine/Crack
3. Heroin
4. Other
5. Have not swallowed these substances in the last six months

Q85b. Additional substances skinned popped in the last six months:
_____

(if substance use above) Please estimate the street value of your habit on a daily basis for the last six months.

Q86a Total cost per day for all substances used: $_____

Q87. (if substance use above) Is it important for you to reduce your substance use?
1. Yes
2. No

Q88. (if substance use above) Is it important for you to quit your substance use?
1. Yes
2. No

Q89. (if substance use above) Do you consider yourself to be addicted to substances?
1. Yes
2. No

Have you ever received treatment for the following?
If yes, was the treatment that you receive voluntary or court-ordered?

Q90a.Substances
1. Yes *2. No* *3. Don't Know*
*Q90aa. If **yes**:*
1. Voluntary *2. Court-ordered*

Q90b. Eating disorders
1. Yes *2. No* *3. Don't Know*
*Q90ba. If **yes**:*
1. Voluntary *2. Court-ordered*

Q90c. Sleep disorders
1. Yes *2. No* *3. Don't Know*
*Q90ca. If **yes**:*
1. Voluntary *2. Court-ordered*

Q90d. Mental health problems
1. Yes *2. No* *3. Don't Know*
*Q90da. If **yes**:*
1. Voluntary *2. Court-ordered*

Q90e. Physical injury

1. Yes *2. No* *3. Don't Know*

*Q90ea. If **yes**:*

1. Voluntary *2. Court-ordered*

Q91. Do you know where you can get free needles and/or exchange needles?

1. Yes

2. No

Q92. If you are a drug user and do not have access to the needle exchange, how do you get your needles?

_____

_____

Q93. Have you ever been hospitalized for injuries incurred in the sex trade?

1. Yes

2. No

Q94. If you have received hospital treatment, what type(s) of treatment did you receive?

_____

Q95. Have you ever visited a doctor's office for injuries incurred in the sex trade?

1. Yes

2. No

Q96. Have you ever visited a health care worker for injuries incurred in the sex trade?

1. Yes

2. No

Q97. Are you/have you been taking medication for health reasons?

1. Yes

2. No

Q98. If yes, what medication(s) are you/have you been using?

_____

Q99a. Do you have your own BC health care number?
1. Yes
2. No

*Q99b. If no, how do you pay for your health care?*_____

Q100. Is there a clinic you like to go to?
1. Yes
2. No

Q101. Is there a health care worker you like to see?
1. Yes
2. No

*Q102. In the past year, how many times have you consulted/seen a physician or health care worker #*_____

Do you havelor have had any of the following health conditions. If yes, please specify whether you have been tested, treated and at what kind of health facility:

	Condition present? 1.Yes 2.No	How many months ago diagnosed or tested (0=never)	How many months ago first treated (0=never treated)	Where treated? 1. Doctors Office 2. Nurses Clinic 3. Hospital 4. Other	N/A
Sleep disorders	Q103aa Yes No	Q103ab	Q103ac	Q103ad 1 2 3 4	88
Migraine headaches	Q103ba Yes No	Q103bb	Q103bc	Q103bd 1 2 3 4	88
Flashbacks	Q103ca Yes No	Q103cb	Q103cc	Q103cd 1 2 3 4	88
Eating disorders	Q103da Yes No	Q103db	Q103dc	Q103dd 1 2 3 4	88
Mental illness	Q103ea Yes No	Q103eb	Q103ec	Q103ed 1 2 3 4	88

Depression	Q103fa Yes No	Q103fb	Q103fc	Q103fd 1 2 3 4	88
Anxiety/panic attack	Q103ga Yes No	Q103gb	Q103gc	Q103gd 1 2 3 4	88
Attempted suicide	Q103ha Yes No	Q103hb	Q103hc	Q103hd 1 2 3 4	88
Chronic Fatigue Syndrome	Q103ia Yes No	Q103ib	Q103ic	Q103id 1 2 3 4	88
Emotional trauma	Q103ja Yes No	Q103jb	Q103jc	Q103jd 1 2 3 4	88
Physical abuse	Q103ka Yes No	Q103kb	Q103kc	Q103kd 1 2 3 4	88
Slashing/harming yourself	Q103la Yes No	Q103lb	Q103lc	Q103ld 1 2 3 4	88
Pelvic Inflammatory Disease (PID)	Q103ma Yes No	Q103mb	Q103mc	Q103md 1 2 3 4	88
STD*	Q103na Yes No	Q103nb	Q103nc	Q103nd 1 2 3 4	88
Q103ne. If yes, Which STDs? **(Does not include the list below)**					88
HIV positive	Q103oa Yes No	Q103ob	Q103oc	Q103od 1 2 3 4	88
Hep A	Q103pa Yes No	Q103pb	Q103pc	Q103pd 1 2 3 4	88
Hep B	Q103qa Yes No	Q103qb	Q103qc	Q103qd 1 2 3 4	88
Hep C	Q103ra Yes No	Q103rb	Q103rc	Q103rd 1 2 3 4	88
Herpes	Q103sa Yes No	Q103sb	Q103sc	Q103sd 1 2 3 4	88
Cervical cancer	Q103ta Yes No	Q103tb	Q103tc	Q103td 1 2 3 4	88

Other(s)	Q103ua Yes No	Q103ub	Q103uc	Q103ud 1 2 3 4	88
Q103ue. If Other Please specify:					88

How often do you use the following forms of birth control?

	Always	Most of the time	Half of the time	Some of the time	Never	N/A
Q104a. Birth control pill	1	2	3	4	5	88
Q104b. Morning after pill	1	2	3	4	5	88
Q104c. Condom/barrier	1	2	3	4	5	88
Q104d. Diaphragm	1	2	3	4	5	88
Q104e. Cervical cap	1	2	3	4	5	88
Q104f. Spermicidal jelly	1	2	3	4	5	88
Q104g. Rhythm method	1	2	3	4	5	88
Q104h. Spermicidal sponge	1	2	3	4	5	88
Q104i. Intra uterine (IUD)	1	2	3	4	5	88
Q104j. Other ? _____	1	2	3	4	5	88

While working in sex tradelin your last sex trade job, how often do you use gloves/finger cotts/female condoms/condoms/barriers with the following types of activities?

	Always	Most of the time	Half of the time	Some of the time	Never	N/A
Q105a. Hand Job	1	2	3	4	5	88
Q105b. Blow Job/oral sex	1	2	3	4	5	88
Q105c. Vaginal Sex	1	2	3	4	5	88
Q105d. Anal Sex	1	2	3	4	5	88

Q106a. Do you have access to free condoms/barriers?
1. Yes
2. No

*Q106b. If yes, from where?*_____

Q107a. Do you have access to free birth control?
1. Yes
2. No

Q107b. If yes, from where?_____
Q108. How often do you and your boyfriend/girlfriend use condoms/barriers when having sex?
1. Always
2. Most of the time
3. Half of the time
4. Some of the time
5. Never

Q109a. When you don't use condoms/barriers with your boyfriend/girlfriend, what are some of the reasons?

_____
_____
_____
_____
_____
_

Q109b. When you don't use condoms/barriers with your client, what are some of the reasons?

_____
_____
_____
_____

Q110. (If female) How many times have you had a pap smear test in the last three years? _____
1. More than once a year.
2. Once a year.
3. Once every few years.
4. Rarely.
5. Never.

Q111. (If female) How many times have you been pregnant? _____

Q112. (If female) How many abortions have you had? _____

Q113. (If female) How many miscarriages have you had? _____

Q114a. How many live children have you given birth to (fathered)? #___

Q114b. How old is your first child (oldest child)?____
Q114c. How old is your second child _____
Q114d. How old is your third child_____
Q114e. How old is your fourth child_____
Q114f. How old is your fifth child_____
115. If you have given birth to (or fathered children), where are they now?

	Q115a Child 1	***Q115b Child 2***	***Q115c Child 3***	***Q115d Child 4***	***Q115e Child 5***
Both biol. parents (1)					
Mother only (2)					
Mother & step-father (3)					
Step father only (4)					
Father & step-mother (5)					
Step mother only (6)					
Father only (7)					
Older sibling only (8)					
Mother & friend/partner (9)					
Father & friend/partner (10)					
Foster-parents (11)					
Other relatives (12)					
Group home (13)					
Adoptive parent(s) (14)					
Child welfare (15)					
Over-18/adult (16)					
Institutionalized (17)					
Detention centre/prison (18)					
Passed away (19)					
Don't Know (20)					

Other (21)					

*Q115aa If first child other, please explain*_____
*Q115ba If second child other, please explain*_____
*Q115ca If third child other, please explain*_____
*Q115da If fourth child other, please explain*_____
*Q115ea If fifth child other, please explain*_____

Q116. Are you presently taking care of dependent children without pay?
1. Yes
2. No

Q117. (If yes) How many children are under your care? _____

Q118. (If yes) Who takes care of the children when you are engaged in sex trade work?

_____

_____

Use the scale provided to show how much emotional support each of the following persons provide/provided to you while in the sex trade and with the knowledge of your sex trade activities.

		Amount of support provided					
	Know / knew	*None*	*Very Little*	*a Little*	*Some*	*a fair bit*	*a lot*
Mother/guardian	*1. Yes 2. No* Q119aa	*1*	*2*	*3* Q119ab	*4*	*5*	*6*
Father/guardian	*1. Yes 2. No* Q119ba	*1*	*2*	*3* Q119bb	*4*	*5*	*6*
Pimp(s)	*1. Yes 2. No* Q119ca	*1*	*2*	*3* Q119cb	*4*	*5*	*6*
Relative(s)	*1. Yes 2. No* Q119da	*1*	*2*	*3* Q119db	*4*	*5*	*6*

Outreach worker(s)	1. Yes 2. No Q119ea	1	2	3 Q119eb	4	5	6
Lover/partner	1. Yes 2. No Q119fa	1	2	3 Q119fb	4	5	6
Social workers(s)	1. Yes 2. No Q119ga	1	2	3 Q119gb	4	5	6
Health care worker(s)	1. Yes 2. No Q119ha	1	2	3 Q119hb	4	5	6
Other sex trade worker(s)	1. Yes 2. No Q119ia	1	2	3 Q119ib	4	5	6
Police officer(s)	1. Yes 2. No Q119ja	1	2	3 Q119jb	4	5	6
Friend(s)	1. Yes 2. No Q119ka	1	2	3 Q119kb	4	5	6
Therapist/counsellor(s)	1. Yes 2. No Q119la	1	2	3 Q119lb	4	5	6
Teacher(s)	1. Yes 2. No Q119ma	1	2	3 Q119mb	4	5	6
John(s)	1. Yes 2. No Q119na	1	2	3 Q119nb	4	5	6
Other ?	1. Yes 2. No Q119oa	1	2	3 Q119ob	4	5	6

*Q119oc. If other please describe:*_____

Who do you turn to first in a crisis situation? (Check the top 3: top=A, second=B Third=C)

1. Mother/guardian	*10. Outreach worker(s)*
2. Father/guardian	*11. Health care worker(s)*
3. Relative(s)	*12. Police officer(s)*
4. Lover/partner	*13. Therapist/counsellor(s)*
5. PEERS	*14. Pimp(s)*
6. Friend(s)	*15. Teacher(s)*
7. Child(ren)	*16. Other sex trade worker(s)*
8. John(s)	*17. Other?* _____
9. Social worker(s)	*18. Other ?* _____

*Q120a. First One (A)*_____
*Q120b. Second (B)*_____
Q120c. Third (C) _____

Please indicate the extent to which you agree or disagree with the following statements:

Q121a. If something went wrong, no one would help me.

1. Strongly Agree	*2. Agree*	*3. Disagree*	*4. Strongly Disagree*

Q121b. I have family and friends who help me feel safe, secure and happy.

1. Strongly Agree	*2. Agree*	*3. Disagree*	*4. Strongly Disagree*

Q121c. There is someone I trust whom I would turn to for advice if I were having problems.

1. Strongly Agree	*2. Agree*	*3. Disagree*	*4. Strongly Disagree*

Q121d. There is no one I feel comfortable talking about problems with.

1. Strongly Agree	*2. Agree*	*3. Disagree*	*4. Strongly Disagree*

Q121e. I lack a feeling of closeness with another person.

1. Strongly Agree	*2. Agree*	*3. Disagree*	*4. Strongly Disagree*

Q121f. People have difficulty feeling close to me.

1. Strongly Agree	*2. Agree*	*3. Disagree*	*4. Strongly Disagree*

Q121g. There are people I can count on in an emergency.

1. Strongly Agree	*2. Agree*	*3. Disagree*	*4. Strongly Disagree*

Q122. At the moment, would you say that you are happy?
1. *Always*
2. *Almost always*
3. *Usually*
4. *Some of the time*
5. *Hardly ever*
6. *Never*

Q123. At the moment, would you say that you are lonely?
1. *Always*
2. *Almost always*
3. *Usually*
4. *Some of the time*
5. *Hardly ever*
6. *Never*

Q124. At the moment, would you say that you are hopeful about the future?
1. *Always*
2. *Almost always*
3. *Usually*
4. *Some of the time*
5. *Hardly ever*
6. *Never*

If currently working in the sex trade and in an off-street venue, skip to the "open-ended" questions below.
Q125a. Has working in the sex trade affected your overall health?
1. *Yes*
2. *No*

Q125b. If yes, how so?

_____

_____

Q126a. If you could live your life over again, would you live it differently?
1. Yes
2. No

Q126b. If yes, what would change?

_____

_____

Q127. What would you say to someone entering the sex trade for the first time?

_____

_____

OPEN-ENDED QUESTIONS (ONLY FOR RESPONDENTS ACTIVE IN OFF-STREET VENUES)

In this open-ended section I would like to explore a little deeper into some of the topics that I have already asked you about. I am interested in learning about your thoughts on aspects of your life, sex trade work, health, and general well-being.

Q128. Do you think that it is important for sex trade workers to have control over their working conditions? Please discuss.

Q129. What conditions would have to change before sex trade workers have control over their work?

Q130. What do you consider to be the minimum work standards that all sex trade workers should be able to enjoy?

Q131. If you owned a sex trade business, how would you run it?

Q132. Do you think that people tend to view sex trade work in a negative light? If so, how do you handle this negative view of your occupation?

Q133. How long do you plan to remain in the sex trade?

Q134. If you were to leave the sex trade, what would be your options for making a living?

Q135. What would be your ideal job, and what's preventing you from doing it?

Q136. Would you need training for your ideal job and, if so, what kind (e.g., upgrading, workshops, apprenticeship, etc.)?

Q137. Does such training exist? Please discuss.

Q138. Has working in the sex trade affected your overall health?

Q139. What are your main health concerns?

Q140. How do you meet your basic needs when you are ill?

Q141. How would you describe your relationship with doctors that you have recently seen and in your life in general? (Treated me with respect, ignored me, etc.)

Q142. Have you used any alternative health providers? If so, please discuss.

Q143. What would the ideal health care worker be like from your viewpoint?

Q144. If you could change any health services available to sex trade workers, what would this "wish list" look like?

Q145. What do you do, if anything, when you feel that your personal safety is at risk?

Q146. What particular health and safety concerns to you think that sex trade workers have in general?

Q147. Can these concerns be addressed by special services?

Q148. What does your future look like?

Q149. If you could live your life over again, would you live if differently? If yes, what would change?

Q150. (If applicable) What kind of future do you see for your children?

Q151. Are any of your children/wards/family members in the sex trade? Please explain.

Q152. What would you say to someone entering the sex trade for the first time?

Q153. Do you have anything to add that we haven't talked about or any questions for me?

***CLOSING STATEMENT** (hand respondent brochure)*
I would like to thank you again for taking the time to participate in this consultation. If you feel that you need to talk to someone about this further, I can make a trained counsellor available free of charge. In sum, thank you very much. Your input is valued and integral for the well-being of our community. Best wishes and good luck with your future endeavours.

CONSENT FORM

Assessing the Health Impact of Sex Trade Work in the CRD

Case Number:_____ Date:_____

Thank you for agreeing to this meeting. My name is _____, and I am an ex-sex trade worker who has joined the research team as an interviewer. The project is sponsored by PEERS (Prostitutes' Empowerment, Education and Resource Society) and funded by the BC Health Research Foundation. The principal researcher is Dr. Cecilia Benoit from the Department of Sociology at the University of Victoria (Phone: 250-721-7578), and the project coordinator is Judy Lightwater (Phone: 250-388-5606).

We would like you to participate in this study on the working conditions and health concerns of sex trade workers in the Greater Victoria Area. The definition of sex trade work adopted is broad: it involves the exchange of sex related activities for economic reward (in kind and/or money). It takes place in a variety of venues: a) on-street locations, including bars; b) off-street locations, including massage parlours, escort agencies, phone sex agencies, strip clubs, movie agencies; c) out of your own place.

This tape-recorded interview will take between one-and-a half/two hours. There is a small payment of $40.00 that will be paid to you to thank you for your participation. All information will be confidential, viewed only by the research team outlined above. Your anonymity will be protected. Your name will be replaced with an alias for both the interview and transcription process. Any other identifying information will be removed from the questionnaire and transcribed data.

I realize that some of the questions may be difficult for you. If at some point during the interview wish to terminate it, your wishes and privacy will be respected, and the partially completed questionnaire and partly taped interview immediately destroyed. You are also free not to answer a particular question. All tapes will be destroyed after transcription.

This project has been approved by the University of Victoria Human Research Ethics Committee (see copy of the approval form). Should you wish to further verify the authenticity of the research project, please call Dr. Howard Brunt, Associate Vice-President Research, University of Victoria (250-721-7968).

PEERS is a Victoria-based agency that provides services to sex trade workers. Counselling is one of the services provided free of charge should you want it. Choosing to participate or not to participate will have no effect upon your access to any physician/health care worker or services that you are now receiving.

Yes, I am willing to participate in this study.

_____ _____

Signed *Date*

CONSENT FORM

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Appendix 2

You are invited to attend a presentation and focus-group discussion on the topic of:

Sex Work, Health Status and Access to Health Services

Drawing on interview data from a study of 201 sex workers located in the Capital Regional District, this presentation will include statistical findings on the health status and health care utilization patterns of sex workers, alongside qualitative findings on their satisfaction with services accessed, perceived barriers to appropriate access/care, and strategies for improving health care access.

Following the presentation of research findings, a focus group discussion will be held to gather insights from health and social service providers on the interpretation of these findings and areas for further research.

A health service information pamphlet for sex workers and stakeholders will be compiled following the meeting, and participants will be asked for input regarding the design and content of the pamphlet.

Date: April 1, 2003

Time: 2pm-4pm

Location: Downtown University of Victoria Campus, 910 Government St (lower level of building).

RSVP: As there is limited space available and material will be sent to participants in advance of the meeting, ***RSVP's must be received by March 19th.*** Please contact any one of the following persons to confirm your attendance or to request further information. A gift will be provided to participants in recognition of their time and contribution to the research.

Rachel Phillips (Presenter)
e-mail: rachelph@uvic.ca
Phone: 721-7578 (University of Victoria)

Megan Alley (Uvic Sociology Student)
e-mail: malley@uvic.ca

Jim Wilton (PEERS Community Partner)
e-mail: jbwilton@hotmail.com
Phone: 382-5118

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