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Perceived Health Concerns and Health Service Needs of Female Street Prostitutes in Calgary

by

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ABSTRACT

The purpose of this study was to explore perceived health concerns and health service needs of female street prostitutes in Calgary. Female street prostitutes were recruited through the Exit Van project using purposive sampling and the snowball technique. Qualitative methods, using open ended interviews, were used to explore and describe the concepts under investigation. This information was supplemented with extensive field observation on the streets of Calgary. The expressions of participants were qualitatively analyzed for trends and patterns in responses which emerged into a framework of three trade groups. The Established Trade, Unsystematic Trade and Entry Trade groups each presented with unique health concerns, health care utilization patterns, satisfaction of services, barriers to access and valued services. The findings of this study provide exploratory work around health issues faced by street prostitutes and their subsequent decision making processes when accessing human service providers and health services. Results should be shared with those who provide human services to this population. It is anticipated that consideration of the findings from this study would improve health service delivery and stimulate further investigation to advance the body of knowledge about the street prostitution culture.

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Chapter 1

The Problem

I. Introduction

Health service providers who are developing health services are challenged. Designing strategies to reduce the health risks and promote health requires a clear picture of the health needs and health service needs of consumers. An understanding of the needs expressed by health service consumers is crucial for the development of effective strategies to reduce the health risk factors of street prostitutes. A driving force for this present study was the observation that the published information and professional understanding about health needs of street prostitutes is limited in Canada. Many groups have commented on the paucity of historical and empirical information about prostitution in Canada. Existing research has focused primarily on risk factors, risk behavior and knowledge of sexually transmitted diseases (STDs) among persons prostituting. There are few studies which explore the health needs and health service needs expressed by prostitutes in Canada.

Calgary, like other Canadian midsized urban centers has a visible street prostitute population. This population has distinct health issues and concerns which they encounter through their work and personal lives. The literature focuses on the prevalence of STDs, risk behaviors and knowledge about risk reduction among this population, and neglects to address wider issues of health beyond STDs. There is no current research which explores the health issues faced by street prostitutes in Calgary and the service needs as expressed by this population. The exploration of these needs will enable health service providers to

plan new services or alter existing services in the city of Calgary. Consequently there is a need for a study to explore the health needs among street prostitutes.

II. Purpose

The purpose of this study is to determine the perceived health and health service needs among street prostitutes in Calgary, Alberta. The data will be useful in expanding or altering existing programs and developing strategies to meet the health needs of street prostitutes in Calgary.

A. Primary Research Goals

- To assess the perceived health concerns of the Exit Van female clients.
- To assess the perceived health service needs of the Exit Van female clients.
- To describe the current patterns of health service utilization of the Exit Van female clients.
- To identify barriers to health service access and utilization as perceived by the Exit Van female clients.

B. Secondary Research Goals

- To assess the level of satisfaction with health services utilized by the Exit Van female clients.
- To assess the Exit Van project as a service mode to the female street prostitution population.

Please see Appendix A for research questions relevant to each of the proposed research goals.

III. Background

In light of the less than adequate state of the literature and the purpose of this proposed study, the following literature review is guided by two components; a review of the literature which is relevant to this population, and the identification of health issues that are relevant to female street sex workers. It is important to describe the socio-cultural context in which these individuals live their lives and the characteristics of prostitution to determine the appropriate health care services and strategies for this population. The review of the socio-cultural context and the characteristics of prostitution will be followed by a description of street prostitution in Calgary. The next section will review previous needs assessment studies conducted in Alberta and follow with a brief description of the existing health services available to prostitutes in Calgary. As a result of the sparse number and dated nature of Canadian studies in the area of prostitution, North American and European studies are cited throughout this literature review. Some discrepancies were noted in their findings, and generalizations of these studies to the prostitute population in Calgary must be made with caution.

A. Socio-cultural Context

Street solicitation is the most visible evidence of prostitution in mid and larger sized Canadian cities (Law and Government Division, 1993; Fraser Committee, 1985). The Fraser Commission (1985) was a special committee established by the Minister of Justice which set out to understand the social issues of prostitution and pornography in Canada. The study collected information via briefs, submissions, and interviews from concerned intervenors. Additional sources of information for this committee were from

three major components: five regional studies conducted in Vancouver, the Prairie provinces, Ontario, Quebec and the Atlantic region; a national population survey of 2,018 Canadians in regard to issues of prostitution and pornography; and a review of prostitution and its control in selected countries outside of Canada. The Fraser Commission (1985) recommendations, which were derived from these three major components, addressed the economic and social reforms which may alleviate the causes of prostitution. This Committee conducted one of the first efforts to explore prostitution in Canada. The information collected concentrated primarily on street prostitution, and the responses obtained from the survey provided a partial and somewhat superficial understanding of the issues. The researchers who conducted this study stated that the results were not intended to be anything more than an overview of these practices, but that there was no reason to suspect that these findings were not representative of the prostitute population in Canada. This report only briefly addressed social and health service utilization and needs of street prostitutes which are the issues explored in this study.

Another major review was conducted in Canada by the Badgley Committee (1984), which was the result of the deliberations of a committee on Sexual Offences Against Children and Youth. The principal source of the Committee's information with respect to juvenile prostitution was a survey conducted among 229 prostitutes under 20 years of age (mean of 18) in eight Canadian cities. Its mandate was to inquire into the adequacy of the laws of Canada in providing protection to children from sexual offences and to make recommendations for improving that protection. Despite the fact that this

inquiry focused on the causes of adolescent and not adult prostitution, the Badgley Committee will be cited throughout this literature review where applicable.

Both the Fraser and Badgley reports are Canadian studies which have made a significant contribution to the understanding of some of the social issues surrounding prostitution, but lack information specific to the question in this study.

B. Types of Prostitution

Prostitution can be classified according to three broad categories. Street prostitution, escort prostitution, and those persons who work as part-time prostitutes with the service sector (i.e., in bars, or in message parlors) are identified by Jackson, Highcrest & Coates (1992) as the three different types of female prostitution. The number of females working in the different types of prostitution varies between urban centers.

1. Escort Prostitution

Escorts are sometimes referred to as inside workers, which is common for sex workers in many cities, and may work alone or with up to two other escorts (Jackson et al., 1992). Escort agencies generally employ between 2 to 15 escorts (Jackson et al., 1992). Escorts typically advertise in newspapers, and their work generally occurs indoors. Some escorts have expressed that the indoor environment is more conducive to the provision of vaginal and anal intercourse as compared to the services provided by street workers (E. McMurray, personal communication, July 26, 1994). Escort work is regarded by prostitutes as a type of work where the health risks and threat of safety are greater than other types of sex work (E. McMurray, personal communication, July 26, 1994).

2. Other/Part-time

Little investigation has been carried out with persons who provide occasional sexual services such as persons working as barmaids, strippers, and massage therapists who receive extra payment in return for sexual services above what is obtained from regular employment earnings. The provision of sexual services is often an implicit part of the job and is an essential part of the individual's income (Jackson et al., 1992). Jackson et al. (1992) further found that these part-time sex workers usually provide sexual services in dark corners of bars and in restrooms.

3. Street Prostitution

Because the population is easier to identify and reach, street prostitution has been the main focus of a large portion of research studies on prostitution. Sources in the literature have estimated that in North America and Europe street prostitutes comprise approximately twenty to thirty percent of the prostitute population (Campbell, 1991; Highcrest, 1992). Street sex work is mostly task oriented, and a sexual transaction is usually provided within 30 minutes (Fraser Committee, 1985; Campbell, 1991). A majority of sexual services provided to the clients by street prostitutes is carried out in motor vehicles (Campbell, 1991) or in a hotel room selected by a prostitute (Fraser Committee, 1985).

C. Population

Several sources have expressed the difficulty of estimating the number of prostitutes in a city (Fraser Committee, 1985; Shaver, 1993). The population involved in prostitution is difficult to identify because of the location and transient nature of their

work, which further complicates the estimation of the incidence of prostitution. Sex workers have been known to work in taverns, bars and lounges, escort services, massage and body-rub parlours, or seek work through private advertisements in the newspaper (Fraser Committee, 1985). Street prostitution remains an important element in the total picture of prostitution. Most estimates of the number of prostitutes on the streets come from the "educated guesses" by police, social agencies and other people who have observed the situation over time (Fraser Committee, 1985).

D. Working

Published data on the professional longevity of prostitute women are sparse, but it is felt to be a short term profession (Potterat, Woodhouse, Muth & Muth, 1990; Fraser Committee, 1985). In a Colorado study Potterat, et al. (1990) found that long term prostitutes work less than four or five years. Interestingly, McIntyre (1995) found that the 50 sex workers interviewed for a Calgary based study had worked between 3 months to 12 years, with a mean of 4-5 years. The longevity of sex work appears to vary between cities and countries. McIntyre (1995) conducted a comprehensive study which explored the legal, theoretical, psychosocial implications of sex work in Calgary. One component of this study comprised indepth interviews with 50 sex workers (41 female and 9 male) involved in street prostitution. This study does not explore the issues central to this research study but does provide valuable demographic and typologic information.

1. Procuring

The persons who procure and maintain people in the profession are often referred to as pimps. The majority of female street prostitutes in the prairie provinces are

managed and controlled by pimps (Lautt, 1984). It is difficult to determine the extent of the pimps' control, as it varies with each pimp-prostitute relationship. The Badgley Committee (1984) described the parasitic pimp-juvenile prostitute relationship as "ruthless psychological and economic exploitation" and "one of the most severe forms of abuse of youths, sexual or otherwise, that currently occurs in Canadian society " (p.19). It appears that pimps do not run large "stables" of prostitutes but usually control two to six women with a well-defined territory" (Fraser Committee, 1985, p. 379). In Calgary pimps manage an average of one or two sex workers at one time (McIntyre, personal communication, Sept. 17, 1994). McIntyre (1995) discovered that 38 of the 41 female sex workers interviewed were managed by a pimp, and 80 % of those women lived with their pimp.

E. Predisposing Factors to Prostitution

With regard to the social background of prostitutes, there appears to be no distinct pattern which would be a predisposing factor to the decision to become a prostitute (Fraser Committee, 1985). There is however support for the contention that prostitutes disproportionately come from disruptive homes where parental drinking, parental conflict, family/child interaction problems, mental illness, spousal abuse, child physical or sexual abuse were frequently present (McIntyre, 1995; Fraser Committee, 1985; Badgley Committee, 1984). In a Calgary based study, McIntyre (1995) found that 85% of the respondents described their family life prior to sex work to be disruptive.

1. Sexual Abuse

Numerous American and Canadian studies have tentatively found that prostitutes have experienced higher levels of child sexual abuse compared to the population in general (McIntyre, 1995; Bagley &Young, 1987; Lowman, 1991; Earls & David, 1990; Silbert & Pines, 1981). Congruent with these findings McIntyre (1995) discovered that 78% of the sex workers interviewed reported to have been sexually abused prior to their entry in to the sex trade. The Badgley Committee (1984) is the most comprehensive Canadian study which explored the history of child sexual abuse among prostitutes. The Badgley Committee concluded that despite the apparent high figures, prostitutes do not appear to have higher levels of child sexual abuse. A national population survey conducted for the Badgley Committee found that 53.5 % of women respondents had been victims of unwanted sexual acts. This tentative conclusion by the Badgley Committee was derived not because persons involved with prostitution are unlikely to have been abused, but because it appears to be a common phenomenon in our society (Badgley Committee, 1984). The lack of understanding about the possible relationship between early sexual experience and/or sexual, physical and emotional abuse and subsequent engagement in prostitution remains as a knowledge gap.

F. Characteristics of Prostitutes

1. Gender

The majority of prostitution continues to be practised by females. The Fraser Committee (1985) estimates the ratio of female to male prostitutes to be at least four to one in adult prostitution in Canada.

2. Age

Most street prostitutes are in the 18-24 age group (Fraser Committee, 1985). McIntyre (1995) found that 42% of interviewed street prostitutes in Calgary were under the age of 18. It is not surprising that numerous researchers have found that many adult prostitutes started working in their adolescence (McIntyre, 1995; Wolff & Geisser, 1994; Fraser Committee, 1985; Badgley Committee, 1984). McIntyre (1995) found that 76% of those interviewed had begun sex work prior to the age of 16 and 85% of the 50 respondents started prior to the age of 18.

3. Socioeconomic Status

Race and education have been used as indicators of socioeconomic status in North American and European literature. McIntyre (1995) reported that 38% of the respondents described their family as financially needy and 80% of the 50 street prostitutes were behind in or had not completed their education. The Fraser Committee (1985) expressed that the street prostitutes are more likely to come from lower socioeconomic backgrounds as compared to off-street prostitutes.

4. Race

Ethnic origin of street prostitution varies greatly among provinces, cities and individual strolls. The study findings from Shaver (1993) and other research indicates that a large portion (80 percent) of prostitutes are white. One anomaly was the 1984 Prairie study (Lautt, 1984) which found half of those interviewed to be of Native Canadian heritage. This sample in the Prairie study was drawn from Regina and Winnipeg, not from Calgary or Edmonton. This field study was repeated in Calgary five

years later and very few of the respondents were of Native background (Brannigan, Knafla & Levy, 1989). McIntyre (1995) found that 15-20% of the 50 Calgary street prostitutes reported to have native heritage.

G. Health Issues

Street sex workers face several health and safety risks. Health issues and concerns for this population include: sexually transmitted diseases (STDs) such as Human Immunodeficiency Virus (HIV), hepatitis B virus (HBV) and gonorrhea infection; substance abuse; depression; and violence (Cameron, Peacock & Trotter, 1993; McIntyre, 1995). The different predominating modes of STD transmission in different settings have resulted in variable STD prevalence findings between developing and developed countries. For the purpose of this study the literature review will refer to European and North American research.

1. Transmission of STDs

A Canadian study by Haug and Cini (1984) determined whether prostitutes made a significant contribution to the spread of STDs. Haug and Cini (1984) found that previous research exploring this issue were methodologically flawed and that prostitutes do not make as large a contribution to the spread of gonorrhea as do other females. They concluded that female prostitutes do not make a significant contribution to the spread of STDs even though female street workers have a higher incidence of gonorrhea than women to whom they were compared. In light of these results the reputation that prostitutes pose as a major source of STD (more predominantly HIV) transmission has been unsubstantiated by epidemiological researchers (Fraser Committee, 1985; Potterat et

al. , 1991). Haug and Cini (1984) noted that this finding is logical considering that prostitutes form only a small proportion of the sexually active population, a large proportion of sexual services consist of oral sex, and most prostitutes regularly use prophylactics. Despite unsubstantiated research findings linking the potential role prostitutes may play in the epidemiological spread of STDs to the general population, it continues to be a potential threat raised in recent literature (Fraser Committee, 1985; Thomson, 1989; Rolfs, Goldberg & Sharrar, 1990).

2. HIV Prevalence and Prostitution

Research on HIV seroprevalence among prostitutes in North America and Europe have shown it to be low or absent in the non-drug using prostitute population (Centers for Disease Control, 1987; Carr, Green, Goldberg, Cameron, Gruer, Frischer, Mackie & Follet, 1992).

In 1987 the Centers for Disease Control (CDC) conducted a multi-center study to determine the prevalence of HIV infection in female prostitution as well as the risk factors for infection in these women. Indepth personal interviews and serous testing were conducted with a total of 1396 female prostitutes from eight centers in the U.S. Some collaborators of this study recruited primarily incarcerated women, others recruited primarily through STD clinics, methadone maintenance clinics or through outreach efforts. The results found that of the 12.3% prostitutes who tested HIV positive, 4.8% were non intravenous (IV) drug users and 19.9% were IV drug using persons. The study results indicates that the HIV infection rate among IV drug using prostitutes is four times higher than among non IV drug using prostitutes. The major risk factor for HIV infection

in prostitution appears to be IV drug abuse. The convenience sampling utilized in this study does not warrant generalization of the results because the sample may not represent female prostitutes in the selected study sites.

Carr et al. (1992) recorded the HIV prevalence among a clinic population of street prostitutes using unlinked anonymous testing in Glasgow, Scotland. These researchers utilized 171 specimens which were taken for hepatitis B testing from street prostitutes, and tested these specimens for the HIV antibody. The overall prevalence of HIV among the samples was 3.6%, and these infected cases were all injecting drug users and known to be HIV infected. There may have been some selection bias in this study because a small number of women refused to be tested for HBV and IV drug users may have been over represented since the clinic supplied injecting equipment. Researchers have found it difficult to establish if prostitution is an additional independent risk for HIV infections since it is difficult to evaluate the independent risk of needle-sharing as opposed to sexual contacts with infected partners.

3. Gonorrhea

Recent North American and European research determining the prevalence and incidence of gonorrhea among female prostitutes are scarce. In 1981, Conrad, Kleris, Rush & Darrow determined the prevalence of STDs among 237 women who were arrested in a U.S. city for prostitution or other related sexual offenses. Conrad et al. (1981) reviewed the medical records of 446 persons (male and female) arrested during late 1978 and found that gonorrhea infection was detected in 17.4% of the 321 females examined at the health department. The prevalence estimate (17.4%) in this study

appears much higher that other North American and European studies which range from 5-11% (Vazquez, Palacio, Vazquez, Berron, Gonzalez & Llaneza, 1991).

Vazquez et al. (1991) studied 757 female prostitutes who voluntarily attended a STD clinic in Spain. The results indicated that vaginal and/or cervical exudates from 7.1% of the sample tested positive for gonorrhea infection, and 54.0% of these women were asymptomatic. It is not known how representative this sample was of the prostitutes in this city as the response rate was not stated by the authors.

From 1987 through 1991, a health department in Colorado Springs conducted a prevalence study of HIV and other STDs in female prostitutes (CDC, 1992). The sample consisted of 71 (1990) and 76 (1991) female prostitutes who voluntarily sought testing at a STD clinic. The estimated prevalence of gonorrhea among female prostitutes visiting this health department was 2.8% in 1990 and 4.7% in 1991.

The prevalence of gonorrhea in female prostitutes in these studies ranges from 2.8% to 17.4%. Convenience sample selection utilized in these studies may not truly represent the female prostitute population and does not warrant the generalizability of results to the street prostitution population in Calgary. It does however give us an idea of the prevalence rates among female prostitutes in developed countries.

4. Hepatitis B

There are three main mechanisms by which Hepatitis B Virus (HBV) infection is transmitted; parenteral blood exposure, perinatal infection and sexual intercourse (Bratos, Eiros, Orduna, Cuervo, Ortiz de Lejarazu, Almaraz, Martin-Rodriguez, Gutierrez-Rodriquez, Orduna Prieto & Rodriquez-Torres, 1993). HBV has been reported with

increasing frequency among women involved in the sex trade (Rosenblum, Darrow, Witte, Cohen, French, Gill, Potterat, Sikes, Reich & Hadler, 1992; Bratos et al., 1993). In 1992, Rosenblum et al. evaluated the prevalence of hepatits B virus in female prostitutes in eight areas in the United States. This study tested 1368 female prostitutes from STD clinics, drug treatment programs, detention centers, and/or outreach efforts for the hepatitis B virus. The overall prevalence of past or present HBV was 56%: 74% in IV drug using prostitutes, 38% in non-IV drug users, 51% in white, 55% in blacks, and 67% in hispanics. Rosenblum et al. (1992) found these proportion to be much higher compared with the estimated 6% among women 18 years of age and older in the general population found by McQuillan (1989). Bratos et al. (1993) conducted a prospective study with 368 Spanish female prostitutes and examined the influence of age and time as prostitute on HBV. The 368 prostitutes studied were clients who were seeking routine medical examinations at a public health center. The blood samples collected showed that 31.2% had hepatitis B infection at some time, compared to the 15.6% in the control group. Congruent with the prevalence rates found by Rosenblum et al. (1992), the prevalence rates of hepatitis B infection were much greater among the prostitutes studied compared with the control group. The generalizability of this study to Canadian street prostitutes is not warranted as Bratos et al. (1993) recruited women who were mostly involved with off-street prostitution. Prevalence rates of hepatitis B among Canadian female street prostitutes has not been researched. The literature clearly suggests however, that sex workers, especially IV drug using prostitutes, are a group at risk for infection of hepatitis B.

5. Other STDs and Prostitution

The Canadian Badgley Committee study (1984) found that half the male adolescent prostitutes and nearly two thirds of female adolescent prostitutes had, at one time or another, contracted a STD. This report did not specify whether these respondents were IV drug users, which would contribute greatly to the risk to health. The rate of STDs appears to be different in the case of adults, particularly women. Four out of the five nation wide field studies conducted as part of the Fraser Committee (1985) found that approximately 11% of adult female prostitutes had contracted an STD. Even though the Fraser Committee (1985) did not specify the type of STD, the results may give a glimpse of the STD problem among Canadian prostitutes. The prevalance (11%) is similar to the prevalence findings of gonorrhea among street prostitutes in North America and Europe.

H. Sexual Activity in Commercial Relationships

In 1992, Jackson et al. explored the potential risks of HIV infection among the different types of prostitution. They suggested that potential risks of HIV infection varies according to the type of prostitution. The potential risk practices faced by sex workers differs because of the organization of work and working conditions of varied types of prostitution. The most frequently requested sexual services in street prostitution are oral sex and sexual intercourse (Fraser Committee, 1985). In a more indepth look at sexual practices, Jackson et al. (1991) found that oral sex and masturbation were more commonly provided services by female street sex workers compared with vaginal or anal intercourse. Literature strongly indicates that sex workers' greatest potential risk for HIV

and other STDs is not through the provision of sexual services to clients, but rather through the private relations with lovers/partners. Several North American and British studies of prostitutes have found a high frequency (greater than 80%) of condom use while working (McIntyre, 1995; Fraser Committee, 1985; CDC, 1987; Mak & Plum, 1992; Day, Ward & Perrotta, 1993).

I. Sexual Activity in Non-Commercial Relationships

Unprotected sex is however a common practice of prostitutes with non-commercial sexual partnerships, such as with their pimps and boyfriends (Jackson et al., 1992; Lyons & Fahrner, 1990; McIntyre, 1995; Day, et al., 1993; CDC, 1987; Philpot, Harcourt & Edwards, 199; Mak & Plum, 1992; Jesson, Luck & Taylor, 1992). The multicenter study conducted by the CDC (1987) found that 16% of the interviewed prostitutes reported using condoms with non-paying partners as compared to 78% with paying partners. Intimate relationships with non-commercial partners apparently do not promote condom use. As a result, the low frequency of condom use in non-commercial sexual partnerships contributes to the health risks for the sex worker population.

Several authors noted that these women are often reticent about discussing personal relationships for fear of reprisals involving their lovers, partners, or pimps (Fraser Committee, 1985; Jackson et al., 1991). This fear poses a major obstacle in furthering knowledge about sexual practices of prostitutes in non-commercial relationships.

1. IV drug using prostitutes

Pandian (1988) suggested that street prostitutes are more likely to use injection drugs than the "inside" (i.e., escort) prostitutes, and therefore the risk of disease transmission through the sharing of dirty needles is increased. Several factors contribute to the increased risk for STD infection among sex workers involved in IV drug use or who engage in unprotected intercourse with IV drug users. Drug using prostitutes are at a high risk of HIV infection and other STDs because they have sex with multiple partners whose health status is unknown. Drug injecting prostitutes place themselves at additional risk if they are responsive to the demand for unsafe sexual services in order to obtain needed drugs. In a U.S. based study, Campbell (1991) found that IV drug using sex workers or sex workers who have IV drug using sex partners, were less likely to use condoms than those prostitutes who do not use IV drugs.

J. Mental Health

Not only are physical concerns important for this population, but health issues such as low self-esteem and poor self-image were a significant concern among female prostitutes (Cameron, Peacock & Trotter, 1993; Jaquet, 1992; Fraser Committee, 1985). The Fraser Committee (1985) described sex workers' status in society and their daily experiences. The themes which emerged from this study indicated that sex workers suffer enormous indignities and violence, which subsequently affect their self-esteem and self-worth. One interviewed prostitute stated; "The reinforcement that you're a whore, that you're nothing, that you're a low life does have an impact on how you feel about yourself" (Fraser Committee, 1985, p. 394). McIntyre (1995) also found mental health issues to be

a significant problem in her study, as 62% of the street prostitutes interviewed reported self harm such as slashing and drug overdose. In addition, 92% of the interviewees thought that prostitution is work that no one should do. Clearly, sex workers experience mental health issues that need to be addressed by health care services in the community.

K. Violence and Abuse

The Badgley Committee (1985) found that approximately two-thirds of the prostitutes interviewed had been physically assaulted while working as prostitutes, of whom 44% required medical attention. The Ottawa Youth Services Bureau (1990) conducted a survey of Ottawa street prostitutes and found that many of the women reported being subjected to life-threatening violence by pimps and customers on a regular basis. In the Calgary based study, McIntyre (1995) found that 82% of the street prostitutes interviewed reported having had a violent or abusive customer. Female prostitutes not only encounter violence while they work; researchers have found that prostitutes are reluctant to discuss their personal relationships because of the violence that is likely to result when pimps learn that they have been talking about the relationship (Fraser Committee, 1985). Research has found that the major source of abuse against prostitutes comes from pimps and customers (Youth Service Bureau, 1990; Fraser Committee, 1985). Sex workers are subjected to violence and abuse not only while working, but also in their personal lives.

IV. Needs Assessments

Numerous studies explore sex workers' knowledge related to AIDS and STD prevention and examine sexual behavior (Rolfs et al.,1990; Jackson et al., 1992; Modan

et al., 1992; Khabbaz et al., 1990), but few studies assess perception of health and health service needs in this population. Several studies in the U.S. have examined health needs of inner city and low income adolescents and minority women (Nyamathi & Flaskerud, 1992; Dobbie & Tucker, 1990; Pletch & Leslie, 1988). The following sections will review research exploring the perceived health and health service needs of female prostitutes. The findings are primarily from a British study by Jesson et al. (1992), and an Edmonton based needs assessment conducted by the Edmonton Planning Council (1994).

A. Street Sex Workers Perceived Health Needs

Jesson et al. (1994) conducted a qualitative study exploring sex workers' opinions on health matters that are directly related to their work and personal lives. In this British needs assessment study the women interviewed felt that they were at less risk of disease than women who did not work in the sex industry. The prostitutes felt that they were more informed and knowledgeable about STD prevention in comparison with people who don't work in the sex trade (Jesson et al. 1994). HIV infection, along with cancer, were the most important personal issues expressed by respondents. The women in the study expressed more concern about HIV infection risks for their children than for their personal risk. Respondents in this study appeared to undermine the health risks to which they were exposed in both their work live and personal lives.

B. Street Sex Workers Perceived Health Service Needs

Several studies have found that prostitutes have difficulty utilizing conventional medical services (Stephens, 1989; Edmonton Social Planning Council, 1994). Sex

workers have little trust in health care providers; consequently, public health departments and community based organizations often lack credibility with prostitutes. In addition to the lack of trust with public and community resources, the stigma involved with this profession and the fear of identification may, in various ways, influence the use of conventional health services (Stephens, 1989; Cameron et al., 1993). In support of this theme, the Fraser Committee (1985) reported that prostitutes appear to use very few social services in the community but further express that most prostitutes are knowledgeable about STDs and visit medical clinics regularly. Service issues which street prostitutes deem important are; confidentiality when seeking services (Cameron, et al., 1993; Matthews, 1989), quicker and hassle free services (Barton et al. , 1987), clinic hours similar to street hours, and no police involvement in health services (Matthews,1989). In response to the difficulties of using conventional service, successful outreach projects have been established specifically to meet the needs of street working prostitutes (Cameron et al., 1993; Jaquet, 1992; CDC, 1992). These programs adopted a client directed, or community development approach, whereby the client identifies her own needs and wants and makes decisions according to her own values (Cameron et al., 1993; Jaquet, 1992).

C. Edmonton Need Assessment

The Edmonton Social Planning Council (1994) conducted a needs assessment with 63 street prostitutes in the city of Edmonton to determine their needs. Sample selection was not addressed by the Council. The interviewees were asked questions regarding their personal history, legal issues, street life, health, safety and community

issues. The health-related issues explored included questions regarding use of conventional medical services, current health status (including HIV serous status), partners' health status, outreach educators, function of the clinic and utilization of community health services.

1. Personal and Partner Health Status

The Edmonton needs assessment found that three out of the 63 sex workers reported being HIV positive, six had cancer (specific type not given), one had tuberculosis and three had health problems related to drug use. In response to HIV sero-status, 12% of sex workers had not received HIV tests, and a few of these persons stated that they would be more willing to go for tests if they "didn't have to answer so many questions about their partners" (p. 10). Interesting to note was that the majority of the respondents were unaware, or did not disclose, if their partners had ever been tested. The unknown health status of partners is an alarming finding considering that numerous research findings report low or rare condom use in sex workers personal relationships (CDC, 1987; McIntyre, 1995; Fraser Committee, 1985; Mak & Plum, 1992). The literature does not address whether the lack of partner health knowledge among sex workers reflects that sex workers are unaware or undermine the health risks they face in their non-commercial relationships.

2. Outreach Educators

The Edmonton Social Planning Council (1994) found in its needs assessment of street prostitutes that ten (16 %) people commented on the negative attitudes of health workers toward street prostitutes which made it uncomfortable to receive treatment.

These ten persons suggested the need for more outreach nurses in the street clinic and outreach van program to deliver health education and service. The majority of respondents did not object to having STD clinic staff work as outreach staff in the city. The authors reported that sex workers could act as advocates for outreach education which would result in non-judgemental and caring human service provision.

3. Clinic Suggestions

The findings indicate that sex workers in Edmonton are receptive to STD education and that anonymity and privacy factors affect health care service utilization. The persons interviewed expressed the need for more education on "what diseases are currently going around" for street prostitutes, and for these services to be provided through street outreach programs. In addition, they expressed the wish for a less conspicuous location for sex workers to receive health care services in order to ensure their anonymity.

4. Utilization of Community Health Services

The majority of the respondents reported having a regular physician, and 84% had a complete physical examination in the previous year. The Edmonton Social Planning Council (1994) needs assessment study found that a majority of the 63 respondents used one or more of the inner city agencies in Edmonton. No information exists on the perceived health need and health service needs of Calgary's sex workers.

V. Prostitution in Calgary: a Demographic Profile

In an attempt to construct a profile of the existing street prostitution population in downtown Calgary, a number of data sources have been utilized. This description will be

supplemented with description and summary of existing health services which service prostitutes in down town Calgary.

A. Calgary

Calgary is a mid-sized urban center located in southern Alberta. Calgary, with a population of approximately 700,000 is one of Canada's fastest growing cities. It is the center of Canada's oil industry (there are about 400 oil companies in the city which produce 90 percent of Canada's oil) and the heart of an extensive ranching area. Calgary was founded in 1875 when the Royal Norhtwest Mounted Police established a fort at the junction of the Bow and Elbow rivers. The Canadian Pacific railroad reached Calgary in 1883; soon a bustling town had outgrown the fort to become the hub of cattle ranches and meat-packing plants. By 1891, the town had attracted 3,100 people. It was chartered as a city in 1893.

Prostitution in the prairies has been a prominent issue from the time of the Northwest Territories Administration of Justice Act in 1886, which developed shortly after the opening of the southern prairies to immigration and settlement with the building of the Canadian Pacific Railway in 1880-1883. Fort Calgary area became a red light district in Nose Hill Creek, just north of the city, which formed the beginning of the sex trade in Alberta (Gray, 1971).

1. Location of Strolls

Calgary police refer to the areas of street prostitution as the "A stroll", "B stroll", and the "C stroll". In the absence of a true red light district in the city, women work in several street areas, notably 2nd and 3rd Ave. S.W. (A stroll), and 7th and 8th Ave. S.W.

Calgary (B stroll), and Centre St. S.W. (C stroll). Urban dweller complaints of traffic congestion, noise, trespassing, and harassment have resulted in the temporary relocation of the B stroll to 10th Avenue S.E., to be effective on September 1, 1994 (Calgary Police Commission, 1994). This relocation was initiated and controlled by the police. Female street prostitutes have on occasion appeared in the vicinity of Chinatown, Inglewood and 11th Avenue and 1st Street S.W., but these areas have been monitored by police and the visible street sex workers have been advised of the "designated" strolls in the city (Calgary Police Commission, 1994). Outreach workers and police have noted that the juvenile (younger than 18) prostitutes work mostly in the 11th Avenue and 1st Street S.W. The other area of prostitution is located between 13th and 14th Avenue S.W. and is an area where male prostitutes work. This area is often referred to as the "gay stroll" or "boy's stroll" by police and social service workers in the city (Outreach worker, personal communication, Summer, 1994).

2. Stroll Counts

Several sources estimate there are approximately 40-50 prostitutes working on any given evening in Calgary (S. McIntyre, personal communication, 1994; Calgary Police Commission, 1981; Calgary Police Commission, 1984; Exit Van, 1994). Systematic counts of the major strolls in Calgary in the summers of 1987 and 1991 registered 40-45 females to 25-30 females respectively, on view (Brannigan, Gibbs van Brunschot & Williams, 1992). The Calgary Police Commission report on prostitution activity in Calgary stated that the average count of prostitutes per evening is 11 and 2 on "A stroll" and "B stroll", respectively (Calgary Police Commission, 1994). The average

counts provided by the Calgary Police Commission may be a gross underestimate of the street prostitutes as the number of street prostitutes served on a daily basis by the Exit Van far exceeds this estimate. The Exit Van staff see on average 10-35 women (all strolls) per evening; depending on the night of the week.

3. Description of Strolls

Outreach workers and the police in Calgary also refer to the "B stroll " as "low track", and the "A stroll" as the "high track". The term "low track" refers to the lower service rates charged by the prostitutes who work in this area as compared to the service rates charged on "high track" (Exit van outreach worker, personal communication, Aug., 1994). From personal observation of the strolls in Calgary the majority of sex workers on "low track" are from lower socioeconomic status, greater number of Aboriginal people, and have greater drug addiction problems compared to the sex workers on "high track". Sex workers on "low-track" appear to have greater health risk issues than the sex workers who work on "high track". The writer was unable to find literature comparing health risks of the different strolls in Calgary or other North American cities.

B. Urban Aboriginal Adults in Calgary

The highest concentration of Aboriginal people are in the following Calgary regions; Bridgeland, Riverside, Connaught, Mission, Victoria Park, Erlton Ramsay, Inglewood, Forest Lawn, Bankview and Bowness (Rockwell, 1990). In light of the high concentration of Aboriginal peoples in the downtown region, McIntyre (1995) found 15-20% of the 50 downtown street sex worker respondents had native heritage. It is therefore important to address the health needs expressed by the urban Aboriginal

population in the City of Calgary (Rockwell, 1990). Rockwell (1990) identified five main threats to health for urban Aboriginals', substance abuse, lack of self-respect, unemployment, racism, diabetes and poor infant health. Access to health care for this population was found to be a significant problem. Underutilization of existing services was found to be common; barriers included discrimination, negative past experience with the health care system and lack of awareness of services available.

C. Health Services in Calgary

The agencies in downtown Calgary which provide health services for women involved in prostitution are the STD clinic, Calgary Urban Project Society (CUPS), hospital emergency departments, Mustard Seed, Servants Anonymous and the Exit Van. The Calgary STD clinic is one of three in the province and provides a medical clinic, mobile unit for contact tracing, education, epidemiology and also conducts research. Patients include individuals with STD symptoms, contacts of persons with STDs, and some who simply want a STD checkup, HIV test or information about STDs. CUPS is a downtown agency which serves the inner city with a walk-in medical clinic, referral services, needle exchange and shower facilities. The services are utilized by disadvantaged groups in the inner city of Calgary. The Mustard Seed is a drop-in facility which provides a safe place for street people, emergency food supply and crisis intervention. Servants Anonymous offers female ex-street youth (primarily prostitutes) the opportunity to change their life style by providing them with shelter and training in life skills, education and job training/employment. The Mustard Seed and Servants Anonymous provide important services to sex workers, but they do not provide clinical

health services to this population. The next section will describe the function and role of the Exit Van program.

D. Exit Van

The Exit Van operates as a program component of Exit Community Outreach program which assists and supports young people (up to 24 years) who exist on Calgary streets. The Exit Van is a mobile health service for sex workers on the street. Services provided by program include referral information service, medical services (limited), and health counselling. In addition to these services, the program provides beverages and snacks dependent on community donations. The Van is staffed by an Exit outreach worker, and by a volunteer driver and a volunteer nurse. The Van operates 7 evenings a week and services the strolls in Calgary downtown area.

VI. Summary

The majority of studies on female sex workers have been conducted using quantitative survey methods and fall into three basic categories: the biographical, descriptive narrative, and epidemiological surveys (Jesson et al., 1994). The studies related to prostitution predominantly explore issues related to high-risk activity as working women, and have found that wider issues of health have been neglected at the expense of attention to STDs. There is a lack of current information on the health and health service needs of street prostitutes. The assessment of health and health service needs of street prostitutes in Calgary would provide health professionals with the knowledge to plan new services or restructure existing services in accordance with identified needs.

Chapter 2

Methods

I. Introduction

This chapter will outline the role of the researcher and the research methods used to carry out this study. The study design, data collection procedures, defining terms, access, trustworthiness, ethical issues and data analysis will follow.

A. Role of Researcher

The qualitative methods utilized in this study required an extensive involvement of the researcher with participants in their natural settings. The guiding premise, congruent with Lincoln & Guba (1985), was that inquiry is influenced by the values of the inquirer. It is important that the researcher's role, potential biases as well as any assumptions are fully described at the outset of the study. Exposing and explicating the researcher's role and values plays a significant part in inquiry, and by taking them into account will limit noncredible findings and interpretations (Lincoln & Guba, 1985). The researcher explicated her role and values through; 1) peer feedback through an informal session prior to data collection; 2) regular debriefing with supervisor during data collection; and 3) consistent journaling of field notes throughout the research process.

At the time of field work the researcher had been working in a volunteer capacity with the population under study for about 2 years through the Exit Van. The majority of study participants were recruited by the researcher during time spent on the Exit Van. The researcher acknowledges that involvement with the van may have affected the participants' responses to the evaluation questions relating to the Exit Van. The researcher

clarified prior to all interviews her role as a researcher and not as an Exit Van staff. The researcher also stated that she would honor anonymity and confidentiality toward concerns raised during the interview process which were beyond the context of the research inquiry. The researcher's knowledge of the context studied allowed her to probe, interview and analyze the information collected during the research process. For example, the researcher was able to discern the nonsuperficial responses and probe effectively for further elaboration because of her knowledge about the street prostitution culture. In addition participants displayed comfort with the researcher because of her previous affiliation with the Exit Van and the population it serves. For example, without the researcher's prompting two informants (street contacts) suggested to drive to a nearby restaurant for the interview.

Prior to the data collection period the researcher had anticipated a certain degree of tentativeness from the participants towards the research questions. She found, however, that persons interviewed readily disclosed intimate details around personal health concerns and utilization of the health care system. As the investigator anticipated, numerous women offered their perceptions and beliefs on issues which were not directly related to the study purpose. The researcher felt that these additional data were valuable to this study and included them in the analysis.

The investigator is aware that her values and experiences as a critical care nurse with part time volunteer involvement with this population influenced the evolving decisions made during the research process, and influenced the analysis and interpretations of the collected information. Her experience as a critical care nurse has

primarily been with individuals who have utilized the health care system out of necessity. Contrary to the acute health care system, the population under study determines which health services to access and utilize. Further, the researcher anticipated that expertise and attributes of health care professionals would be expressed as influencing factors for health service satisfaction and consequent utilization of these services. On the contrary, most of the participants identified positive interaction and acceptance by health care professionals as influencing factors to satisfaction and motivation for future access. For example, the informants often chose to access health services or professionals because they were "nice" and "accepting" of their "lifestyle and culture" (researcher's fieldnotes).

Given the extensive reading and experience of the researcher in the area of study, the researcher acknowledges her preconceived understanding of the population studied. However, she feels that her knowledge allowed her to attain a level beyond objectivity which was also achieved through continuous interaction with the study population (Lincoln & Guba, 1985).

II. Study Design

The study was designed as an exploratory study. Lincoln & Guba (1985) note that qualitative methods may be used appropriately in any research paradigm. Because the proposed study was exploratory in nature, qualitative methods were utilized to explore and describe the concepts under investigation. Certain qualitative methods were selected because they were more adaptable to multiple realities, and because they were more sensitive to and adaptable to the many mutually shaping influences and value patterns that might have been encountered (Lincoln & Guba, 1985). Standardized face-

to-face interviews using open-ended questions were used to assess health concerns and health service needs of street prostitutes. The purpose of open-ended interviewing is to access the perspectives of the person being interviewed (Patton, 1990), and in this study the researcher wanted to discover what the perceived health concerns and health service needs were of the female street prostitute population in downtown Calgary. The research methods chosen for this study allowed for the design to be responsive to situations rather than to be totally constructed preordinately.

One advantage of face-to-face interviews is that this type of survey typically attains high response rates because relatively few people refuse to be interviewed in person (Polit & Hungler, 1991; Babbie, 1989). Another advantage is that within the context of the interview, the presence of an interviewer generally decreases the number of "don't knows" and "no answers", because the interviewer can use probes to minimize such responses (Babbie, 1989; Gilmore et al. , 1989). Using a face-to-face interview survey method allowed the interviewer to provide a guard against confusing questions. The interviewer clarified matters if the respondent clearly misunderstood the intent of a question (Babbie, 1989). Finally, face-to-face interviews were beneficial because the interviewer could observe as well as ask questions. For example, the interviewer noted the respondent's race, the respondent's education level or the respondent's general reactions to the study (Babbie, 1989).

One disadvantage of face-to-face interviews is that they are time consuming and rather costly. Another disadvantage noted by Polit & Hungler (1991) is that interviews rarely probe deeply into such complexities as contradictions of human behavior and

feelings. However the qualitative methods used allowed the investigator to probe and explore responses given by the informants. For example, the investigator would restate information that the informant had provided and repeat questions to encourage the informant to provide more detail around an expressed response. Interviews are usually done once and do not permit the researcher to have much confidence in inferring cause-and-effect relationships. This did not pose a problem since the study purpose was to explore perceptions and not infer cause and effect relationships.

III. Defining terms

The following section will define the terms health, health services, need and prostitute as they were used in this study.

A. Health

The definition of health held in a population or community will depend on its health status and culture. Given the relative and inferential nature of perceived health status, this study does not define health in terms of poor, good or excellent but in relation to an implicit norm of this prostitute population.

B. Health Services

Health services refers to those "services that are performed by health care professionals, or by others under their direction, for the purpose of promoting, maintaining, or restoring health" (Last, 1988, p.58).

C. Prostitute/ Sex Worker

Prostitutes/Sex workers are defined for this study as women who exchange sex for money or other items. The terms prostitute and sex worker are used interchangeably

throughout this report.

D. Need

Need was defined as anything essential for a satisfactory mode of existence or level of performance as perceived by the participants (Scriven, 1991, p. 242). The withdrawal of, or failure to provide these things, results in serious failure, by any reasonable standards of functioning (Scriven, 1991).

However as the data collection began participants themselves did not refer to the word "need". The participants framed their responses to questions concerning health service needs in reference to "wants" or "convenience". A number of the participants appeared to be perplexed or unsure how to respond to the questions regarding health service needs. The researcher sensed that this may be related to the marginal status of this population, education level of participants and the infrequent vocalization of their perceptions. Again, the researcher was confronted with complexity around the definition of need and the participants' perceptions and understanding of the term. Further discussion of this term as it was interpreted by the participants throughout the research process will continue in the analysis and discussion section.

IV. Access and Entry

The researcher initially approached both the program director and the director of community services of Wood's Homes, both in charge of Exit Community Outreach Program. Following discussion of the research project, the researcher provided the board of directors with a one page summary of the project. Once the ethics review committee at Wood's Homes and the University of Calgary approved the study the researcher met

with the outreach team at Exit. The researcher felt it crucial for the outreach staff to be included throughout the research project, as recruitment strategies required their involvement, expertise and knowledge of the street prostitute population. Following this meeting the researcher distributed a pamphlet to the Exit Van clients to inform and invite them to participate in the study (Appendix B). In addition, prior to any subject recruitment, the researcher spent two weeks on the Van introducing the study, familiarizing herself with the outreach team and the clients and to allow this as an entry method to the culture as a researcher, rather than as a volunteer nurse.

V. Sampling strategy

Purposive sampling was utilized to increase the scope and range of data exposed by the researcher (Lincoln & Guba, 1985). Purposive sampling assists transferability because it could be pursued in ways that take adequate account of local conditions, local mutual shapings, and local values (Lincoln & Guba, 1985). For example, the women selected for interview varied in age which is characteristic of the female street population in Calgary (McIntyre, 1995). Intent of the purposive sampling used in this study was not to acquire a representative sample which allows the investigator to generalize, but the intent was to maximize the extent of information obtained (Lincoln & Guba, 1985). The selection of each participant in this study depended on the characteristics of preceding participants to ensure the maximum scope. The researcher stopped selecting participants when the information being collected from the participants became redundant.

A. Participant Selection

Female clients of the Exit Van project were invited to participate in the

study by either the investigator or the Exit Van staff. Only female clients were invited to be participants to this study. Male prostitutes were excluded from this study because of feasibility issues and safety and security reasons.

The researcher recruited 15 female street prostitutes through the Exit Van project. The participants varied in age from 16 to 34 years old. Five of the women interviewed worked on 3rd and 2nd Avenue S.W. (A stroll), five women worked on 8th Avenue S.W. (B stroll) and five women worked on Centre street S.W. (C stroll). It was intended to select participants primarily through the Exit Van but the researcher was able to recruit two teenagers through the Exit storefront, three women through "snowballing" technique and two women through street contact. Each of these women were using or had used the Exit Van while working on the streets. The strengths of the various recruitment methods allowed the researcher to interview women who may not have accessed the Exit Van during the time of the study. These other recruitment strategies proved to be positive to some of the women; they may not have agreed to participate otherwise. For example, women would suggest participation to their friends or they would bring a friend along for the interview.

The outreach staff at Exit played a significant role in the promotion of the study both in the Van and through their storefront location. Several of the teenagers were selected for the study by the researcher and the Exit staff through the storefront and consequently the interviews took place at this location. This location was a familiar and a comfortable environment for the informants and therefore conducive to a fruitful interview.

VI. Data Collection

A. Interview Location

After written consent was obtained (see Appendix C), the interviewees were given a choice of interview site. Gilmore et al. (1989) noted that conducting the interviews in a place that has some association with the needs assessment is more convenient and may also help the individuals focus on the subject of interest. The alternatives for interview locations were: outside on the street, at a nearby public location, in the researcher's vehicle or at the Exit Community Outreach storefront location. Two interviews took place on the street, four interviews occurred at the Exit storefront location, and the remainder of the interviews took place in public locations such as restaurants and coffee shops. All interviews were audio-taped with permission from the informants. The interviewer permitted more time for the completion of the interview if the participant allowed. The interview time varied from 30 minutes to 90 minutes depending on the environment and comfort of the participant with the researcher and the study questions. The interviews conducted on the street during cold temperatures were noticeably shorter than the interviews conducted in the environment of a coffee shop. Length of interview on the street was not only influenced by the weather, but also by the possibility that a potential customer for the informant could drive by at any time. On one occasion an informant ended the interview before completion for this reason, however the researcher was satisfied with the information collected.

B. Instrument

Existing needs assessment tools for this population are minimal, and existing tools focus on health status and health behaviors. This interview assessed the health concerns and health service needs as perceived by the female street prostitute population. Open-ended interview questions were augmented and modified from the following sources: Calgary Health Services (1990), Edmonton Social Planning Council (ESPC) (1993), Piette et al. (1993), Pletch & Leslie (1988), and the literature review for this study. See Appendix D for interview guide. The interview questions were phrased at a grade 7 (or less) reading level assessed by the Gunning Fog Index (Gunning, 1952). This reading level was chosen because an Edmonton study found that only 54% of 47 female prostitutes interviewed had completed grade 10 education (ESPC, 1993). Congruent with this finding, McIntyre (1995) found that 80% of the 50 street prostitutes in Calgary interviewed had not completed their high school education. In this study, the interviewer was also considered a data-gathering instrument because "it would be virtually impossible to devise *a priori* a nonhuman instrument with sufficient adaptability to encompass and adjust to the variety of realities that will be encountered" (Lincoln & Guba, 1985, p. 39). Human-as-instrument is inclined towards methods which observe, take account of nonverbal cues, and interpret inadvertent unobtrusive measures (Lincoln & Guba, 1985).

Other reasons why a standardized open-ended interview was used in this study are: 1) the exact instrument used is available for inspection by decision makers and information users; 2) the interview is highly focused so that the interviewee time is carefully used; and 3) respondents answer the same questions, thus increasing the

comparability of responses (Patton, 1990, p. 285). Collecting the same information from the respondents for the evaluation of the Exit Van project with a standardized interview promotes legitimacy and credibility.

The order of the interview topics and the phrasing of the questions and probes remained flexible because: 1) the emergent nature of this qualitative study design must allow for flexibility and unfolding of the interview process; 2) what emerges as a function of the interaction between the investigator and participants was unpredictable in advance; and 3) various value systems are involved for both the inquirer and the participant which interact in unpredictable ways to influence the outcome (Lincoln & Guba, 1985).

The interviewer documented in her field notes any ad hoc decisions or changes during an interview. The interview site, participants responses and interviewer intuition guided decisions made during the interviews. The interviewer used probes during the interview which involved the use of neutral prompts to persuade the interviewee to answer questions fully and completely. Throughout each interview the interviewer summarized main concepts that had been presented by the informant. This strategy allowed the interviewer to confirm understanding of the information provided by the informant and allowed the informant to consider other information that might be relevant. The researcher used elements of the constant comparative method (Glaser & Strauss, 1963) by adapting, adding and deleting questions during the data collection process as a result of previous interviews.

The demographic items were selected based on two needs assessment with HIV persons (Calgary Health Services, 1990; Piette et al. , 1993). Demographic variables

such as age, race/ethnicity, living arrangement and education were asked at the end of the interview. Age and education variables have repeatedly shown to be related to a person's behavior and attitudes. The second reason for collecting this information was to enable the researcher to describe the characteristics of the female street prostitute sample interviewed in this study.

C. Validity/ Reliability of Interview Tool

The first phase of this study was to establish the validity and reliability of the interview questions. Professionals with expertise in the area of street prostitution and needs assessments were asked to review the questions. These experts judged the content validity of the interview questions. The researcher modified the instrument significantly by collapsing questions, altering terminology and changing the sequencing of the questions. The interview questions were pilot tested for clarity and completion time with a group of three women similar to the study participants. These steps allowed the interviewer to probe meaning, task difficulty, respondent interest and attention to specific questions (Converse & Presser, 1986). Modifications were made to the interview tool based on input from the three women and the expert panel. The second phase of this proposed study consisted of data collection by the researcher.

VII. Trustworthiness

Rigor in naturalistic inquiry is met by trustworthiness criteria, which are defined as credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985). The researcher's familiarity with the "culture" of street prostitution and time spent on the Exit Van as a volunteer nurse increased the likelihood that credible findings and

interpretations were produced. For example, the researcher would rephrase or alter questions when informants gave an indirect or improbable response. In addition, credibility of the data was established through "member checks". Member check is a procedure where the researcher both informally and formally, during the course of the investigation, relays a summary of an interview with a participant or participants for feedback (Lincoln & Guba, 1985). Member checks allow the investigator to assess intentionality, correct errors, obtain additional information, clarify interview data, garner opportunity to summarize and confirm overall assessment, and confirm individual data points (Lincoln & Guba, 1985). During the course of the data collection and analysis period, the researcher reviewed a summary of the interview with 3 participants (one woman from each of the three areas of prostitution in Calgary) for feedback. These participants verified the interpretation and summary of the interview as reviewed by the researcher and added further comments or analytical insight to the main concepts.

Transferability of this study depends on the degree of similarity between sending (female street prostitution in Calgary) and receiving contexts. It is not this investigator's responsibility to provide an index of transferability, "it is his or her responsibility to provide the data base that makes transferability judgments possible on the part of potential appliers" (Lincoln & Guba, 1985, p. 316). Readers must judge for themselves the extent to which this context matches their contexts and determine the degree of transferability that is warranted.

The investigator established dependability of the study by asking two peers (not involved with the study) to examine the research records and determine their accuracy.

These peer reviewers examined the data (including the transcripts), findings, interpretations, and recommendations to establish confirmability of the research study (Lincoln & Guba, 1985). During this process the reviewers generally agreed with the coding scheme, interpretations and found the analysis to be complete. On several occasions the researcher and reviewer discussed differences in findings and reached consensus. Both the dependability of the peer review, as indicated above, and the field notes compiled by the interviewer established the confirmability of this study.

VIII. Field Notes

The investigator maintained and developed field notes as part of the research process. Field notes consisted of: (1) a daily schedule of the study; (2) a personal diary which allowed for reflection of personal values and interests; and (3) a methodological log. Field notes have application to the four areas of trustworthiness, as described above, and provide information about methodological decisions made during the study. The researcher was able to reflect throughout the research process on decisions made, emerging themes and determine possible gaps in data collection through the use of the daily field notes.

IX. Safety and Security Issues

Prior to study approval the researcher and thesis committee attended a special meeting with representatives from the Conjoint Medical Ethics Review Committee at The University of Calgary with regard to safety issues for both researcher and participants during data collection. This meeting was to ensure that adequate guidelines were in place to avoid any potentially unsafe situations. Among those guidelines were: to distribute an

information pamphlet prior to data collection; to conduct interviews in public locations and ideally during daytime hours; to arrange quick telephone access for the researcher; and to inform other people (Van, Exit storefront, peers) of time and place of interviews.

The researcher distributed a brief pamphlet (Appendix B) containing the study description to the female Exit Van clients over a 2 week period prior to subject recruitment. The clients could refer to the pamphlet for the study description, which allowed them time to discuss study participation with peers and pimps. Prior to proceeding with each interview the researcher determined with each subject that participation in this study did not compromise security or safety for either the participant or the researcher. The researcher carried a cellular phone for safety reasons during the data collection period of this proposed study. The investigator communicated (verbally or by phone) frequently with the Exit Van staff during the interviews which often took place during Exit Community Outreach Program operation. However the majority of interviews took place during the afternoon hours at public locations. The interviews on the street were conducted during day time hours and an Exit staff was always in close proximity of the interview site.

X. Ethics

Participation in this study was entirely voluntary, and written consent was obtained after discussing the content of the interview, the procedures for ensuring confidentiality and anonymity, as well as the participant's right to choose not to answer questions. Confidentiality was protected through the use of initials to identify participants, which will be destroyed upon the completion of this study according to

University of Calgary protocols. In addition, the participants' initials or identity will fade with distance and time, and were not documented in the research report. Before the interview was conducted the investigator clearly explained to the participant that she was acting as a researcher and not as an Exit Van staff member, and that she was not responsible for service provision. The researcher honored anonymity and confidentiality toward concerns raised during the interview process which were beyond the context of the research inquiry. The researcher would offer the option of referral information and support to meet the needs of the participant, but would not be responsible for follow up. If the investigator believed that there were reasonable grounds that a child (a person under 18 years of age) required protective services she would have reported this to the Child Welfare authorities. This situation did not arise during the data collection period. The interviewer provided refreshments for the respondents but they were made aware that no rewards for participation (and no penalty for non participation or incompletion of the interview) in the study would be given. Results of this study will be made available to participants, Exit Van personnel and other community services upon request as recommended by Patton (1990).

Ethical approval was obtained from the Conjoint Medical Ethics Committee of the University of Calgary, and Wood's Homes Ethics Committee (Exit Van Community Outreach) prior to proceeding with the study.

XI. Data Analysis

A. Coding Procedures

The interviews were transcribed verbatim from audio tapes (interview excerpt in Appendix E). The researcher started by creating a provisional "start list" (Miles & Huberman, 1994) prior to tackling the stack of data. This start list was developed from the research questions, hypotheses, problem areas, and key variables that the researcher brought to the study shaping an outline. As a result seven or eight larger categories emerged which were each broken down into subsections. The subsections were developed based on the verbal expressions of the participants. The coding scheme was modified with each interview and consequently the researcher recoded the previous interviews when alterations were made. Elements of comparative analysis (Glasser & Strauss, 1967) were used in creating new codes, even though the purpose of the study was to examine the data for trends and patterns. As new themes or subsections began to emerge they were named and incorporated into the coding scheme. A copy of the coding scheme and exemplars from responses can be found in Appendix F. Most of the codes were descriptive, however certain codes have interpretive meaning (for example perceived barriers). The codes were applied to sentences or monothematic "chunks" of sentences using Ethnograph software package. Each "chunk" of data was coded with 2-4 coding terms. The researcher examined the data 3 times before she was satisfied with the descriptive coding phase and was ready for peer review. Following peer review the researcher examined the data once more and at this time identified pattern codes, gaps in the data and relational links. At this time core categories were identified within the

study's main research questions, and then were systematically related to the other categories; the researcher validated those relationships by revisiting the data. Simultaneous to peer review the researcher developed a "data accounting sheet" (Miles and Huberman, 1994) which allowed her to see which concepts or research questions were addressed in the interviews. With each apparent missing data piece the following were asked: 1) Was the question asked by the researcher? If not why not?, 2) Was the question not answered by the participant? If not why not?, 3) Was the missing data an issue for this participant?, 4) Was the question answered indirectly at a different stage of the interview? and, 5) Were there other reasons such as environment or other situations which affected the data collection? Upon review of the data accounting sheet the data collected was found to be thorough and complete. However, some questions did not apply to certain participants or they chose to address certain questions indirectly. Following this process another peer reexamined a set of three interviews and the interpretations, to validate the findings. Throughout this process of coding and peer review the researcher used analytic memos to herself throughout the process to help with the generation of themes and linkages. See Appendix G for an outline of analysis process.

XII. Summary

Fifteen female street sex workers (Exit Van clients at one time) were interviewed to explore their perceived health concerns and health service needs. Written consent was obtained prior to audio taped discussions with the researcher. The researcher selected a number of women of different ages, varying lengths of prostitution involvement and

different work areas in the city. The discussions were guided around personal health concerns, satisfaction with health services, health service utilization patterns, barriers to access, health service needs and evaluation of the Exit Van project. The transcribed interviews were coded using The Ethnograph computer software. The data were then analyzed for trends and themes and were analyzed with respect to the research questions.

Chapter 3

Results

I. Introduction

This chapter provides an overview of the results. Characteristics of the study sample are presented, followed by the categories of responses obtained through the data collection process. The results will be presented using six main categories which emerged from the data analysis:

- Personal Health Concerns
- Patterns of Health Care Utilization
- Level of Satisfaction with Health Services
- Barriers to Access and Utilization
- Valued Health Services
- Evaluation of the Exit Van project

Not unexpectedly, participants raised concepts and expressions which were not directly related to the study purpose which I will include within the appropriate categories. In the next section I will describe the participants so that the reader has a context for understanding the research findings.

II. Study Sample

As the interviews proceeded, patterns emerged from the participants' responses: there appeared to be three distinct categories of women in the sex trade in downtown Calgary. Women working in certain areas were similar to each other and tended to express similar perceptions.

A. Characteristics

The researcher interviewed 15 women who were working as street prostitutes in Calgary at the time of data collection. Demographics obtained from informants were: age, level of education, children, living arrangement, number of days of the week they work, and age when they started working in the sex trade. These demographics are shown in Table 1.

Table 1: Demographics (15 Informants)

AGE	# Informants
<18	5
18 - 30	5
>30	5

LEVEL OF ED.	# Informants
< Grade 9	8
Grade 9 - 12	6
> Grade 12	1

STARTING AGE	# Informants
<14	9
14 - 20	5
>20	1

LIVING ARR.	# Informants
Alone	7
With partner	4
With others	4

CHILDREN	# Informants
Yes	11
No	4

DAYS PER WEEK	# Informants
2 - 3 days	2
5 - 7 days	13

It became evident that the informants fell into three groups; 1) Established Trade, 2) Unsystematic Trade, and 3) Entry Trade. These three groupings emerged through the investigation of such factors as area of work, age and working status of the women interviewed. In this study, working status is perceived by the women as either

independent or dependent. An independent street prostitute is one who works without a "man" or "pimp". However, the researcher is aware that the definition of a pimp or person living off the avails of prostitution can vary. For example, using the income of a prostitute is seen as "living off the avails" by human service providers. The researcher therefore has chosen to define these relationships (working status) as described by the informant. For example, the informant may tell the researcher that she is not "working for anyone" or "working independently" even though she lives with her partner who consumes her income. The three groupings of street prostitutes are often used by human service providers who work with this population; however, the researcher has chosen to label them differently. It is important to clarify that the researcher set aside biases prior to field entry, but the groupings naturally emerged as the data collection proceeded. The area of work, age and working status of informants are shown in Table 2.

Table 2: Trade Group Characteristics

		AGE			*STATUS*	
TRADE GROUP	*STROLL*	**< 18**	**18 - 30**	**> 30**	**Independent**	**Dependent**
Established	A	0	3	2	0	5
Unsystematic	B	0	2	3	5	0
Entry	C	5	0	0	5	0

There appeared to be merit to using the three groups as a framework to present results of this study. The similarities (and differences) between the women in the three groups will be illustrated throughout the ensuing chapters. Both the researcher's experience and feedback from the informants regarding the three groupings allowed the

researcher to use this terminology to frame the results. However, the researcher does not want to generalize about the groups as there are both the similarities and differences within and among these groups. The following section will illustrate the characteristics noted by the researcher within these three groups.

1. Established Trade

It is not the purpose of this section to generalize about all the women who appear to belong to this identified group, but rather to describe the groups which emerged in this study and to provide a framework for presenting the results. Five of the informants worked in the area known to professionals as "A stroll". These women (see Table 2) were all greater than 18 years of age, and worked in a dependent fashion (working for a pimp). It was obvious during the data collection process that it was unusual if not impossible to work in this area independently. The women all worked in designated areas on the streets which were determined by their "pimps". This territorial arrangement did not allow a great deal of flexibility in terms of working area. As noted in Table 2, these women reported working 5-7 days a week which the researcher understands is a characteristic of working for a "pimp" in this area of town. During the field work, numerous women in this group verbalized the expectation by their "pimps" to work an average 6-7 days a week. The grouping of women did not only emerge from working status, number of days they work or working area, but also from the similar responses by informants to research questions. The women in this group were clear on the unspoken "rules" and expectations as a street prostitute; informants expressed similar themes when talking about their relationships with their pimps and the sexual services they provided

and prices they charged when working.

2. Unsystematic Trade

Five of the informants in this study work in the area known to human service providers as the "B stroll". On average these women were 30 years of age and worked on an independent basis. They told the researcher that they "work for themselves" and "not for a man". Unlike the Established Trade group, these women appear to have fewer rules around working area, services and prices. In addition to fewer rigid rules, these women worked on an inconsistent basis. Some weeks they worked seven days of the week and others they worked once or twice per week. These women told the researcher that they worked as needed to support their lifestyles.

3. Entry Trade

Five of the informants were under the age of 18 and will be referred to as the "Entry Trade" group in this study. These young women worked in an area identified by human service providers as "kiddie stroll" (C stroll). However, two out of the five women had worked in other areas of town. From the informants' responses, there were few working rules expressed by this group of women. Area of work and prices were often determined by the women themselves. All of the informants worked independently and stated that they were not interested in working for a "man". However, many spoke of the future threat when they would be forced to work for somebody. These young women worked on an inconsistent basis and their hours were very flexible. These women told the researcher that depending on their need for money they would work a few hours in the early or late evening.

III. Presentation of Findings

The open coding of the interviews, member checking and field notes yielded numerous concept phrases which described the issues raised. These phrases were collapsed into a final coding scheme (Appendix E) which resulted in six major categories. These categories are: personal health concerns; patterns of health care utilization; level of satisfaction with health services; barriers to access and utilization; valued health services; and evaluation of Exit Van project. The results within each of the six categories are presented using the three groups of informants; Established Trade, Unsystematic Trade and Entry Trade. Informants' responses are presented with definitions and illustrative quotes.

A. Personal Health Concerns

Health issues or worries reported by informants will be referred to as "Personal Health Concerns". The results are presented according to the three groupings of informants.

1. Established Trade

The informants in the Established Trade group expressed their primary health concern as Sexually Transmitted Diseases (STDs) and Acquired Immune Deficiency Syndrome (AIDS). The researcher needed to probe for further insight around health concerns with this group of informants. Following prompts and inquiries the Established Trade informants believed that stress was a significant part of their daily lives.

> You can see it sometimes when girls aren't making money or they're stressed with their boyfriends slash pimps. Whatever. You can tell that they are, like, he is an asshole. Or when you see somebody else that is making all the money and you're not making anything at all. You get depressed; like, what is wrong with me. I have seen a lot of it. (Eth 3 - line 426)

> Yes, I am stressed all the time, stressed that I won't be able to pay his rent. Let alone my rent on top of it. Oh, I would never kill myself or something stupid like that. I sleep all the time; I'd rather sleep than think. I'd rather sleep than think about things. (Eth 4 - line 338)

This group primarily spoke of STDs during the interviews. However, during field work the researcher observed that many women in this group worry about their weight. The concern around weight arose in the context of appearance and consumer demand, not in the context of physical health. In the same light, the women in the Established Trade group were the only informants who spoke of exercising. Most women in this group admitted to some degree of alcohol consumption.

> I'll have a few drinks with dinner. I don't get to go to the bar or anything. Once in a while you raid those little minibars in the hotels with your tricks. Last week we did it actually. But not serious. (Eth 4 - line 288)

a. Preventive Behavior

The women in the Established Trade group believed their risk to be primarily from street work and believed there was minimal risk in their personal lives. All the women in this group spoke of the importance of using condoms with all customers.

> I am very very very safe. I always use double condoms. Always for blowjobs... there is never mouth to mouth contact or my body to his body. Still, it is in the back of my head sometimes. That is why I am extra, extra careful and I don't take any chances. (Eth 3 - line 190)

Field observation affirmed the consistency with which these women use prophylactics with their customers but they are similar to the Unsystematic Trade and Entry Trade groups and do not use them in their personal lives. The women in this group did not articulate their preventive behaviors as clearly as other groups yet they spoke of reducing stress and exercising.

> Exercise is important to me. It wasn't before. It is because I am getting older and stuff like that. Can't have heart problems that is for sure. It affects me actually, cause I don't want to go anywhere or do anything. (Eth 15 - line 114)

Interesting to note, through field observation and discussion with outreach workers that it appears that far fewer "bad dates" are reported by these women compared to the other trade groups. A related factor may be the organization and underlying rules by which this group works.

b. Coping Mechanisms

The women in this group identified either their peers or friends as their support system.

> I think that for most of us working, girls have their little groups. I know for myself I can tell these guys (other sex workers) anything. If I have a problem or something... I can tell them anything. (Eth 11 - line 240)

The researcher noted through field observation that some of the women interviewed were disconnected from or in conflict with their families. Yet, several informants indirectly expressed to the researcher that their family was a resource if necessary.

> My family would be the first place I would go... my mom. She would always know what to say or what to do or...whatever. For any situation. She would be the first to say, well lets deal with this; let's sit down and talk. (Eth 3 - line 686)

Most of the women in this group did not regularly use alcohol and drugs to cope with issues that arose in their lives. As a group, the researcher found them to be discreet about their private lives. Several women mentioned that their boyfriends or pimps could offer them support at times, but seldom offered any elaboration about these relationships.

c. Overall Health Beliefs

"Overall health beliefs" refers to the opinions or feelings expressed by the participants which relate to health in general. The women in the Established Trade group generally reported a sense of control with personal health concerns. They reported self directed behaviors in accessing health services and support. None of the women reported current drug use other than "smoking up" on occasion. This group of women are independent and expressed reluctance to use health services and treatment centres for health concerns such as counselling. Through both field observation and interviewing the researcher believed that the women in this group could not use drugs such as coke or intravenous drugs and continue to work in this area for long.

> I did that, well it was about a week. I never ever ever, like nothing until last year. And I got wheat and stuff, I did it for a couple of days in a row every day. It hit me and I was like no. I wasn't like in tune all the time, and I was... I just stopped. I didn't need any doctor or whatever. I could just see myself, you know I was sleeping all the time, I wasn't doing anything. I haven't touched it since. (Eth 3 - line 399)

> I used to be a cocaine addict. I smoked it, I snorted it, I did everything. And umm, when I met one of my friends [pimps], they said, hey you can't do this anymore. I was spending 800 dollars a day. So I was locked in my apartment

> for 3 weeks, no phone, no visitor, except for that one person. I had sweats, I was sick, I was throwing up. I couldn't do nothing. After 3 weeks I finally let go and I haven't touched it since. (Eth 12 - line 493)

2. Unsystematic Trade

The informants in this group expressed STDs and AIDS to be their number one health concern. The women in this group believed that their risk is mostly through their work on the streets.

> There is a lot of guys out there that are still looking, driving around looking for girls who don't use condoms and they find them. They do that and that is a little unnerving. We keep hearing rumours about a girl on 10th who is HIV positive and one who has full blown AIDS. That is really unnerving. So, I don't touch anything that isn't wrapped in latex first. (Eth 8 - line 44)

In this group the women discussed other health issues such as stress, nutrition, weight and respiratory concerns (e.g., colds). Most of the women in this group acknowledged the stress that exists in their lives by their work on the street.

> I am stressed out all the time. I watch girls do ten dollar dates, how can you respect yourself. If you are going to be out here you might as well be making some money. (Eth 6 - line 246)

There was one exception to this general theme in this group. One informant believed that there was little stress in her life working as a street prostitute.

> Well, I am very passive these days. I am relaxed, I don't let shit get to me anymore. This stress is nothing... spending a month in a cab and not putting a dime in my pocket, that was stressful. This is like water off a ducks back. I am used to this. (Eth 8 - line 331)

The researcher encouraged these women (Unsystematic Trade group) to express further health concerns, beyond STDs and AIDS. Other health issues, when they were

discussed, were often brief and superficial.

> My weight... like Oprah, I was 140 pounds when I got back to town and within 9 days I lost 14 pounds. When I left town for Red Deer I weighed 88 pounds and I am 5 foot 6. Colds, but I drink grapefruit juice by the gallons. I don't drink alcohol, which I should more often cause then I would stay away from the coke. (Eth 2 - line199)

All the Unsystematic Trade group women had used or were using substances (drugs and alcohol) on a regular basis. None of these women viewed this as a health concern unless the researcher probed further into drug use and coping.

a. Preventive Behavior

Unsystematic Trade informants shared thoughts and perceptions around preventive behavior with the researcher. All informants from this trade group expressed the necessity of using condoms while working on the streets. This group used their instinct and "gut feelings" as their guide for choosing dates. Some of the women expressed their ways of ensuring safety:

> I am the type that if he is not clean then I get out of the car. You can tell. I do most of mine in a car, I won't do them in my house you know. I don't want people knowing that part of my life. (Eth 7 - line 130)

The majority of women in this group expressed some sense of control over their health and well-being. Two women who reported using substances currently expressed less concern for their well-being. One women said:

> I don't worry about that. If you get it.. you get it. If it happens it happens, shit happens and you deal with it then, otherwise you get an ulcer. (Eth 7 - line 145)

b. Coping Mechanisms

The majority of women in this Unsystematic Trade group used substances regularly. The substances of choice consisted of alcohol, marijuana, crack, cocaine, or a combination of these. Informants spoke of using drugs and alcohol to "deal with" the stress or frustrations in life. Women expressed the importance of friends and peers in their lives.

> I am the type no matter how stressed out I am, I buy the needles first then I look for the drugs. If she [other sex-worker] finds them on me she throws them away. She can tell when I am stressed out I use them. (Eth 6 - line 482)

Drug and alcohol use appeared more common in both the Entry trade and Unsystematic trade groups.

> I woke up last night, like 1 o"clock I came down, as soon as I got out of my cab I made 200 bucks. I went to the bar, I bought two flaps of blow and half a pealer and my friends put me in my cab and said "let's go home and smoke dope..." Then we smoked dope till 5 o'clock this morning. And that is really cool, like two flaps of dope in a day, in a waking period has got to be the least blow I have done in Calgary. (Eth 2 - line 162)

The researcher asked the participants what resources (persons) they accessed for support or advice. One woman regularly spoke with an outreach worker from the needle exchange mobile unit. Other women spoke of relying on their peers, friends, or other resources.

> I usually write in a dairy. I used to do it years ago and I have started doing it again since I came back, and I write in it every night how I felt about the day. I write down the good experiences and the bad experiences and that helps. (Eth 5 -line 208)

Some women expressed opinions and ways of dealing with the violence they have experienced or could encounter, while working on the streets. Some utilized the police service and others had their own ways of dealing with this concern.

> Stick my husband on him. My old man would just kill anyone who would try to touch me or looked at me cross-eyed. And he is just a little guy. (Eth 7 - line 611)

> Like if he gives me a slap upside the head, you know I'd probably have one of my friends from downtown go and knock the guy out when he is going to the bank or something. But if the guy really hurt me, he put me in the hospital for two weeks

> say. As far as I am concerned in my line of life you don't fuck with kids and you don't fuck with women. But when it is not a kid or women then they have to be punished. (Eth 2 - line 473)

c. Overall Health Beliefs

The group of women in the Unsystematic Trade group (average age 24) expressed concern and frustration of other young women (teens) working on the streets or in their area. With further probing the informants would express the fear they felt for young women working on the streets.

> I wish that there was some other way that I can get it through their heads. Cause I don't want kids to end up like me. I am only 23 years old and I have been doing IV drugs since I was eight years old. It is not a nice life at all... no. Through work there is straight contact with the drugs. Like pot I have no problem with pot. Kids in school who sneak away to smoke pot on their break, hey... you got no problem when your kids are doing that. But when they are 14 or 15 years old and working the street. I'll yell at them, scare them, I'll never hit them or take their money but I will walk up one side and down another. (Eth 2 - line 340)

3. Entry Trade

The informants in the Entry Trade group were consistent with their responses in this category. Each of the young women expressed acquiring sexually transmitted

diseases and AIDS as their most pressing concern. Secondly, informants expressed fear of violence and stress because of the work they do. They identified work as the main source of risk for these health concerns.

> It is scary you know being out there, and you think about it sometimes when you are doing a trick, if I catch something am I going to die? If I get AIDS, you know... What would I do if I did? I'd shoot myself. I wouldn't be able to live with AIDS or some shit like that. (Eth 9 - line 229)

In addition to STDs, the informants in the Entry Trade group expressed fear of violence, both from customers and pimps.

> I am more afraid of STDs actually, and getting the shit kicked out of you by a trick or a bad date. (Eth 10 - line 257)

A number of the younger women expressed the fear of having to work "for someone" and valued their independence while working on the stroll. All informants worked on an inconsistent basis but were immersed in the street culture.

One informant stated:

> The big thing that worries me when I am working is black guys; pimps.... that is my biggest worry, pimps. They could just drive by and grab us and say you are working for us where as oh no... I am not working for you. I have done that before. (Eth 13 - line 326)

The Entry trade informants did not report many other personal health concerns besides STDs without prompting by the researcher. Not until the researcher probed into issues such as stress and healthy living did informants express their thoughts.

> I am stressed out every day. I usually want to go pick fights every night. Smoke a couple of joints... and everything feels a lot better. (Eth 14 - line 76)

> Stress is a big deal. I think that everyone needs a little help with their stress, especially out there, they are so stressed out. (Eth 1- line 250)

All of the young women interviewed expressed their regular use of drugs and alcohol. None of the informants expressed this to be a health concern at the time of the interview.

One young women stated:

> I can admit that I have a problem but I am not really concerned about it right now. I have a really hard time quitting, because I like being high, it is a great feeling. You can do whatever you want and no one cares. They all just laugh at you. (Eth 14 - line 178)

a. Preventive Behavior

Although many of the questions in the interview were directed toward personal health concerns, informants' expressions did not always directly relate to the research questions. Instead the Entry Trade group informants were concerned with telling the researcher about preventive behavior, coping mechanisms and overall health beliefs. On this basis, the researcher was able to infer what the source of concern was.

All the participants in the Entry trade group felt very strongly about using condoms while they work the streets. Even though there were external pressures, such as monetary incentive, they insisted that they always use condoms when they serviced their customers.

> I use a condom, and if the guy doesn't like to then you don't go with him. I usually ask before I get into the car. Like last night... he wanted a blow without a condom. (Eth 13 - line 151)

> I never do it without a condom, to undercut is sometimes very tempting. One time there was a guy with two hundred bucks and he wanted a blow job without a condom. The thought crossed my mind, but I never did it. Cause that would have been my rent, food .. you know and clothes. (Eth 14 - line 174)

With probing and further questioning informants admitted to inconsistent use of condoms in their personal relationships. One way women differentiate their work lives from their personal lives is by not using prophylactics.

> We are so sick of using them, in my personal life I usually don't use them. I just want to do sex once in a while without a condom. OK! (Eth 14 - line 407)

Most young women in this group expressed similar thoughts about condom use. However few informants would discuss behaviors in their private lives without instigation from the researcher. Some of the young women in this group would contradict themselves in their answers to personal questions, but easily clarified responses with the researcher's prompts.

> I never used to use them but I do now. I hate condoms with a passion. But all of the sudden it kind of hit me, what am I doing? I could die ....right. There are some guys I just don't use them with, cause I have slept with them before... it's stupid but there comes a point where that is enough. (Eth 1- line 95)

After further discussion in the interview many of the informants in the Entry Trade group recognized that the risk for acquiring STDs is a threat in both their personal and work lives.

> So I am going to try to prevent it from happening, but if it does.. it is one of the risks of what we do. Not just with work, but just with being downtown. STDs are like a big thing downtown. It is mostly not a lot of serious shit, but it is stuff like everybody gets their round of scabies and round of crabs. (Eth 10 - line 289)

The Entry Trade informants openly admitted the lack of safer sex practices in their personal lives but spoke primarily about the risks faced through work. A few young women recognized the risk in their personal lives but reported no intention of changing sexual practices. Almost all women thought that other street prostitutes in the Entry trade

performed condomless dates. A number of these young women had been tempted by condomless propositions yet none admitted ever having done a condomless date.

Through field observation and interviews with Entry Trade women the researcher learned that many will have friends (often males) whom they don't consider as their "pimps", watch out for their safety while they work on the street.

> Use a spotter... stuff like that, sometimes I carry a knife. I am always really careful with the guy, I am always on my guard. (Eth 14 - line 278)

b. Coping Mechanisms

During the interview informants shared their "ways of dealing" with health concerns. Coping mechanisms in this groups consisted of friends or substance use like drugs and alcohol. Several informants in this group expressed the importance of drugs and alcohol to deal with the stress in their daily lives.

> Drugs! It is an escape from reality and that's good. With me I don't abuse them and I don't have a very addictive personality. I have done it many times.... I just like it to escape from reality. (Eth 1- line 63)

Friendship was important for support during difficult times while living on the streets. Every informant in this group spoke of their friends as confidants, support figures, listeners, and as resources. Parental relationships were not revealed of and did not appear to be a part of their lives on the streets.

> It has been like the hardest year for me and the only way that I got through it is because I couldn't ever see without the support. If you want to talk to somebody, there is always somebody to go to the mall with you, there is always somebody to talk to, there is always somebody there who will give you a hug. I think that is the only way we have gotten through it. (Eth 10 - line 792)

c. Overall Health Beliefs

The expressions provided by the respondents were all very similar and a reflection of the street culture in which these young women live. The researcher found that the informants' knowledge level around the transmission of STDs and other health issues to be fairly high. However, as illustrated above, this did not appear to change sexual and lifestyle behaviors. The informants in this group expressed a lack of control with regard to disease and treatment. The informants were particularly dismal when AIDS was discussed in the interviews.

> I would shoot myself. I'd like go and party and end up overdosing or something. I'd die or shoot myself. (Eth 14 - line 619)

> Because it is your own fault and people will look at you differently even though they should not but they do. Because it is your own fault cause you should not have had your ass out there. Dying slowly but surely, you are going to die.. I can't. (Eth 10 - line 248)

The informants in this group expressed their lack of self esteem since they have been working as prostitutes. They attributed this to their poor self image created by their work on the streets.

> It is also degrading when people recognize you. You know when I am out there I can't go out there stoned, because of the fact that you get these guys who sit there and go yaa baby you like my dick. Inside of me I think I don't like being treated like this. You don't feel like much and people look at you and see nothing but a hoe. (Eth 9 - line 149)

Other informants did not express the self esteem issues themselves but would indirectly express the feelings which they experience while working on the streets.

> On nights that I don't break I sit there and think I am so old and ugly. You think that wow, people pay me for sex... you know.... (Eth 13 - line 879)

> I always get told that I am pretty and have a nice body. It makes me feel good, but it doesn't. I spend all my money because I look at it and am saying... oh I know what I did for this. (Eth 14 - line 889)

Informants felt the frustration and lack of esteem while working on the streets. Some of the informants in the Entry Trade group reflected on the effect prostitution has had on their relationships, societal role and self esteem. Others chose not to verbalize how prostitution and the street life affects their self esteem. All the informants in the Entry Trade group expressed similar feelings towards preventive behavior, coping strategies and overall health beliefs.

B. Patterns of Health Care Utilization

The types of facilities used as well as the frequency and the reasons cited for use, define the parameters of health care utlization. The results are presented by the three groupings of informants; Established Trade; Unsystematic Trade; and Entry Trade.

1. Established Trade

Congruent with the health concerns expressed by this group in the previous section, women sought health services primarily for STDs and minor health concerns. However, informants volunteered insight around issues such as birth control information, pregnancy, violence, substance abuse and gynaecology check ups. The results are presented in the following categories; type of health facility/service, frequency and motive for accessing services.

a. Health Facility and Service

The majority of women in the Established Trade group used a general family physician for basic health concerns. Consistent with all in this grouping, they used their family physicians for general check ups and minor concerns and utilized walk-in clinics for STD screening and treatment. All of the women in the Established Trade group used both their family doctors and walk-in clinics for specific reasons.

> I go to my doctor every 6 months. Well, anytime I have a problem I go to my doctor. For other things than STDs like colds and stuff like that. I just went to her for my ear and get my usual pap smears and stuff like that. I go to the STD clinic once or twice a year. (Eth 15 - line 159)

> I go to my family doctor to get my birth control prescription filled and stuff. For an ear infection I just go to the walk-in clinics. Last year I went to the STD clinic... someone in the van gave me a card.. I went in the summer time. (Eth 4 - line 141)

One women stated that she would use either her family doctor or walk-in clinics for health concerns. However, she then concluded that was more comfortable with a more anonymous facility like a walk-in clinic for STD issues.

> Ummmm, I am not embarrassed, I think I would go to my family doctor. I'd go to the STD clinic. I would probably go to the STD clinic because you can walk in and boom get tested right then and there. (Eth 3 - line 238)

None of the women in this group had disclosed their work to their family doctors. They felt their work was either irrelevant or believed that the physician would pass unfair judgement on them.

> No, I only go there to get my prescription filled and stuff. It [profession as a sex-trade worker] never came up and she is so huffy.... prissy kind. She is kind of up on herself. She really really is... I don't think that I'd ever tell her. (Eth 4 - line 262)

> Informant: No. No, I don't think that she does [know profession as a sex-trade worker]. But you never know some people change when they find out. They don't want to treat you or whatever. Researcher: Have you had that before? Informant: Well, we get it from all over, our friends... why do you do this, why do you do that. You shouldn't be doing that. (Eth 15 - line 237)

All of the informants in this group stated that they would access the police if they encountered violence while working on the street. However several women expressed ambivalence or reluctance about using the police if this violence involved their peers or boyfriends/pimps.

> I don't know what I would do if I got beat up by one of the girls down there. They are pretty tough and they are street wise and a lot of them have been there for years. And me I am just like, I never said anything, I never said anything.. you know. (Eth 3 - line 610)

> Depends [using the police and hospital services]. If it's at home no, but if it is at work yaah. (Eth 15 - line 418)

During the interviews informants expressed their views on emotional support and who they would access. All of the women felt that their friends/peers were their primary support systems and some identified their families. None of the women believed that human service providers would be persons they would access for this personal emotional support.

> No, I couldn't talk to anyone who is not a friend. I never have. I saw a psychiatrist for a while. I thought that it was a waste of time. I don't think that they can really understand cause they are not there. They learn by reading a book. So I decided that it was a waste of time, it was just a place to go to bitch about life. (Eth 11 - line 277)

> Someone who has lived through what you have lived through. Other than that, they are not going to understand it. Not at all. (line 292). People who haven't worked are like yaah, I understand where you are coming from. I have heard that before. They don't really understand because they have never been there. (Eth 12 - line 325)

There was consensus among the women in this group that persons who work closely with this population are "easier" to talk to than persons who don't.

b. Frequency

All of the women in the Established Trade group reported seeing a health professional every six months. Informants with family physicians would see them every six months and go for a complete STD check at a walk-in clinic. Some of the informants had delivered a child less than a year ago and tended therefore to have a higher rate of use of health services over the last year than those who had not given birth recently. Almost all informants in this group had used the police and hospital services in the past for health concerns as a result of violence encountered through work.

c. Motive for Health Service Utilization

Informants expressed their motives for using certain health services or health professionals. The women in the Established Trade group preferred to use walk-in clinics for STD testing because of confidentiality and anonymity. Most women also mentioned the "quick" and "hassle-free" service they receive at the walk-in clinic.

> Well, they test you for everything, whether you like it or not. Like if you have a problem, they test you for everything. (Eth 15 - line 174)

> It was fine, it was quick it was done real quick and they were gentler than most places. They don't poke and hurt in places where you don't need to be. They were fine. (Eth 12 - line 522)

One woman expressed her motive for choosing to see her family doctor to be trust, quality of service and convenience.

> Oh yaa, I actually have two doctors. A female doctor and a male doctor. I use my male doctor for everything but my female doctor is very close to my house. He is great, he gives you anything you need. Like he is the one who prescribed prozac for me. My female doctor does my lab tests and my physicals, concerns like colds and stuff. When I do go it is to whomever is closer or who I feel like seeing today. (Eth 3 - line 271)

1. Unsystematic Trade

The primary health concerns expressed by the Unsystematic Trade group were STDs, substance abuse and violence. As in the previous section, results will be presented through patterns of health care utilization, frequency and motive for using health services or professionals. The informants in the Unsystematic Trade group tended to use downtown walk-in clinics, hospital emergency departments and family physicians. Women who were involved in substance abuse primarily used the walk-in clinic, hospital services and outreach services for their health concerns. Women who reported currently not using substances would access both family physicians and walk-in clinics.

a. Health Facility and Service

The women from this Unsystematic Trade group who disclosed substance abuse to the researcher said they would rely on a clinic and outreach services for health services.

> In the summer I went to _____ cause in the summer I got raped by some guy and he wrote on the mirror "welcome to the wonderful world of AIDS". I flew to the doctor to see if something had come up yet... but I went to _____ (walk in clinic) because you don't have to tell them your name or nothing. (Eth 7 - line 171)

Outreach services were mobile and important for emotional support.

> I use ------ (walk-in clinic), cause Liz is an outreach worker and she is like when I am down she'll phone me, she'll come to my hotel and talk to me and she is really really helpful. I sat in my hotel room when I came back to town this time and had an ounce of blow and I tried to kill myself. I couldn't put enough in the rig, I don't know how I am still alive. (Eth 2 - line 279)

Two women in this group expressed their belief and trust in their family physician for health concerns.

> My family doctor. I trust a female. With those male doctors...if they would have found the cancer sooner, I would have been having a child and none of this would of happened. (Eth 5 - line 41)

> I see my doctor every 3 months. Sometimes when I am stressed out and I go and talk to him He is a great doctor... he is a great doctor, I never have had a doctor where I could have gone for anything. (Eth 6 - line 765)

Contrary to the Established Trade group all of the informants in the Unsystematic Trade group had told their family physicians about their work in the sex trade.

> I don't tell them... but my doctor knew before I even told her and she said that is OK, it is our secret . It is embarrassing ... people see you and it is embarrassing. (Eth 5 - line 134)

All the informants spoke of their rapport with the police. A number of informants shared opinions about the police and how they have used police services in the past. Some of the women had utilized them when they encountered violence on the street, but the majority of this group were reluctant to use police services. Women in more stable living circumstances (no drug use and control of their lives) tended to have better relationships with the police.

> I think that they are great. Mind you I have not had the experiences with them like other people have. I firmly believe that you condition people to treat people in a certain way, and if you act like a big pig than they are going to treat you like one. If you give them respect, then they will give you a measure of it back. So I have never had those kind of problems. (Eth 8 - line 392)

Others recounted negative experiences with the police and their lack of faith in these professionals.

> No, I didn't go to the hospital for that, I didn't even go to the police for that. When they find out that you are a working girl they think that you asked for it. (Eth 7 - line 652)

b. Frequency

All of the informants in the Unsystematic Trade group had seen a physician in the previous twelve months. Women who currently did not report using substances expressed the importance of yearly routine checkups with a physician.

> I go every six months, I go to my family doctor... I am more at ease going to my family doctor than to go to the walk-in clinic or something. (Eth 8 - line 112)

> I was reading my horoscope and I don't believe in them, but ever since it happened I believe in them. It told me to go see a doctor, I hadn't seen a doctor in 2 years. I go every year but I hadn't been out on the street for years. (Eth 5 - line 95)

Women who reported current substance abuse spoke of using health professionals when necessary and not in terms of routine visits. These informants also expressed lack of control over personal health throughout the interview.

> Since June I have seen the doctor 12 times. To check up and re check up.. I had to go back about 7 times ones, cause I was convinced that I had caught something. I wanted to know... (Eth 7 - line 781)

> When I break one (a condom) then I am right at the doctor, 2 days later... cause you have to let it gestate for a couple of days. You can't go that night and say... did I get something? (Eth 2 - line 237)

c. Motives for Health Service Utilization

All of the women in this group expressed that trust, a non-judgemental attitude, comfort and confidentiality are factors which influenced their decisions in choosing human service providers and services.

> One time I thought that I had a venereal disease and I went to my doctor and they phoned my mom and said: No, she doesn't have a disease she just has a bladder infection. You know that is wrong. I just go to _____ and they tell me and nobody but me. They tell me to my face they don't tell me over the phone, I have to go there. (Eth 7 - line 199)

> Sometimes I am just stressed out and I go and talk to him. He is a great doctor, he is a great doctor. I never have had a doctor where I could have gone for anything. (Eth 6 - line 765)

Informants in this group would prefer to "deal" or "take care" of violence encountered in their lives independently of health professionals and police services if possible. Women talked about the roles they played in their encounters with violence and the personal resources they access in these circumstance.

> Depending on the circumstances (reporting to the police). If I have gotten myself in the situation where I have been just a little too stupid well that is my problem. I was on the street and got dragged into a car well then yaah.... Rape is another one of those cycle things, once you start you never stop. I was raped three different times, when I was quite a bit younger. I am not a victim anymore. (Eth 8 - line 411)

> Stick my husband on him. My old man would just kill anyone who would try to touch me. . (Eth 7- line 620)

3. Entry Trade

The young women in the Entry Trade group reported their primary health concerns as pregnancy, STDs, stress and violence. Informants told the researcher which health care facilities they prefered to use, how frequently they accessed these services and why they chose to use these resources when coping with health concerns.

a. Health Facility and Service

The women in the Entry Trade group used only walk-in clinics for their health concerns. Similar to the other two groups, their health concerns consisted mostly of pregnancy, STDs, stress, violence, and miscellaneous health issues such as colds. One young women expressed her mistrust for health professionals.

> I don't go to the doctor and waste my time unless somebody is there. There is no fucking way that I will go in the first place, but if somebody is there, there has to be somebody in that room. (Eth 9 - line 982)

Only one of the young women stated that she would access the police in a situation where she was raped or beaten up.

> The only place I'd ever get beat up would be at work. If it was a nigger that beat me like a pimp, then I'd leave it. Cause when your man hits you, other girls don't even know about it. It is a big secret. You know that they are getting beat, but you are not supposed to talk about it, cause your not supposed to. If I got raped at work I would go to the cops right away. (Eth 1 - line 496)

Other young women stated:

> Forget it I don't talk to the cops. It always feels like you know, I don't know they make me nervous. (Eth 14 - line 297)

> I am not going to walk up to a chop and say hi I am a hooker and I need you to help me. [You're] 15 [years of age], bang you are in jail. (Eth 13 - line 310)

All but one woman in this group expressed mistrust for the police. Contributing to this mistrust is their age and the resulting obligation of the police to pick them up.

b. Frequency

All of the young women in the Entry Trade group said that they utilized health care services at least every six months. A number indicated that they visited a health care professional monthly or even more frequently.

> Lots... I have had a kidney infection, bronchitis, tonselitis... I am in at least once a month with tonsillitis. (Eth 10 - line 956)

> I go to the _____ clinic and get checked every month regardless if I have a problem. (Eth 13 - line 206)

All of the walk-in clinics these women named and used are clinics which are free of charge and do not require a person to have an Alberta Health Care Number.

3. Motives for Health Service Utilization

"Convenient, hassle free and accessible" were motivating factors for the use of facilities or health care professionals.

> It is like open all the time, and you don't need an Alberta Health Care number, that is the only reason I go there. (Eth 13 - line 245)

> Whichever is closer I guess. Depending if there is a shit load of people at _____, and you want to get checked for Chlamydia... then I would go to the STD clinic. (Eth 10 - line 386)

> It is the only place I know and I have a file there and everything. I don't care. (Eth 1 - line 489)

A good rapport with human service providers was often a motivator for accessing a service; this will be discussed further in the following section.

C. Level of satisfaction with health services

Level of satisfaction has been referred to as factors which influence the participants' satisfaction with health services utilized. All informants expressed the importance of respect and non-judgemental care from human service providers. The researcher noted that informants often spoke of their past experiences with the health care system and consequently derived their present beliefs on those experiences. The women currently involved in substance abuse (Unsystematic Trade) and the younger women (Entry Trade) had encountered a greater number of negative experiences with health care professionals than the Established Trade participants. Results will be presented in the next section according to each of the three trade categories.

1. Established Trade

a. Human Service Providers

Throughout this study "human service providers" refers to persons such as doctors, nurses, social workers, police and other people involved in social and health service provision. The women in the Entry trade group report violence (work related) to the police and access police services while they work on the streets.

> The cops even tell the guys that they pick up down there [Low track] that if you want to get a lady go to the high stroll. Down here you are going to get yourself into trouble, the girls up there are really good and they make sure that you know. If you talk to the cops, and it's funny cause people think that the cops are enemies, but they really help us out. They are the first to say like there is some bad date or something... and they are there to get the guy and get him into trouble. (Eth 3 - line 7)

Some women in this group had a different perspective:

> Some are assholes, what do you want me to say. Some don't like us because of what we do, they call us names. Some treat us ok, some treat us like dinks; call us names. All kinds of things. If they don't know you, if they don't work downtown, they are not stroll police, they don't know what goes on then it is bad. (Eth 15 - line 446)

About half of the expressions about human service providers in this group were positive. The women were quite mistrusting of persons who work in the human service field and would often recite previous negative experiences without prompting. Women in the Entry Trade group believe that a human service provider needs to be respectful and provide nonjudgmental care in order to be accepted.

> I think that he can be very condescending, maybe he just has a dry sense of humour, but I do think that he is condescending. (Eth 11 - line 64)

> They really wanted me to have the kid... pressure, pressure. I said no, that is all there is to it. They tried to say you should have it. I am like no, I don't want it. They are like really really pressuring. Maybe it was just the woman. I said no, I am too unstable, I can't have it. She said well no, we could help you. (Eth 15 - line 278)

b. Health Services

When the women in the Entry Trade group were asked about satisfaction with health services they utilize, they mentioned privacy, anonymity, convenience, and speedy service as positive factors.

> I think I go there because they don't know who I am, they are not my family doctor. I don't know, it's just more anonymous I guess. The location is convenient. (Eth 11- line 184)

> Well it is private. They give out no information, they'll call you back, your doctor will not call you back. The STD clinic will call you and tell you either your OK or you need to come back in. Sometimes it's nothing, but it looks like something, so they ask you to come back to get retested. (Eth 15 - line 189)

Many of the women spoke of the interaction with health care professionals at the facilities they access.

> I like the ___ Hospital better, they are quicker, more understanding with people a little different like myself. Because they do have different clinics and stuff. They have more facilities. (Eth 11 - line 587)

Most of the women in Established Trade group are skeptical of health services and human service providers. On a whole these women reported good relationships with the police but used their services only when they encountered work related violence. All but one woman in this group expressed skepticism and mistrust towards the health professionals they chose to access.

2. Unsystematic Trade

a. Human Service Providers

Some of the women in the Unsystematic Trade group expressed intense dislike towards human service providers. Their opinions were based on negative experiences, which were not necessarily related to individuals they encountered in the system, but more about the misfortunes they had experienced.

> Oh, too many doctors have lied to me, that is why I ended up going for a full hysterectomy. (Eth 5 - line 46)

One woman spoke of the good rapport she had with her personal physician:

> I can tell her anything and there is no judgement. She has been my doctor for 19 years, she delivered my daughter. I trust her implicitly. (Eth 8 - line 105)

Many of the women in this group expressed negative feelings toward the police and related previous experiences to the researcher.

> Yaah rape... you asked for it. I had invited him to my room for a beer or something. I didn't ask him to come up and have sex with me. I didn't ask for him to hold a knife to my throat while he had sex with me. I didn't ask to pull half of my hair out of my head. Police don't see it like that. Oh, I am a hooker... I asked him to come smoke a joint. You asked for it bitch. (Eth 7 - line 665)

> They have more concern finding the dead ones than for the ones that are hurting and get a description of who was doing what. (Eth 6 - line 692)

Contrary to the Established Trade group the majority of women in the Unsystematic Trade group did not have a good rapport with the police and were reluctant to use their services.

b. Health Services

The women in the Unsystematic trade group expressed varying opinions toward health services but they, like women in the Established Trade group, related previous experiences which validated their current perceptions. The women in this group expressed skepticism and mistrust toward health facilities and professionals.

> Hospitals, hospitals, I went in there because I got baseball batted to a hospital. They saw the IV lines on my arms OK, I got no pain killers whatsoever. I had a broken arm from the baseball bat. I said you know, I need a painkiller. The nurse said, I was at the _____, and I was shocked. She said why, don't you go to the nearest crack house or whatever it is that you get your drugs and purchase some more so you won't be in any more pain. (Eth 2 - line 333)

> And I went through all the tests and while my legs were all strapped up my doctor opens the door and yells to another doctor: come here and look at this. It was really degrading for me. (Eth 6 - line 374)

The women in this group often did not have an Alberta Health Care (AHC) number and consequently used the walk-in clinic where an AHC number is not required.

> The fact that she didn't have an Alberta Health number. She needed a doctor, she had a serious medical problem with her heart. They just made it a lot easier for her. (Eth 8 - line 540)

All the women in this group related previous negative experiences with health care services to the researcher. Women expressed the importance of respect, privacy, non-judgemental care, professional competence and convenient access as important factors for satisfaction with health services.

3. Entry Trade

a. Human Service Providers

The young women in the Entry Trade group expressed a great deal of mistrust of human service providers. These women related numerous events to the researcher which attested to these feelings.

> "Well you know, I really don't think that you should have so many sexual partners". Well look bitch, just because your sex life sucks doesn't mean that mine has to too. (Eth 1 - line 439)

Young women in the Entry Trade group expressed a lot of anger when they spoke about their relationships with the police.

> If you tried to bring a charge up on a cop, the judge would just look at you and laugh in your face. But they don't know how the cops treat the street kids, because you are a street kid. They will smack your head off the fucking wall, they will kick you in the face. They call you a two bit hore, a slut, fucking bitch. You can't do shit to them cause when you bring it to court you don't even have a chance. They are legit, they are the government. (Eth 9 - line 712)

> I don't like cops, they make me nervous. What could they do to help, without getting us in trouble? (Eth 14 - line 301)

Similar to the previous discussion with the Unsystematic Trade group, the young women in the Entry Trade group did not have a good rapport with the police and avoided

contact with them if possible.

b. Health Services

Similar to the Unsystematic Trade group, the young women in the Entry Trade group expressed the importance of anonymity and accessibility of health services.

> Yeah, you don't have to give your real name, if you have caught something. The nurses and doctors are there to help you and they don't go out telling people. If someone was to go up there to ask, even if it was your boyfriend, they aren't going to tell him. It is confidential, that is what I like. You also don't need Alberta Health Care, which also helps cause if you want to go to a doctor you need an Alberta Health Care number. (Eth 10 - line 352)

> It is like open all the time, and you don't need an Alberta Health Care number, that is the only reason I go there. (Eth 13 - line 245)

D. Perceived Barriers

Perceived barriers refer to factors which participants felt prevented them from accessing and using health services or health care professionals. These identified barriers are presented according to the three groups: Established Trade, Unsystematic Trade and Entry Trade. The researcher noted that women in all three categories had difficulty expressing their thoughts regarding barriers or obstacles against accessing health care professionals and services.

1. Established Trade

The women in the Established Trade group were very private about their lives on the street and rarely disclosed to human service providers. They spoke of the caution and hesitancy they felt around human service providers and their fear of being judged.

> They asked a lot of questions about if I was sure I wanted to do it [abortion] ..all that. All the stuff that makes you cry, you know. Researcher: Are you glad they asked those questions? Informant: No, cause I knew what I wanted

> to do. There was no like, oh should I keep it. No, cause I can hardly take care of myself. You know what I mean, so I would never keep it. And it was an accident, my birthcontrol pills ran out. I was stupid, I went for a month or was it two months and that's when it happened. (Eth 4 - line 215)

The majority of women in this group did not disclose their profession to human service providers they chose to access.

> No, I don't think that she does [know that informant is a sex-worker]. But you never know some people change when they find out. They don't want to treat you or whatever. (Eth 15 - line 229)

Several women in the Established Trade group expressed the preference for female health care professionals.

> I don't go to male doctors period. Even if she is not there I will not go to her husband. (Eth 15 - line 542)

The women in this group spoke of the support they received from their peers at work and the lack of understanding by human service providers of their culture and lifestyle.

> I do too [seek support from peers], I don't think that there is a lot of places you can go and they'll understand. The girls on the street understand, because we have all been there. (Eth 11 - line 257)

2. Unsystematic Trade

As previously discussed in the "satisfaction of health services" section, the women who used substances in this group did not have a good rapport with the police. They related previous experiences to the researcher and indicated reluctance to use police service for health concerns such as street-encountered violence and sexual assault.

> I was screaming and they punched my head open and I reported it to the police and the police didn't do nothing. (Eth 5 - line 259)

Only one of the women who reported regular substance abuse believed the lack of an Alberta Health Care card prevented her from using health services.

> I can't go to a doctor, I don't have my Alberta Health Care number. I couldn't even plan to try, you know. I know that there is a number you can phone, but save all the bull shit and go to a doctor or something. (Eth 2 - line 305)

A number of women in this group, similar to other informants, did not feel comfortable going to group meetings such as ones used by addiction treatment programs. The women often spoke of using one or two specific health care providers with whom they felt comfortable, as opposed to seeking out group sessions for their health concerns.

> I went to one meeting, and I know that sounds ridiculous, but I am not a meeting person. Just going in there, my ex-husband was in AA and still is, he has been for eleven years. I went to meetings with him cause he wanted me to. They were really depressing, it was just terrible. (Eth 8 - line 149)

3. Entry Trade

The young women in the Entry Trade group were asked by the researcher if there were "barriers" or "things" which prevented them from accessing health services for their health concerns as they encountered them. Convenience and privacy were felt to be important for accessing services but women alluded to the mistrust, judgement, and skepticism they have encountered while seeking services. Young women in the Entry Trade group often spoke of easy accessibility and convenient location when accessing services.

> I don't go there but there is really nothing in general. I just don't go, if I am close or near by I will go. I won't make an effort. It's just me.
> (Eth 1 - line 672)

> Whichever is closer I guess. Depending if there is a shit load of people at _____ and you want to get checked for chlamydia. I would go to the STD clinic. (Eth 10 - line 386)

Several young women interviewed expressed the fear of being judged by persons in the "straight world".

> If they tell you it is a shame that you screwed up. If they are going to say... well rub your face in it. I am worried about that. Ever since I went to school, I was afraid of screwing up and now I screwed up royally. (Eth 13 - line 822)

Some women in the Entry Trade group spoke of the mistrust and fear they experience.

> I don't go to the doctor and waste my time unless somebody is there. There is no fucking way that I will go in the first place, but if somebody is there... there has to be somebody in that room. Otherwise they can kiss my ass goodbye. (Eth 9 - line 982)

> Probably the same reason [why she does not like doctors] that I hate cops because they [doctors] are authority figures. (Eth 10 - line 969)

The women in this group spoke of the negative rapport with the police and their mistrust of them. All of the young women in the Entry Trade group shared previous experiences with the researcher.

> If I was raped at work, I am not sure that I would call the cops because I saw how they treated Mary when she had her bad date and they are really down on hookers when it comes to bad dates. It really sucks. We were waiting for four fucking hours, four hours for Vice. It was because of what she did for a living. You know if it was any girl who had come to the cops and said: look I was just walking down the streets and just got raped. It would have been a rushed deal. Boom, boom boom, lets get out there and get this guy. But they take their time, she is just a hooker, she deserved it. (Eth 1- line 519)

Even though this group reported a positive rapport with most human service providers (outreach workers etc.) they indirectly highlighted their poor rapport with some

health professionals and police as a barrier to service access.

E. Valued Health Services

Valued health services are defined as attributes of human service providers and services which participants described as "ideal" or "user friendly", in order to meet their health concerns. In the previous sections the three trade groups were presented by level of satisfaction with health care professionals and services, and perceived barriers to accessing services were discussed. In the following section, people (human service providers) and services which the informants felt would be most valuable are presented. There was a consensus among the trade groups when valued health services were identified, consequently the information from the three groups are combined for the purposes of discussion in this section. The Established Trade group appeared to have fewer comments or suggestions compared to the Unsystematic Trade and Entry Trade groups, but all groups' comments were congruent throughout.

1. Human Service Providers

During discussions about health services, informants from all three trade groups spoke of programs and services which could assist them in leaving the sex trade. Support from close friends was important to a number of informants when discussing changing or leaving their current lifestyle on the streets. None of the women interviewed spoke of their "pimps" or boyfriends as people who prevented them from leaving the sex trade.

> Someone who has lived through what you have lived through. Other than that, they are not going to understand it. Not at all. (Eth 12 - line 292)

> It would have be a friend from downtown to get me off the dope, someone who has known me for more than 5 years. Those are people who can help me because they know me and know my history and I couldn't sit there and can't tell...but like you a little bit about my life, like because it is helping other people. They know just about anything that has happened in my life. They know every aspect of my life and they know... nobody else, anyone who doesn't know could not help me. (Eth 2 - line 508)

Everyone believed that caring people with non-judgmental attitudes were important when accessing any service.

> They give you food. No, but they sit and talk with you and everything. They don't condemn you ... they are caring people. (Eth 14 - line 730)

One women believed that empathy and understanding for this population was more important than knowledge obtained through education.

> I compare that to my drug problem, I was in various detoxes.. in Calgary they were all school taught, but in Vancouver, they had all been there. I was more comfortable with that, and if I had a problem I was more apt to talk to somebody about it, than I was here.. cause here I don't think that they actually understood. You can have the educational background, but that doesn't mean you have the sympathy factor. The understanding factor. (Eth 11 - line 310)

2. Health Services

Women from the three trade groups valued anonymity, non-judgmental care and easy access in health services.

> I like the _____ clinic, because they don't care who you are, or what you do.. they don't say anything, they don't go into shock when you tell them about your life. (Eth 12 - line 607)

> A centrally located place for everybody, where you could just walk-in and I know it sounds rude but on a 24 hour basis. A clinic, a place where you could make appointments with a doctor. Make sure there is always a non stop nurse in case it is for something more serious. A place where you can sit down, have coffee and restrooms, and counseling. A place where you can talk and share;

> to talk about the street but not about who is doing what. A little bit of recreation would be nice like a little stereo where you can listen to the news. (Eth 5 - line 486)

> I would actually like a place where I knew that they were actually there to help me and not just do their job. Where everyone is honestly trying to get help instead of being there because they have to be. A place where I can be at home and be myself and relax you know.. not have to worry about too much, not have to work anymore. (Eth 14 - line 577)

When asked what services they wished would be provided for them, several women said that they would like to be given a chance at a new life.

> A total new life. A total replacement. I couldn't be in transition, it would have to be a total replacement. I would have to be put in...taken out of this life directly and put in another one with a house and a dog. (Eth 2 - line 592)

> Yeah, a place where you can just go, to get the fuck away from down town. Not have anywhere back.. like a normal person. (Eth 9 - line 1015)

Not all participants (from the trade groups) expressed the need for specific health care services. Women reporting current or past substance abuse recommended the need for a new treatment centre.

> I think that we could use a methadone program, big time. There is a lot of services here, it is just a matter of using them. There is a lot to be said for Calgary; Calgary is a great city. (Eth 8 - line 635)

The young women in the Entry Trade group expressed the need for creative and interesting services/programs.

> That is the whole thing behind anything, when we look at all these services and everything and all these opportunities we have. There is nothing that gives us a sense of, hey that would be cool to do that, we could really handle doing that, like that is something that I'd be interested in. Instead it is you have to do this and this and this.. at this time. We've been out here for so long with no rules, basically cause we rebelled against authority in the first place. They can't stick us in an environment where it is this and this... and expect us to adjust like that. (Eth 10 - line 1105)

The range of ages among street prostitutes may create the need for services which are sensitive to differences among the trade groups.

F. Evaluation of Exit Van Project

All the participants were asked about the Exit Van service; their utilization pattern, satisfaction with service, and recommendations or suggestions for service improvement. Since there was little variation in response by trade groups, responses were again combined.

1. Frequency and Service

The Established Trade group reported visiting the van almost everytime they were working. Entry Trade and Unsystematic Trade groups reported inconsistent van access which was dependent on service need. The Established Trade group reported accessing the van on a consistent basis and appeared to have a closer rapport with the outreach workers compared to the other trade groups. All three trade groups reported using the mobile van service for a break from the street, warming up, condoms and to get information such as bad date sheet or program services.

> The bad date list and the hot chocolate is really appreciated down here. (Eth 5 - line 425)

> See what is going on, like we had the Hepatitis B shots. I was one of the first to go down and get my vaccination. (Eth 3 - line 53)

The Unsystematic Trade group and some of the women in the Entry Trade group used the van only when they felt they needed condoms, to warm up, socialize with peers

and outreach workers or get medical advice.

> It has been beautiful lately and I have had my condoms on me, so it's usually like no I don't need to get in the van. I don't need to warm up, I am not sick. If I need an aspirin or something I will jump in the van. They are always really nice in there. (Eth 2 - line 22)

Several women (from all three trade groups) expressed some discomfort with male outreach workers in the van.

> I am not going to pull my shirt off [to show the nurse]. In front of other women it doesn't bother me, but in front of another guy. Even though you are doing this there is still a strange man in the van. (Eth 5 - line 318)

2. Satisfaction

The Established Trade workers spoke positively of the van service but admitted that they are more comfortable and likely to open up to outreach workers if there were fewer clients in the van.

> If there was a health thing or anything like that. I don't think I would tell them in front of all the other girls or anything like that. (Eth 11 - line 27)

The women in the Established Trade group were more private about their lives than the women in the Unsystematic Trade and Entry Trade groups.

> Some of them don't ask too many questions, and just treat us normal. Even though we are prostitutes they treat us normal. They don't look down on us or treat us any different. Some will ask about you know, what we're doing, or basically ones they should not be asking. Some of them try to pry into the life. (Eth 15 - line 50)

The women in all three groups who came into the van on a regular basis felt comfortable interacting with the outreach workers and felt that workers boosted their spirits while working on the streets.

> It warms me up. It is nice to have a break, it is nice not to stand there for 20 minutes. Gives you a break, and if you have a problem they always try to make you feel better. I sometimes go in there bitchy, seriously bitchy and I come out and am happier. They make me feel good. It is kind of nice to talk to someone normal for a minute. You know what I mean, not talking to a hooker or trick or something. (Eth 4 - line 74)

> They don't look down on you, they worry about you, even if they don't know you. They are there to help, I don't know. They are not judgmental at all. They respect you, when you don't respect yourself. If you have a bad night, they make you laugh. It boosts your self-esteem a little bit, just a little (Eth 9 - line 74)

3. Client Recommendations

Women from all three groups expressed the need for longer van hours in both afternoon and later evening.

> Yaa, if they could come down here more often, cause some of the girls get stuck here late late or early early. I am stuck doing the afternoon shift because I am spending the rest of the time looking for a job. (Eth 5 - line 381)

> I don't know, sometimes I wish they could stay longer. (Eth 13 - line 58)

Some women, primarily in the Unsystematic Trade group, felt uncomfortable with the interaction with outreach workers, and choose not to enter the van for service.

> I usually see the _____ van only because I met them first and they just drive up and hand us safes and drive away. (Eth 8 - line 5)

Contrary to women who felt connected; Established Trade group and some of the women in the Entry Trade group believed that this rapport increased satisfaction with the outreach service.

> They are really considerate, kind and understanding. You're not just medical and that makes you want to go to the van. You are not scared to go in that van. You are not like;"what will they think of me".. it is comfortable. (Eth 5 - 391)

IV. Summary

Findings from interviews were divided into three groups according to the characteristics of informants. Each group expressed unique determinants for health which were specific to their circumstances and lifestyles.

The Established Trade group were discreet and mistrusting of human service providers and other "outsiders". They solved personal issues (including some health concerns) on their own or with support from peers. This group appeared more self-sufficient and fortunate than other groups (higher level of education and higher income).

Women in the Unsystematic Trade group were relatively open with human service providers but did not access police services. They reported substance abuse as one common coping mechanism. Women were mistrusting of human service providers and based these opinions on previous negative experiences. Walk-in clinics were commonly used and barriers to access were the lack of AHC, transportation, low level of education and poverty.

Entry Trade group women were open with human service providers but did not access police services. Health services such as walk-in clinics and emergency departments were most often utilized. The young women reported that substance abuse was common and did not use prophylactics in personal lives. Women in the three trade groups expressed the importance for non-judgemental and respectful treatment by human service providers and valued privacy and comprehensive services.

Chapter 4

Discussion

I. Introduction

The purpose of this study was to explore the personal health concerns and health service needs of female street prostitutes. The study has evolved beyond the proposed research questions and allowed greater development of knowledge about this population and its health determinants. Both the interviews and field observation conducted provided broad and rich data for this study. This final chapter presents a profile of the three groups; Established Trade, Unsystematic Trade and Entry Trade. The profiles provide a highlighted review of the study results and offer a consolidated portrait of each of three unique groups. Discussion of findings in relation to existing literature follows the profiles. Recommendations to human service providers with suggestions for the modification and improvement services are presented. Strengths and limitations of the study will be considered, followed by a discussion of the significance of the study and of the need for further research in this area.

II. Health Promotion Framework

The health promotion framework offers a comprehensive description of mechanisms and strategies which are fundamental to the achievement of health. This framework identifies a set of health promotion mechanisms and implementation strategies. Health promotion represents a mediating strategy between people and their environments, synthesizing personal choice and social responsibility in health to create a

healthier future (Epp, 1986). Health promotion is defined by the World Health Organization as the process of enabling people to increase control over, and to improve their health; health promotion integrates the ideas from public health, health education and public policy (Epp, 1986). Strengthening community health services to increase their role of promoting health and preventing disease among disadvantaged groups is a strategy identified by the health promotion framework.

The Epp (1986) framework was used as a guide to explore the study objectives and together with the trade group framework assisted the presentation of the findings. The Health Promotion Framework was not constraining and data did not have to be moulded into the concepts identified by Epp (1986). The framework provides a "means of linking the ideas and actions we regard as fundamental to the achievement of health for all" (p.7). Health promotion mechanisms and implementation strategies as they relate to the health promotion framework by Epp (1986) will be discussed throughout.

III. Trade Group Profiles

A. Established Trade Profile

STDs and AIDS were the foremost health concerns expressed by this group of women. They saw the risks for transmission to be through work, even though they all reported using condoms with every customer, and believed there was minimal risk of infection in their personal relationships. Following some prompting by the researcher the women spoke of the daily stress they experience both through work and their personal lives. The majority of these women did not speak about relationships with their "pimps" unless they felt comfortable with me. These women reported infrequent alcohol and drug

consumption and did not consider it a problem. They identified their peers and friends as their primary support system and mentioned family as a potential resource. All the women in this group used a general family physician for basic health concerns, such as check-ups and minor concerns (respiratory problems), and used walk-in clinics for STD screening and treatment. They chose walk-in clinics specifically for STD screening because it was anonymous, quick and "hassle free". A fairly good relationship existed between the police and the Established Trade group women, and they would access the police service for violence issues encountered through work. This group would not contact police for personal violence which they encounter from other sex workers or in their personal relationships (pimps). They didn't believe that human service providers (outreach workers, nurses, doctors and police) would be persons they would use as support systems. However, they admitted that persons who work closely with the people in the sex trade are "easier to talk to" than people who don't.

Each of the women interviewed reported that they visited a health professional at least once every six months. Satisfaction with services was dependent primarily on non-judgemental treatment, anonymity and quick service.

The researcher found that this group was private and discreet about their lives and there is a reluctance to share details with "outsiders". The participants reported little faith in human service providers or health services and tended to solve their personal problems, such as violence or stress, on their own. However, this group of women had a higher level of education and greater self-sufficiency compared to the Unsystematic and Entry Trade groups.

1. Established Trade Group and Relation to Health Promotion Framework

Epp (1986) referred to self-care, mutual aid and healthy environments as mechanisms intrinsic to health promotion. The Established Trade group takes action towards these mechanisms by using condoms consistently while working, seeking social support from peers and friends and regularly attending health professionals for STD screening. Mutual aid arises in the context of their community of friends and working peers. This informal network was seen as their primary emotional support system which still enabled them to live interdependently yet still retain their valued independence (Epp, 1986). Unfortunately this group isolates themselves by not seeking out human service providers for access to appropriate information. Human service providers might also act as a support system for the stress prostitutes encounter or help them to help them to access services to cope with violence encountered through work and personal lives. This group of women takes steps towards isolating themselves and attempt to cope with little "outside" support. Congruent with Epp (1986), I believe that encouraging these women to access appropriate health information and surround themselves in manageable surroundings will foster healthy choices.

B. Unsystematic Trade Profile

Similar to the Established Trade group these women identified STDs and AIDS as their primary health concerns. Stress, nutrition, weight, respiratory concerns and drug use were other health concerns identified. This group of women also spoke of the violence they encountered on the streets as a concern. Almost all the women reported past or

present consistent substance consumption such as: alcohol, marijuana, crack and cocaine. The researcher found this group to have less concern for their health and well being compared to the women in Established Trade group. Women who reported current regular drug use believed they used drugs as a coping mechanism at this point in their lives. Peers and friends were identified as the primary support system; all the informants in this group had regular contact with their families.

The women in this group mostly use downtown walk-in clinics and hospital emergency departments; some access family physicians. Women who reported drug dependency primarily resorted to clinics, hospitals and outreach services in the city. Contrary to the previous group, all of the women disclosed their involvement with the sex trade to the health professionals they accessed. All of the women reported a poor rapport with police and claimed reluctance to use police services, both in personal and work lives. However, women currently not using drugs professed to have a better rapport with the police compared to women currently using drugs. All women in this group reported annual visits to a health professional. Contrary to the Established Trade group, the women used a walk-in clinic for health concerns as they arose, and did not visit health professionals on a consistent basis.

Similar to the previous group, trust, non-judgemental treatment, confidentiality, and comfort influenced their decisions when choosing services. A few women expressed an intense dislike towards human service providers based on previous negative experiences. Women expressed skepticism and mistrust toward health facilities and human service providers. Women admitted that poor rapport with human service

providers prevented them from accessing certain health services and resources. However, women in this group were more open to me about their experiences; an observation congruent with field observation. The majority of women in this group reported not having an Alberta Health Care (AHC) number which played a role in the health services they accessed. This group of women had limited access to human service providers and health services due to lack of an AHC number, poverty and little education.

1. Unsystematic Trade Group and Relation to Health Promotion Framework

The Unsystematic Trade group differs from the previous group in the way they practice self-care, mutual aid and create a healthy environment. Contact with human service providers was more sporadic yet women attained STD screening and other health services as needs arose. Low income and lack of education among this group results in less opportunity for self-care and the fostering of healthy choices. Substance dependency was more common in this group which further debilitated them in their practice of self-care. Mutual aid was evident in this group as they used peers and friends as their primary social support system. The mutual aid mechanism and access to information and resources was impaired by the mistrust and poor rapport with human service providers even though this group appeared more open with me during the data collection process. Work environment and personal lives of these women were based on survival which consequently offered little structure and few guidelines; these obtacles prevent Unsystematic Trade women from preserving and enhancing optimum health as suggested by Epp (1986).

C. Entry Trade Profile

STDs and AIDS were identified as the most pressing concerns to the young women in the Entry Trade group. Similar to other groups, work was seen as the main source of risk. This group identified violence on the streets as a major health concern and felt that this was one factor which made street work stressful. Contrary to the other groups; these women expressed their fear of possible recruitment by pimps while they work the streets. All of these young women had at one time "worked for someone" but were gladly working independently at the time of the interviews. This group saw condomless dates as a dangerous practice and insisted that they always used condoms while they worked. Women readily disclosed to the researcher that even though they always use condoms while they work, they consciously chose to differentiate their personal lives by not using prophylactics. Yet, these young women spoke knowledgeably of STD transmission and recognized the risk of STD and pregnancy in their personal lives. Women in this group admitted to regular drug and alcohol consumption as a way to cope with the stress in their lives. More pronounced than other groups, these women expressed the importance of friends while they lived on the streets. Except for one woman, no one identified their family as a potential support system while living on the streets.

This group of women was particularly open about self esteem issues and the effect prostitution had on their self image. These women expressed the increase in self esteem they felt during times in their adolescence when they were not working as prostitutes. Not only did they express how prostituting negatively affected their self esteem and self

image but also the negative impact prostitution had on their personal relationships. Substance use was commonly identified as one way to "block" out their work on the streets.

Women in the Entry Trade group primarily used walk-in clinics for their health concerns. Health services and health care professionals were accessed at least every 6 months. Several young women indicated more frequent visits to walk-in clinics. Similar to the other trade groups the women in the Entry Trade group felt mistrust for human service providers. This apprehension was felt for health professionals and police in particular. None of the women felt that they would access police services if they encountered violence on the streets. Anonymity and accessibility were identified as important factors for accessing health services. Perceived barriers to health service access was primarily the fear of facing judgmental treatment by human service providers. Contrary to the Unsystematic Trade group, none of the young women interviewed saw their lack of having an AHC number as a barrier to accessing health services.

1. Entry Trade Group and Relation to Health Promotion Framework

This group of young women practice self-care, as described by Epp (1986), by adopting practices specifically for preservation of their health. They use condoms regularly while they work, and access a health professional at least twice a year for health concerns. Unfortunately this group underestimated the risks to which they are exposed in their personal lives when they choose not to use condoms. This group of Entry Trade women places high value on mutual aid. They rely on friends for emotional support while they live and work on the streets; this support is often crisis oriented. Congruent

with Epp (1986) the loss of contact with family of origin makes this informal network a fundamental resource for promotion of health. This group was more receptive to human service providers than the previous groups, yet still anticipated judgement by providers because of their lifestyle choice. This group of women prostitute for survival and acceptance and are constantly exposed to violence and stress. Continual uncertainty and lifestyle practices provide a unstable social, economic and physical environment for this group of women which is not conducive to a healthy existence (Epp, 1986).

D. Valued Health Services

The three trade groups expressed similar factors when identifying valued health services. The women all expressed the importance of nonjudgmental treatment and respect as important factors when accessing health services. The Unsystematic and Entry Trade groups often relayed previous negative experiences to the researcher when articulating valued health services. Contrary to these two groups, the Established Trade group reported fewer negative experiences yet expressed a strong mistrust for human service providers (health professionals in particular). All three trade groups expressed the importance for services to be accessible (location and hours of operation) and to provide confidential and anonymous health services. Women in the Unsystematic Trade group identified the importance of accessible walk-in clinics (no need for AHC number) but suggested hours of operation to be extended to 24 hours. The young women in the Entry Trade group spoke of programs which were conducive to their personal lives (friendships) with flexible rules yet completely removed from the downtown streets (areas of prostitution).

IV. Key Findings in Comparison to Existing Literature

A. Health Issues and Sexual Practices

Previous studies (CDC, 1987; Carr et al., 1992) found HIV infection among IV drug using prostitutes to be much higher than among non IV drug using prostitutes. These studies could not establish if prostitution was an additional independent risk for HIV infection. Even though this study did not set out to determine HIV prevalence among street sex workers it was interesting to find that, similar to Jesson et al. (1994), HIV was the primary personal health issue identified by respondents. Contrary to Jesson et al. (1994) the women in this study spoke little of their children's health concerns. However, the interview questions in this study focused solely on the sex workers.

McGee, Morgan, McNamee and Krajicek Bartek (1995) examined health problems of and services provided to 408 homeless sheltered women who used a mobile health van. McGee et al. (1995) retrospectively reviewed charts over a three year period and presented the findings according to women ages 15-25, 26-40 and 41-70. The authors did not mention the participants' sources of income or whether they were involved in prostitution. McGee et al. (1995) reported the number one health problem among homeless women to be respiratory concerns upon review of health charts. In this study, women from the three trade groups spoke of accessing health services for respiratory concerns, yet did not believe this to be their primary concern. This difference may be attributed to the actual health concerns recorded in the health charts because the women used the mobile outreach unit (McGee et al., 1995), compared to potential health concerns expressed by women in this study. The primary concern for STDs and HIV

voiced by the sex workers may be a more preventive care issue as opposed to actual health problems experienced by this population. McGee et al. (1995) also reported that genitourinary infections were present in all age groups of women; these results are reflective of the expressed health concerns by the sex workers in this study. The volunteer medical staff on the Exit Van, the health service through which the participants were selected, does little or no documentation on presenting health concerns of sex workers in this study who access the service. Lack of this documentation renders it impossible to retrospectively review charts for health concerns presented by clients of the Exit Van.

This study's findings are congruent with Jackson et al. (1991) and other studies which found sex workers' greatest potential risk for HIV and other STDs to be through private relations with lovers/partners as opposed to the provision of sexual services to clients.

1. Non-Commercial Sexual Practices

Congruent with other studies (Jackson et al., 1992; Lyons & Fahrner, 1990; McIntyre, 1995; Day et al., 1993; CDC, 1987; Philpot, Harcourt & Edwards, 199 ; Mak & Plum, 1992; Jesson, Luck & Taylor, 1992) this study also found that for prostitutes unprotected sex is a common practice with non-commercial sexual partnerships. The researcher found that women, particularly the Entry Trade group, openly discuss not using prophylactics as a way to differentiate their work lives from their personal lives.

The Established Trade group in particular were reticent about discussing personal relationships, which coincides with other literature (Fraser Committee, 1985; Jackson et

al., 1991). This is not an unexpected finding with the controlling pimp/prostitute relationships that commonly exists in the Established Trade group. I discovered that the women in this group disclose information about their boyfriends/pimps to trusted "outsiders", few of whom are human service providers. This poses an obstacle in furthering knowledge about sexual practices in non-commercial relationships. However, women in the Unsystematic and Entry Trade groups were more open about their personal lives and shared intimate information with me. I speculate that the lack of openness among the Established Trade group may be due to the controlling nature of the pimp/prostitute relationship and the general "secrecy" and privacy the women value. Additionally the Unsystematic and Entry Trade group have fewer skills and accessible resources for their health concerns.

2. Commercial Sexual Practices

Numerous studies have found a high frequency (greater than 80%) of condom use while working (McIntyre, 1995; Fraser Committee, 1985; CDC, 1987; Mak & Plum, 1992; Day, Ward & Perrotta, 1993). All the women in this study reported frequent condom use while working, however the researcher suspects the frequency varies according to the trade group (Established, Unsystematic, and Entry). Shortly into the data collection process I realized that none of the women would ever admit to not using condoms regularly with their customers. Yet, according to the women interviewed, customers request condomless dates regularly and allegedly some prostitutes provide this service. In addition, Edmonton Vice reported during a recent sting, using a disguised police officer, 50% of 36 female sex workers on "low track" agreed to do condomless

dates (Vice Constable, Personal Communication, Nov. 2, 1995). I suspect that women who are in desperate need for money, either for basic needs such as food and shelter or to sustain a drug habit, would provide sexual services for little money or without a condom. For this reason it is speculated that less frequent condom use with customers would more likely occur among the Unsystematic and Entry Trade groups.

B. Mental Health Issues

This study did not set out to determine past medical histories as previous studies have done, but instead to explore women's perceived health concerns. The researcher is in agreement with previous findings which reported that a large number of sex workers have a low self-esteem and a poor self image (Cameron, Peacock & Trotter, 1993; Jaquet, 1992; Fraser Committee, 1985). The women in this study spoke of the daily threat of violence and the indignities they experience at work. Only the Entry Trade group openly expressed how their work on the street negatively affected their self esteem and self image. Even though this was evident for all the sex workers, the Unsystematic and Established Trade groups were more discreet about this issue and did not openly discuss the effect prostitution had on their self esteem. I speculate that the length of prostitution involvement influences the ability to distinguish the influences of prostitution. Another possibility is that young women in the Entry Trade group have not yet had negative experiences which generally attributes to the mistrust of "outsiders" (including human service providers).

Research findings concur with previous studies (McIntyre, 1995; Fraser Committee, 1985; Youth Service Bureau, 1990) which found that the main source of

abuse against sex workers comes from pimps and customers. However, none of the literature speaks to the abuse (emotional and physical) sex workers perpetrate upon each other. All the women interviewed spoke of the violence and threats they experience from other sex workers.

C. Health Service Needs

Service needs expressed by women in this study are congruent with the literature (Barton et al., 1987; Cameron et al., 1993; Mathews, 1989) confidentiality, quick and hassle free service, and extended hours of operation were factors seen as important. Unlike other research this study also explored the utilization patterns and service needs expressed by the three unique trade groups (as discussed in the profiles). Congruent with McGee et al. (1995), this study found that factors such as lack of transportation, poverty, lack of Alberta Health Care numbers, and unemployment create special barriers to accessing health care services.

V. Recommendations to Human Service Providers

The following recommendations are based on the interviews with and my observation of female street sex workers in this study. Further discussion examines how several recommendations identified correspond to fostering public participation, strengthening community health services and coordinating healthy public policy set out in the framework for health promotion (Epp, 1986).

STD and HIV testing was reported to be a popular method of addressing the health concern most commonly expressed by female sex workers in this study. The frequent testing can create a false feeling of safety. Human service providers should

continue to counsel women on safer sex techniques and other preventive education.

All of the women clearly stated that they identify best with a person who is caring, non-judgemental, nonintrusive and somewhat knowledgeable of their culture. However, I believe that there are few human service providers they trust and with whom they will truly be open. Accessible services were identified as those which were in convenient locations, to provide a quick and "hassle free" competent service, and operated on extended hours.

The data show that the needs of female sex workers vary depending on the trade groups. The three trade groups are unique in the factors of age, length of time in prostitution, working status (independent or not), level of education, and whether or not they have a substance addiction; all these factors are health determinants and determine their ability to access and utilize health services/resources. These factors may also influence the ability to trust human service providers which would affect comfortability and utilization of resources. I believe that all human service providers who work with this population should have some basic knowledge of this culture. Additionally, human service providers need to take an effective preventive approach which is needed to empower these women to make healthier choices. This is not an easy task as they are often poor, uneducated and isolated. Even though specific trade group recommendations are presented it is not meant to categorize and generalize a sex worker within a trade group because they each have individual and unique health determinants.

A. Recommendations: Established Trade Group

The women who fell into the Established Trade group had mistrust for human

service providers and often were in controlling pimp/prostitute relationships which allow relatively little freedom. Based on the interviews and observation I found that this group is sensitive to the terminology (language) used by human service providers and "outsiders". For example, the women take offense for anyone to refer to their boyfriends as "pimps". Referring to this partner as "friend" instead is more acceptable. They are very private and object to personal questions (relationships) unless they give permission to probe or if asked by a trusted human service provider. None of the women disclosed their involvement with street prostitution to their regular family physicians and accessed walk-in clinics for STD screening. I believe that human service providers need to focus on developing better rapport with these women which ultimately would lead them to access providers and the resources more readily. If opportunity does not allow for rapport building between human service provider and sex worker, then this group of women value respect, non-judgmental care and privacy when accessing community health services. Education of human service providers contributes to the strategy of strengthening community health services as outlined by Epp (1986). Fostering public participation appears to be an important part of living in this population. Numerous women felt that "outsiders" could not understand their situation unless they had experienced it themselves and consequently this group asserted control over the factors which affect their health. They identified mutual aid as a primary social support system. In accordance with Epp (1986), it is important to enable and equip these women to act in ways that improve their own health. I believe that peer support is also an area human service providers should foster as it may open a pathway to this trade group.

B. Recommendations: Unsystematic Trade Group

The women in this group tend to access walk-in clinics and emergency departments on an infrequent basis for their health concerns. This infrequent and inconsistent visiting pattern requires providers to provide as many services as possible to these women. Barriers which these women face are poverty, lack of education, no transportation and trying to meet the necessities of life such as food and shelter. For example, referring a sex worker from the Unsystematic Trade group to a personal physician to receive prenatal monitoring may not prove successful. This woman may not have transportation or may lack incentive to access this service. Instead, providing support and guiding them through the system of seeking these services may be more appropriate. Outreach services is one example of how to enable this group to access services which also strengthens community health services to assist the health challenges identified by this disadvantaged group of women.

I found this group to be more trustful of human service providers than the Established Trade group and were more likely to discuss personal issues and situations. Self reported drug use was higher among the women in this group and these women often depended on outreach services as opposed to health care facilities with day time hours of operation. These women reported a negative rapport with the police; human service providers whom I believe need to develop a better rapport with this group of women. Factors such as drug dependency, poverty, lack of education, lack of transportation, no AHC numbers prevented these women from accessing services. Coordination of public health police was not directly discussed with sex workers in this study. Epp (1986)

defined healthy public policies as "policies that are healthy help set the stage for health promotion, because they make it easier for people to make healthy choices" (p. 10). Some of the public policies which affect sex workers are related to health care access (AHC number), working environment, employment, education, justice and transportation. Change in public policy in these sectors, just to name a few, may remove barriers and allow equitable access to health for these women.

C. Recommendations: Entry Trade Group

These women relied on walk-in clinics and emergency departments for health care services and were less mistrusting of "outsiders", compared to other trade groups. They were open to discuss personal issues and reasons for prostitution involvement. This general openness allows human service providers to develop a rapport with these women. I believe that this is an important group to target with preventive health education, not only because of their openness, but also of their youth and relatively short time of involvement with prostitution. Based on study findings, preventive education needs to focus on self esteem issues, relationships, sexual practices, pregnancy and substance abuse. In light of these young women's low self-esteem human service providers need to promote individual coping skills and healthy self-esteem to seek safer ways of income earning. Additionally, further education on disease prevention and health promotion could increase self-care effort, as well as promote a healthier environment in which to live and work (Epp, 1986).

Similar to the Unsystematic Trade group, these women accessed health services on a sporadic and inconsistent basis which would require human service providers to

offer a number of services. Consistent with the Unsystematic Trade group, contacting women in their surroundings (outreach on the streets) in order to develop rapport and offer services is crucial for this population. Survival is their primary concern and seeking services for their health issues may become secondary. I believe that this group needs a lot of support and tools (i.e. , education) from human service providers to enable self-care and mutual aid which will lead to health and well being.

D. Recommendations: General service Exit Van

Unlike other mobile outreach units (McGee et al., 1995; Edmonton Outreach Unit, personal communication, January 17, 1996), the visiting patterns of the Exit Van tended to be frequent and consistent. This pattern allows for outreach workers and other human service providers (nurses, doctors and dentists) to provide a more comprehensive follow up around health issues. Congruent with the recommendation by McGee et al. (1995), clients who access the van on an infrequent basis require numerous services/referrals from providers.

Women, from the three trade groups, spoke about pregnancy yet did not express it as a concern. The number of pregnancies among sex workers requires that services include prenatal referral to physician or nurse providers and comprehensive education that addresses substance abuse, infant care, and parenting. Documentation of client health information is a necessity when providing comprehensive services. Proper documentation of cases will provide improved follow up and update on clients progress. Currently the lack of documentation does not allow for tracking clients' health concerns and communication among outreach workers and volunteer nurses except for informal

verbal exchange.

VI. Study Strengths and Limitations

This study was motivated because of the minimal understanding of health concerns and health service needs among female street prostitutes, particularly in Calgary. In an effort to explore the self reported health service utilization patterns, satisfaction of services, barriers to access and service recommendations, this study utilized qualitative methods. This exploratory study design was selected to obtain a preliminary understanding of the problems as seen by female sex workers. Discussion of strengths and limitations of the study sample, self-reported data, data collection and analysis follow.

A. Study Sample

Study participants were primarily selected through the Exit Van project, but the researcher also used the snow-balling technique in this process. Fifteen women were interviewed for this study. No further interviews were conducted when it became apparent that no new data were being generated and the data categories were saturated. It was not the intention of this study to make generalizations to the larger female street prostitution population, but rather to examine the range of sex workers' opinions regarding health concerns and health service needs. The purposive sampling used allowed the researcher to access a wide range of women in the prostitute population in Calgary. Using the Exit Van allowed me to observe and select participants I felt would provide rich data. The Exit outreach workers provided access to young women who may not have agreed to interviewing had they not had this support and encouragement The

snowballing technique used during sample selection provided participants I may otherwise have been unavailable. The women selected through this latter technique infrequently or rarely used the Exit Van service.

B. Validity of Self-Report Data

The fifteen interviews with female prostitutes consisted of self-report data. Recall bias, where participants may be unwilling to reveal information or inaccurately recall experiences and perceptions, is a potential threat in this study. However, trustworthiness ensures credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985). I felt that the data collected during the interviews and field observation were valid because of informal interview style, member checking, and peer review during data collection and analysis process.

Confidentiality of participants was guaranteed and I also gave the participant the right to choose not to answer questions, which reduced my reluctance to discuss their experiences. The interview guide consisted of open ended questions to guide the discussion. I allowed participants to direct the interview as they wished. Neutral prompts were used which minimized my bias on informants' views and opinions (see transcript in Appendix E). Consequently the conversational tone of the interviews appeared to ease informants. My knowledge of the study population and connection with Exit Community Outreach increased my credibility to the informants. There were times where the informants appeared to give socially acceptable or expected responses to my questions. However, I clarified and reviewed informants' responses, through member checking, to ensure data accuracy.

C. Data Collection and Analysis

I used the member checking technique whereby I reinterviewed three of the women (one from each of the trade groups) some time after the initial interview and reviewed informants' categories of responses and researcher's perception of initial interview. This process confirmed the data interpretation and affirmed validity of data obtained. Verbatim transcripts provided an accurate record of the interviews. I personally reviewed all the transcripts with the audio tapes which allowed me to consider the interview dynamics and other element of communication that cannot be recorded in the written transcript.

A possible limitation relates to the interview process of the participants. Repeat interviews over time as opposed to the one time interview may have provided more in depth disclosure and information. However, this study's intent was to explore and describe this topic under study and future research could assess issues in a more comprehensive way.

The coding process in itself is quite selective in nature and subject to a researcher's biases and values. I used several methods to reduce possible biases. First, during the first stage of the open coding procedure a transcript and codes were reviewed by a peer reviewer. Coding scheme was generally agreed upon and the process offered some further insights to data interpretation. Peer review was repeated at a later stage, whereby a colleague with expertise in the study design, reviewed transcripts, coding and interpretive analysis. Again, this process consolidated themes and interpretations found in the data.

Second, I used elements of the constant comparative method (Glasser & Strauss, 1963) during data analysis. New codes were created, combined and modified on an ongoing basis upon new occurrences of data. This process allowed me to review the interviews up to three times and minimize inappropriate coding of the interview data.

Third, near the completion of the coding process I developed a data accounting scheme which tallied data collected and identified gaps in the data which were then later addressed in the member checking procedure. This data accounting scheme served to help me address the research questions set out at the beginning of this study. The qualitative methods used in this study would likely result in another researcher reaching similar finding based on the data collected. However, my role as the researcher and the influence I had on the data collection procedure and analysis will remain unique to this study.

1. Valued versus Need

Early in the coding process I repeatedly felt constrained by the definition of need. I was continually finding conflict between the definition of need set out in the study and the definition as perceived by the subjects. I found that many of the categories such as utilization patterns, satisfaction with services and human service providers and barriers to access inferred the concept of need. I have reported these above categories as they arose in the data but maintained a separate section which alludes to valued services. This category emerged from a compilation of the valued services and attributes in human service providers women expressed throughout the different categories discussed in the interviews. Primarily, valued services reflect those qualities or factors which women

preferred or sought out in health services and about human service providers.

2. Human Service Providers versus Health Professionals

As the data collection process began the women interviewed often referred to violence as a health concern they encountered through their work and personal lives. These discussions led to the role of the police and the service they provided for the women around this health issue. As this theme emerged I decided to include the police into the group originally termed "health professionals". The more encompassing term "human service providers" refers to all people who provide a health service to this population such as: outreach workers (including Exit staff), health professionals (physicians, nurses, counsellors, etc.) and police persons. This term also refers to persons who provided a health service even though they were not "professionals".

VII. Significance of the Study

This study explored the health concerns and valued health services expressed by female street prostitutes in Calgary. Factors such as age, length of prostitution involvement, working status (independent or dependent), area of work, and level of education differentiated the women into the Established, Unsystematic and Entry Trade groups. Trends and patterns emerged into three trade groups, each group distinctive in their expressions of personal health concerns, satisfaction of health services and human service providers, health service utilization patterns, barriers to access and valued health services. The findings of this study are significant because little research has explored the perceptions of female street prostitutes.

Health determinants for sex workers were income and social status, social support networks, education, working conditions, environment, personal health practices, coping skills and health services. Street culture varied among the trade groups which is presented through unwritten rules, working status and working conduct in general. Each of the three trade groups was distinct in its patterns of health care utilization and interaction with human service providers. Social support networks were identified as important to all the women in the trade groups. Even though not all support systems were positive or health enabling I found this a noticeable strength among these of sex workers. This support network could be complemented with strengthening community health services such as providing support programs designed to increase mutual aid (Epp, 1986).

Although this study occurred in Calgary, the results are potentially transferable to other cities in Canada where street prostitution exists. This study poses implications for human service providers who work with other disenfranchised and marginalized women. For example, homeless women face distinct health concerns and experience comparable barriers and value similar services (McGee et al., 1995).

This study explored the perceptions of female street prostitutes and the health facilities and human service providers they access. The knowledge gained in this study can serve to accomplish several things:

- to educate human service providers about street culture so that they can provide more sensitive and appropriate services,
- to design preventive health education interventions that reflect street prostitutes' priorities, which will foster self-care, mutual aid and healthier environments,

- to alter and modify the existing practices of human service providers to increase accessibility and acceptability of services to this population,
- to ensure that institutional and community service health policies are health enhancing for this population; and
- to provide a foundation for future research to further explore issues raised in this study.

VIII. Future Research

A number of questions are raised by this study which generate potential for related studies. Are other cities or countries seeing the same groupings which emerged in this study? Do these trade groups exist in other cities and does each have unique attributes and characteristics which influence their utilization of health services and human service providers? Further qualitative research and analysis should be conducted to derive additional insights into groupings of street prostitutes and how this affects the range of health determinants identified in this study. Women who found themselves in more fortunate situations (Established Trade group), without substance addictions and higher level of education, had fewer negative experiences with human service providers and health services than the less fortunate women. More information is needed around human service providers' perceptions and attitudes towards sex workers. Are human service providers judgemental and insensitive toward persons involved in the sex trade? Which leads to the following question; are human service providers informed and knowledgeable about health determinants identified by this population?

These are only a few of the many questions that may be generated from this study. Further research is needed to validate these findings and explore health determinants of this population to provide more comprehensive and effective resources to address these women's needs.

IX. Summary

This study examined the personal health concerns and valued health services of fifteen female street prostitutes in Calgary. A wide range of health determinants were identified by the women; income and social status, social support networks, education, working conditions, physical environments, personal health practices, coping skills and health services (Lalonde, 1974; Epp, 1986). Street prostitutes feel little sense of control over their lives and their environments. They engage in health practices deleterious to their health and often do not have access to relevant primary care and preventive health services. This study has attempted to answer the inevitable question: what difference will it make to have this information? In light of the study findings it is evident that we need to invite a true partnership among the human service providers and street sex workers to create systems which focus on the need of the whole person. Restructuring and alteration of existing services is only one step toward enabling this population to attain health and to make healthier choices. An overwhelming theme throughout this study was the importance of socioeconomic and cultural factors on health and how this affects accessibility and acceptability of specific service options. As a community we need to create healthier policies and provide preventive education to this marginalized group of women which will bring them closer to feeling empowered. We can not simply rely on

adjusting health services to "fix" the health of this population, instead it requires a wholistic approach toward the manifold needs of these women.

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Appendix A

The literature review of material pertaining to needs assessment indicated that there are a series of question which pertain to this study's research goals. These questions include:

Primary Research Goals:

1. **To assess the perceived health concerns of the Exit Van female clients.**
    i. What are the personal health concerns of the Exit Van's female clients?
    ii. Are any of these concerns sexual-reproductive health and/or lifestyle risk factors?
2. **To assess the perceived health service needs of the Exit Van female clients.**
    i. What health services do the female clients of the Exit Van program feel they need to address their personal health concerns?
3. **To describe the current patterns of health service utilization of the Exit Van female clients (sexual-reproductive health and lifestyle risk factors).**
    i. What type of health services do/would the female clients of the Exit Van use?
    ii. Which health services do/would the female clients of the Exit Van use?
    iii. How frequently do the female clients of the Exit Van use health services?
    iv. Are the female clients of the Exit Van aware of existing health services in downtown Calgary?
4. **To identify barriers to health service access and utilization as perceived by the Exit Van female clients.**
    i. What factors influence the female client's access or utilization of health services in Calgary?
    ii. What do Exit Van female clients perceive as barriers to meeting their needs for health services?

Secondary Research Goals:

1. To assess the level of satisfaction with health services utilized by the Exit Van female clients.

i. What factors influence the female client's level of satisfaction with health services utilized?

ii. How can service delivery systems be modified to be as comprehensive, accessible and responsive as required?

2. To assess the Exit Van project as a service mode to the street prostitution population.

i. How frequently do the female clients of the Exit Van utilize the services provided by the project?

ii. What health services do the female clients perceive the project provides for them?

iii. Are the female clients of the program satisfied with the services provided to them by the project staff?

iv. Do the female clients of the Exit Van have any suggestions or recommendations for altering the project?

Appendix B

What is your opinion?

Marlies would like to talk with you for about 30 minutes over a coffee about your health concerns and health service needs.

Interviews will start in mid february

Marlies will ask your feelings and opinions about:

- the Exit Van;
- your personal health concerns and;
- how you would like to receive health services.

How will this interview help you?

- it will give you a chance to express your needs and opinions;
- your response will help the Exit Van staff to provide better service;
- what you say may change the health services available.

* Everything you tell Marlies will be **CONFIDENTIAL!**

Appendix C

Consent form

Research Project Title:
Perceived health concerns and health service needs of female street prostitutes in Calgary.

Investigators:
Marlies Van Dijk (MSc. Student), Dr. A. Vollman (Adjunct Professor)

Sponsor:
Department of Community Health Sciences, University of Calgary

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This form is only part of informed consent, or your agreement to be in this study. It should give you an idea of what the study is about and what it will mean to be in it. If you would like to know more about this study please feel free to ask. Please read this carefully.

The purpose of this study is to learn more about the problems and needs related to health and health services that are encountered by female street prostitutes. This will be done through interviews with 15 or 20 women. The interview will take about 20-30 minutes and will be audio-taped with your permission.

Women who are working on the streets as prostitutes will be asked 12 questions about health needs and health service needs. They will be asked to give their opinions.

Being part of an interview is voluntary. Women who are being interviewed will not have to answer anything if they do not want to.

If anything you tell the interviewer means that a person under 18 needs help Marlies Van Dijk shall have to tell this to the Child Welfare authorities.

Being part of an interview will have no effect on your relationship with the Exit Van or on health services received in the future.

Marlies Van Dijk (MSc. student) and her supervisor Dr. A. Vollman, will get information from the interviews. Your answers to the questions will be kept confidential and you will never be identified. A code will be used in place of your name on the transcripts. The audio-tapes will be kept in a locked filing cabinet in the investigators personal office for one year following the successful defense of the thesis. At that time the data will be erased, before the tapes are discarded.

If you initial this form, it means that you understand the information about being in this study and agree to be part of it. Marlies Van Dijk (investigator) will witness your initials on this consent form. This does not change your legal rights or release the researchers, sponsor, or involved institutions from their legal or other responsibilities. You are free to drop out of this study at any time. Ask questions at any time by calling Marlies Van Dijk (220-5330 or 283-7210) or Dr. A. Vollman (220-8053).

If you have any questions about your rights in being in this study, please call the Office of Medical Bioethics, Faculty of Medicine, University of Calgary, at 220-7990.

To be filled out by the participant:

Please write your initials below. Marlies Van Dijk will sign under investigator and then give you a copy of this form.

_____ _____

Participants Initials Date

_____ _____

Investigator Date

Thank you!

Appendix D

Interview Guide

1) How often do you use the Exit Van?

2) What do you use the van for ? (probes)
a. What does it not do for you and you would like it to?

3) How do you feel about the service the Exit Van; provides (probes: positive/negative)

a. What do you like best about the Van?
b. Is there anything you don't like about the Van? (probes: people, resources, hours, place)

4) Do you think the van could do other things to help you? If yes, what? (this question may overlap with question #3 and may be deleted as the interviews are underway).

Health Concern/Health service need

Interviewer will introduce the following sections

5) Do you have personal health problems which are you concerned about? (probes)

a. What are they?

b. How did or do you deal with these concerns?
   i. Person
   ii. Place
   iii. Other

c. Why did you choose to deal with these health concerns in that way?(probes: rephrase the resources utilized)

6) Who (person or service organization) would/do you find most helpful to help you (meet your health concerns/ needs)?

a. What about this someone or something would/do you find most helpful? (probes to define someone or services)

7) What would you do if you had or suspected to have the following health concerns?

Note* i. Person
ii. Place
iii. Other

Sexual reproductive health and lifestyle factors

Pregnancy
Birth Control

Alcohol use
IV drug use
non IV drug use

HIV/AIDS
STDs
Hepatitis B

Stress
Depression/low self esteem

Violence or/and abuse
Sexual attack/rape

8) Have you received health care or help with your general health in the last 12 months?
If yes, can you describe:
a. Where or to whom did you go?
b. Why did you take this route? (may reword)

(above questions revealed awareness of resources/or organizations)

9) Which of these services are you aware of ?

a. Have you used any of these?
b. How did you feel about it? (probes: feeling about the services; positive/negative)
c. Which ones would you not use?
d. Why not?

10) Are there any health services that you can think of that you need but are not available? (probe: if health thought of as too narrow elaborate on same)

a. People
b. Places
c. Other

11) Is there anything that keeps you from getting (help) health (care) services?(probes: location, hours, people, circumstance, or work schedule)

12) Describe to me the ideal person or place which you would feel comfortable getting health services?

Probes:
a. What kind of services would it provide?
b. Where would it be located and why?
c.. What hours of operation do you suggest would meet your needs?

13)

Children? # _____, ages _____ Expecting? EDC _____
Age (<18, 19-30, >30): ____ Living alone/or with others _____
Gender: ____ Race: ____

Education level completed (<grade 9, gr. 10-12, >grade 12): _____
How old were you when you started working on the streets? ___.
Avg. days of the week you work ____ /7

Appendix E

Interview Excerpt

10: They are not judgemental.

09: They don't look down on you, they worry about you, even if they don't know you, they are there to help, I don't know. They are not judgemental at all. They respect you, when you don't respect yourself. If you have a bad night, they make you laugh. It boosts your self esteem a little bit. Just a little.

R: What do you think about your self-esteem?

09: Very low...

10: Non-existent..

09: Yeah, exactly...

R: Why do you say that?

09: Being a prostitute... it boosts it down.

10: Some days you can't even look at yourself.

09: Yeah and family and shit.

10: You really think that other people think of you like that.

09: Because you have sex just like that, and it is that way, so if you think that way than you really don't care for yourself.

R: How do you think that it changes you, you said something about how people look at you differently.

10: You think that because you look at yourself in a certain way, that everybody looks at you that way. I mean I don't want anybody to see me

the way that I look at myself. you know...

R: How do you look at yourself?

10 and 09: Nasty, alcoholic, drug addicts two bit hoes (synchrony) [laughs].

10: We figured this out the other night.

09: That explains how we feel about ourselves. That is how I feel about myself.

R: Do you feel that way only when you are working?

10: Even when I am not.

09: Even when I am not.

R: You guys look very confident to me anyways.

10: [laughs] It comes with practice, once you do it for a while.

09: It is also degrading when people recognize you... you know I am out there I can't go out there stoned. Because of the fact that you get these guys you know who sit there and go yeah baby you like my dick. Inside of me you think I don't like being treated like this. You don't feel like much and people look at you and seen nothing but a hoe.

10: When you go back after, back to your boyfriend, you don't even want to have sex with him.

09: They say well your nothing good but for sex, well look what kind of job you guys are doing. Then you go back to your boyfriend, I don't know, it interferes with your relationship, your love life. You know, I can't go home after and sleep with my boyfriend. It's not that easy, maybe if I was all fucked up with junk you know.

R: Do you think that your self esteem has anything to do with what you are doing right now?

10: Oh, yeah...definitely... cause I know that I quit for a while and I feel sooo good about myself.

09: I quit for 2 years and I felt the best about my self esteem.

10: The reason we go back is that; well that is all that I am good at.

09: And the money... what is also really degrading for me is for someone to come up to me, I don't like it if people meet me as a hoe. I would like people to meet me as me, before theyfind out about what I am. There are people who come up to you and want this and that. You know what I mean, you bust your ass out there.

10: Yet, at the same time your trying to provide people with what they need so that they don't have to be out there.

R: Right. How old are you [09] --16 -- [10] -- 18. You have talked about what you can do for other people, how do you feel about that.

10: It makes it a little easier to deal with, cause you not just doing it for yourself. You know when I was doing it for my coke it made me feel like shit. When I am doing it for other people, it makes it a little easier. Cause your hey, not just snorting it up your nose. I am doing it to help other people. It may be an excuse, but it makes you

Appendix F

Coding scheme

1) Personal Health Concerns: Larger category under which participants directly or indirectly spoke of health issues or worries which affects(ed) them and their lifestyle.

[under personal health concerns]

Sexual Reproductive Health Concerns Personal health issues which pertain to the sexual reproductive system of the participants.

Self identified — Identified by the participant without the researcher prompting.

Researcher prompted — Acknowledged after identification by the researcher

Categories under sexual reproductive concerns:
STDs/AIDS (often identified together or as one category)
Pregnancy
Birthcontrol

Example: [question about health concerns] AIDS, AIDS, syphilis, gonorrhea.... crabs. I understand that crabs is going around here really bad [self identified/sexual reprod./STDs/AIDS].

Lifestyle factors Health Issues which participants encounter in their culture.

Categories under lifestyle factors:
Mental Health
Substance Abuse
Violence/Sexual Assault

Example: R: What about things like stress... 06: I am stressed out all the time...[researcher prompted/lifestyle factor/mental health].

Perceived risk behavior in relation to health concerns identified

Participants perceived risk behavior in relation to work or personal life (outside work).

Categories under risk behavior:
Commercial
Non-commercial
either/both

Example: 03: I am very very very safe, I always use double condoms... R: Do you think that there is any danger in your personal life? 03: Ummmm, no, no.... Not really no.... [Perceived risk behavior/commercial].

Reported Behaviors/Reported Knowledge

Participants activities related to health and understanding of health issues.

Example: I use condoms, and if the guy doesn't like to then you don't go with him. I usually ask before I get into a car.

Strategies in coping with health concerns

The way participants choose to manage/handle identified health concerns, other than accessing health services.

Categories under strategies:
Substances (drugs, alcohol)
Extended support (includes peers, friends and family)
Insider (support from a person who is or was living in the street culture)
Self (coping with health concerns without others)

Example: No, I usually wouldn't cause I write a diary. And I just started doing it again since I came back, and I write in it every night how I felt about the day [category: self].

Example: The nights that I go out and work, I get high after. Otherwise I'll just sit there and think about it all night [category: substances].

Factors which affect health

Influences in participants lives which play a part in increasing or decreasing their healthy behaviors.

Categories under influencing factors:
Extended (Peers, friends, or family)
Self
Experiences (past events which influence)

Example: [participant]: I never ever shared or used the same ones twice. She throws them away if she catches them on me. [peer]: yeah if I find them on her I throw them out. [participant]: she can tell when I am stressed out I use them [Facors influences: extendedl].

Example: It would have to be a friend from downtown to get me off the dope, someone who has known me for more than 5 years [Factors influences: extended].

Perceived control over health status

Participants perception of the degree of control they have over their health status (including prevention issues).

Categories under perceived control:
internal (participant feels that they have a role to play in their health status)
external (participant expresses a sense of hopelessness or inability to influence health)

Example: I think that if I was working out at a regular basis I would be more health. But I eat good food at home and stuff, I am pretty healthy [perceived control: internal].

Example: I don't worry about that, if you get is.. you get is. If it happens it happens, shit happens and you deal with it then, otherwise you are going to get an ulcer [perceived control: external].

Role when others in need

Participants role when a peer, friend or family member is in "trouble" or requires help (including health related issues).

Categories under role:
Advisory (minimal involvement)
Friend/support

Example: And all I can say is... I don't turn my friends away just because they fucked up. I'm their friend, and that's it. Same as raising a child, it is unconditional love [role; friend/support].

Overall Health Beliefs

Opinions or feeling expressed by the participants which relates to health in general (or personal health concerns).

Categories under Overall Health Beliefs:
Personal Health Concerns (illness/health, high risk behavior, self image)
Public awareness/knowledge
Culture (in relation to the street world, including street rules)

Example: I can admit that I have a problem but I am not really concerned about it right now. I have a really hard time quitting, because I like being high, it is a great feeling. You can do whatever you want and no one care [Personal Health Concern].

Example: It really pisses me off. It just doesn't happen that way. I just wish that, even after we have been exposed to AIDS so long, our society still thinks that way [Public awareness/knowledge].

Example: R: Do you call the cops? 15: Depends. If it's at home no, but if it's at work yeah [Culture].

History which relates to personal health concerns

Historical experiences (does not include use of health services) by the participants which pertain to health concerns.

Categories under history:
Events/situations

Example: R: What if you got raped? 10: I'd be like I just want to cure this, like 9 months ago, my ex fiance (tears in eyes) [events/situations].

Example: The second time was this summer, and I wanted the baby but I think that subconsciously I didn't because I did things that I shouldn't have [events, situations].

Example: I quit doing heroin a year and a half ago for good [events, situation].

2) Valued Health Services

Those components of health services which the participant appreciates or cherishes and will access if available.

Categories under Valued Health Services:

Human service provider	Person working with an organization which influences the health of participant (including police).
Attributes	Resourceful Rapport (interaction, attitude)
Services Issues	Medical Services, counselling services.

Accomodating/accessible
Resourceful
Anonymity/confidentialit

Factors/recommendations — Leisure, Peer interaction and Get-away

Example: Yeah, I like friendly people [Professional; Rapport]

Example: R: If you could think of a place which could help you what would it look. like? 09: Have you ever seen that show with the ranch for the street kids? It's a ranch in the middle of nowhere. I have always dreamed of a place like the one in neon rider [Services/factors].

Example: A centrally located place for everybody, where you could just walk in and I know it sounds rude but on a 24 hour basis. A place where you can sit down, have coffee, and restrooms, and counselling [Services/accomodating/ Accessible/ resourceful/factors].

3) Patterns of Health Care Utilization — The type of health facilities participants access, frequency and the motive for seeking services.

Categories under Patterns of Health Care Utilization:
Concern sexual/reproductive, lifestyle or miscellaneous such as colds
etc...

Source — Professionals (health related fields)- doctors, nurses, including police officers.

Walk-in clinic;

Downtown service agencies - these agencies include the prostitution mandated or general health mandated;

	Hospital - which includes emergency rooms.
Frequency	Yearly, every 6 months, or more than every 6 months
Motives	Reason for seeking health services

Example: [question around HIV] I'd go to the STD clinic, because you can walk in and boom get tested right then and there [concern: sexual/reproductive; source: walk-in clinic].

Example: No, I usually see CUPS only because I met them first. And they just drive up and hand you safes and drive away [motives].

Example: R: Who introduced you to these AA meetings? 11: A friend of mine, realized that I had a problem and needed help [motives]. (this example also falls under strategies for coping, which is a category under Personal Health Concerns)

4) Barriers to access and utilization — Factors which prevent participants from using health services.

Example: [question around treatment centre] I just haven't made it there yet cause I was living in a foster home and I had a child and a robbery charge, and I chickened out, they said that I wasn't going to get jail time but I thought that they still would [Barriers].

5) Level of satisfaction with health services — Factors influencing the participants satisfaction level with health services *used.*

Categories under Level of Satisfaction:

Human service providers	Person working with an organization which influences the health of participant (including police).

Attributes	Resourceful Rapport (interaction, attitude)
Services	Services which affect the health of participants. Accomodating/accessible Anonymity/privacy Resourceful
History	Participants experiences in the past (events/situations) with health services.

Example: Yeah, except they are really religiously orientated, and I didn't like that. When I first moved here I told her how many partners I had, how with my partners I never used a condom. She completely shunned me [health professional; rapport].

Example: Women for Sobriety; you walk in and the up beat sort of thing. They start things on a positive note. You say "Hi, I am Darlene and I am a confident woman" [services; resourceful].

6) Evaluation of the Exit van — Self explanatory (see coding scheme)

7) Miscellaneous

Categories under Miscellaneous:

Beliefs	Participants beliefs about issues which are not related to research questions.
Relationships	Participants discuss relationships (present or past) which includes friendship and family relations.

Example: Every person I meet, they say, you don't act 15. Maybe that is part of the reason that I don't get along with kids my own age [miscellaneous; beliefs].

Example: My mom gained, she was 105 pounds and she went up to 200 pounds, but she retained a lot of water [miscellaneous; beliefs]

Example: I wouldn't let another man touch me again that is why I am getting out of my marraige. If any man feels that he has control over you and feel that he can hit you then he has a problem and he should get looked after. If he says oh, I love you... you are fooling yourself.

8) Demographics

Demographics of participants are often discussed throughout the interview.

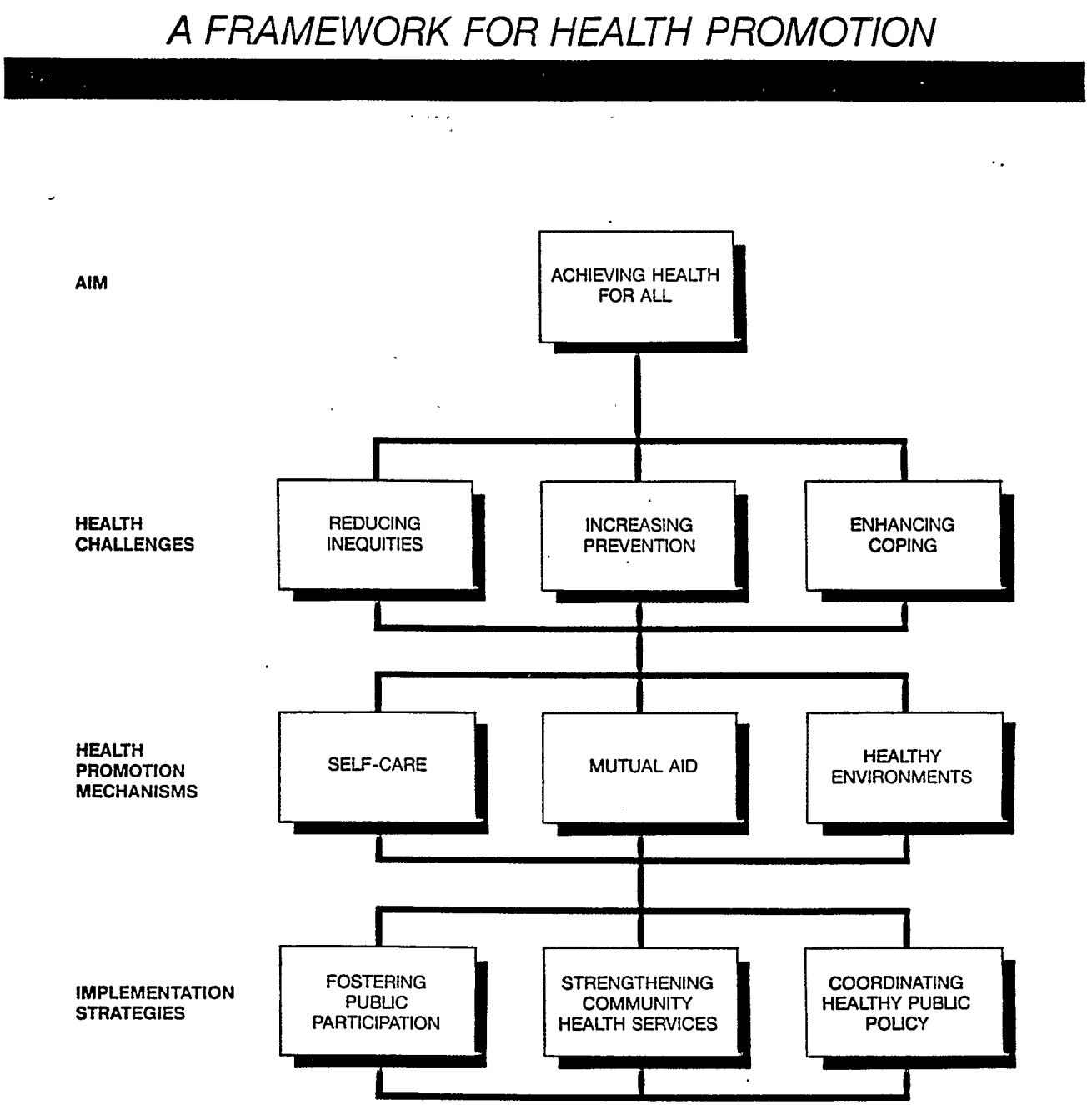
Appendix G

Steps Taken in Data Analysis

1. Memoing following each interview and reflection on interview in relation to previous interviews.
2. Interviews transcribed verbatim from audio tapes.
3. Codes were created using a start list.
4. Start list was developed from the research questions, hypotheses, problem areas, and key variables.
5. Start list consisted of 30 codes (with subcodes adding to nearly 70);both descriptive and interpretive.
6. This start list was revised; collapsing codes, deleted codes etc. and continued to change over time that further interviews were coded.
7. "Codes" were applied to "chunks" of data.
8. Initial review the codes were mostly "descriptive" with some "interpretive"
9. As themes and recurrences among informants became evident; certain codes became more interpretive.
10. Simultaneous to pattern coding a peer reviewed a transcript with the start list (check-coding)
11. Following peer review some alterations were made but attained consensus for the most part.
12. Pattern coding: recurrences in data; relationships among people; causes and explanations; categories were identified the study's main research questions, and were systematically related to the other categories.
13. Data accounting sheet tallied up the research questions which were addressed, or not addressed.
- Was the questions asked by the researcher?
- Was the question not answered by the participant? if not, why not?
- Was the missing data an issue for this participant?
- Was the question answered indirectly at a different stage of the interview?
- Were there other reasons such as environment or other situations which affected the data collection?
13. Second peer review; pattern coding (themes) to pick out premature analytic closure or other observations.
14. Throughout this process of coding and peer review the researcher used analytic memos to herself throughout the process to help with the generation of themes and linkages.
15. As the results were written up the researcher collapsed certain codes.
16. The writing stage allowed for more interpretive analysis of what differences exist within the three trade groups and why they exist (pertaining to all research questions).

17. While between trade group comparison occurred it became obvious that for certain research questions (codes) the data could be combined for the three trade groups (valued health services and Exit van evaluation).
18. The discussion chapter also alludes to these possible hypotheses and questions for future research.

Appendix H


A FRAMEWORK FOR HEALTH PROMOTION
AIM
ACHIEVING HEALTH FOR ALL
HEALTH CHALLENGES
REDUCING INEQUITIES
INCREASING PREVENTION
ENHANCING COPING
HEALTH PROMOTION MECHANISMS
SELF-CARE
MUTUAL AID
HEALTHY ENVIRONMENTS
IMPLEMENTATION STRATEGIES
FOSTERING PUBLIC PARTICIPATION
STRENGTHENING COMMUNITY HEALTH SERVICES
COORDINATING HEALTHY PUBLIC POLICY