

**The Health and Wellbeing of Female Street
Sex Workers**

Nalishebo Kay Gaskell Elliott

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Abstract

Previous research on female street sex workers (FSSWs) has primarily concentrated on the stigmatisation of women's involvement in the sex industry particularly with reference to the spread of HIV/AIDS. The response of the criminal justice system to the regulation of the illegal aspects of women's engagement in street sex work has also been criticised. However, the impact of street sex work on the health and wellbeing of these women requires further research.

The aim of this study was to explore the perceptions and needs of female street sex workers in relation to their own health and wellbeing. The study used a qualitative mixed methods approach that included analysis of three sets of data: visual data, secondary data and primary data. There were 10 FSSWs recruited for the primary data sample.

The epistemological position underpinning this study is social constructivism and a feminist paradigm has informed the conduct of the research process and data analysis. The theoretical application of Bourdieu's framework of habitus, capital and field has provided the lens through which to explore the socially constructed experiences of FSSWs health and wellbeing.

Findings from this study revealed that FSSWs experienced poor physical, mental and social health and wellbeing. They faced limited life choices and often felt discriminated against by the agencies and institutions that should have offered support. The women spoke of their personal histories especially traumatic life events in childhood consisting of sexual abuse, neglect, loss, rejection as well as intimate partner violence in adult life. The loss of their children to social services, housing difficulties and addiction to alcohol and crack cocaine were also significant in contributing to social exclusion and their multiple positions of vulnerability.

This study contributes to the body of work on women's health and wellbeing. In particular, it adds to our understanding of the lived experiences of women

involved in street sex work. A key public health priority should be the development of policies and systems to provide quality services to support the health, safety and wellbeing of FSSWs.

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List of Acronyms

This research study has used the following acronyms.

Acronym	Definition
ASBOs.....	Anti-Social Behaviour Orders
BSA.....	British Sociological Association
CRIPACC.....	Centre for Research in Primary and Community Care
DOH.....	Department of Health
DHRes.....	Doctorate in Health Research
FSSW.....	Female Street Sex Worker
HIV.....	Human immunodeficiency virus
NMSCC.....	Nursing, Midwifery, Social Work, Criminal Justice and Counselling Ethics Committee
STI.....	Sexually transmitted infection
STD.....	Sexually transmitted disease
WHO.....	World Health Organization

Chapter 1 – Introducing the Research

1.0 Introduction

The co-founder of anti-human trafficking campaign A21 Christine Caine gave a presentation at a women's empowerment conference I attended in 2007. A21 is a non-profit organisation that exists to abolish modern day slavery in the 21st century. During the presentation, Caine gave many narrative examples of schoolchildren lured from their homes in Eastern Europe, South East Asia and African countries and forced into sexual slavery.

After hearing about the sexual abuse, shame and emotional pain these children now adults experienced at the hands of the traffickers and men they serviced, I began to think about the short and long-term health and wellbeing ramifications these experiences had on the women trapped as sexual slaves. This raised questions about the vulnerability of young girls and the need for protection against harm. It also raised questions about their empowerment and rehabilitation after the trauma they had experienced.

Literature shows that sex trafficking is a global phenomenon. In order for me to establish a research question, it was incumbent on me to narrow the research problem to an achievable topic from the outset. Another consideration was that exploring a research question on sex trafficking had the potential to put my safety at risk and could jeopardise my ability to gain ethics approval from the University.

There was also an assumption that regulating the sex industry leads to better health and wellbeing. However, literature on the topic shows there was a gap in current discussions. This literature gap was identified in a consultation paper called *Paying the Price* published by the UK Home Office and based on the Sexual Offences Act (2003). In this paper, sex work is perceived as 'a threat to public health, public order, decency, the formal economy, the integrity of borders, and women's rights. Responses pertaining to the subject range from repression, especially of sex workers, to criminalisation and

discrimination' (Ward & Day, 2006: 413). This example of sex work policy 'fosters misinformation about the sex industry and workers' health needs' (Day & Ward, 2007: 187).

From this gap in British policy, the research question aims at exploring the health and wellbeing of women engaged in street sex work. The objectives were established in order to explain the context of female street sex workers' (FSSWs) lived experience in relation to their health and wellbeing and to explore how government policy has failed to engage with the health needs of these women.

This chapter will begin with a background context to the research focus from the literature before presenting the theoretical framework that underpinned it. In the previous paragraphs, the justification for undertaking the research will continue in the following sections followed by the overall research question, aim, associated objectives, and an outline of the chapters.

1.1 Background Context

Scambler and Scambler (1997: 11) state that a cliché frequently used to introduce discussions of 'prostitution' claims it as one of the oldest of professions (Basserman, 1967) and the subject of many discussions in feminist theory. Some feminist perspectives provided in the literature regard this type of work as 'the absolute embodiment of male privilege' (Kesler, 2002: 19). Other postmodern work considers human rights and repressive legislation in the UK linked to dominant forms of ideological perspectives evident in the Contagious Disease Act, which constructs women's bodies in sex work as a 'site of moral and medical degeneracy' (Scoular, 2004: 350).

The stereotyping of sex workers in relation to the 'whore stigma' (Pheterson, 1993) has also been an overdue debate seen to further 'dehumanise women in the sex industry and make them more vulnerable' (Day & Ward, 2007: 187). Day et al. (2007) report that the murders of five young women in Ipswich involved in street prostitution 'created a media controversy over whether

labelling them as “prostitutes” was dehumanising, as well as raising questions about our duty to protect such women’ (p.187). Therefore, in a bid to redefine commercial sex as a form of employment for women to move away from the stigma associated with the term ‘prostitute’ (Bindman and Doezema, 1997), those involved in the trade coined the term ‘sex worker’. The term ‘prostitute’ will henceforth not be used in this research study unless in a direct quote.

Spice (2007: 322) reveals ‘the pathways that lead people into commercial sex work are varied’. Clark and Squires (2005) describe how, ‘at one end of the spectrum are those who work autonomously, undertake sex work by choice to improve their economic circumstances and are independent with respect to their sexual health and accessing of services’. On the other hand, there are ‘those women driven into commercial sex work through drug addiction or coercion and who have little autonomy’ (Spice, 2007: 322). Maggie O’Neill cited in Scambler et al. (1997: 5) identifies that in contemporary UK society, women involved in sex work are ‘perceived as immoral, a danger, a threat to “normal” femininity and as a consequence, suffer social exclusion, marginalisation and ‘whore stigma’.

In this study, FSSWs are the group likely to have the greatest health needs (Costello, 2003). Jeal and Salisbury (2004) also suggest that street-based sex workers tend to experience very low standards of health and frequently experience violence at the hands of their clients (Church et al., 2001). May, Harocopos and Turnbull (2001: 28) recognise that while street sex workers are ‘dependent on drugs, treatment services are often not tailored to their needs’ and they ‘may often not access services because of fear of discrimination if they reveal details of their lifestyle’ (Pitcher et al., 2003: 3). Drug dependency can also keep women working in the sex industry and can increase their vulnerability to exploitation (May et al., 2001: 1).

Moreover, by reviewing previous studies on street sex work, the focus has widely been on work-related issues and sexual health rather than on the ‘wider health of these women and how their needs relate to their service use or health seeking behaviour’ (Jeal and Salisbury, 2007: 879). For instance,

many of the studies concerning the health of sex workers 'focus on risks associated with transmittable infectious diseases like human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS)' (Rossler et al., 2010: 2) but their general health seems to be a neglected area.

What has often been missing in earlier research is a narrative account from the very women who are working in the field of street work. As a result, the important question that required research was an in-depth understanding of what women involved in street sex work said about their personal experiences in relation to health and wellbeing. Thus, the main purpose of this research is to explore the accounts of FSSWs lived experience in sex work on the perspectives of their health needs. Keeping this principal research purpose in mind, this research attempts to answer the following question:

What is the lived experience of female street sex workers in relation to their own health and wellbeing?

The aim is to explore what the perceptions and needs are of FSSWs in relation to their own health and wellbeing. The key objectives identified to address this research question included the following:

1. To examine the key health and wellbeing needs of FSSWs.
2. To identify their experiences of health services and agencies in addressing their health needs.
3. To investigate how FSSWs construct their experiences and understandings of health needs.

Having now provided a background context concerning the argument for this research study and the associated research question, aim and objectives, the following section will explore the concept of health and wellbeing. A particular focus will be whether this definition is applicable to the lived experience of FSSWs.

1.2 Health and Wellbeing as a Concept

The World Health Organization (WHO, 1948) defined health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'. Although this definition of health has been criticised for being too utopian and unachievable (Nutbeam, 1986; Sax, 1990), it nonetheless provides a definition of health that goes beyond the biomedical model. The biomedical model of health assumes a mind/body dichotomy. It does not place much emphasis on how an individual's mental health might affect physical health status, which is an important consideration for this study. Day (2007) notes that a range of mental health problems have been reported by sex workers including depression, stress, panic attacks, insomnia, eating disorders and manic depression.

In this study, the WHO definition of health (1948) will be the chosen vision for a reflection on what is a positive picture of health and wellbeing. This is because it offers a holistic view on health beyond the one that focuses on the biomedical model of just disease prevention. Although the definition of a state of wellbeing has proved difficult to accurately define and measure, government bodies are increasingly recognising that good health, safety and wellbeing are key components of a successful business. These bodies are also considering that poor workforce health has a high cost. The next paragraph will elaborate on the consideration given by government reports to improve the health and wellbeing of the workforce in the United Kingdom (UK).

The UK National Health Service (NHS) and the Department of Health (DH) have recognised the need to support and improve the health and wellbeing of the national workforce. Both bodies developed an interim report commissioned following Dame Carol Black's report on the health and wellbeing of the working age population, *Working for a Healthier Tomorrow* (2008); together with Lord Darzi's report *High Quality Care for All* (2008) and the Department of Health report *A High Quality Workforce* (2008). *The NHS*

Constitution (2009) also acknowledges the role the NHS plays in supporting the mental and physical health and wellbeing of UK citizens.

Similarly, the Wanless report (2004) identifies many factors that influence health and wellbeing including past and present behaviour, healthcare provision and 'wider determinants', such as social, cultural and environmental factors. Whilst this is relevant to consider, also applying a theoretical framework to the conduct of health-related empirical research is necessary to optimise understanding in revealing perspectives on health and wellbeing. The next section identifies the theoretical approach selected to facilitate the discussion of this study.

1.3 Theoretical Framework

In order to assist in generating new knowledge on the health needs of FSSWs, Bourdieu's (1930-2002) framework suggests an approach where the social structure's that exist in society that help shape the experiences of individual agency can be reconciled. Bourdieu recognises three key concepts to explore this relationship and they include habitus, field and capital. The interlocking of these three main key concepts is significant in understanding the socio-economic processes and structures that have an influence on the health and wellbeing of women involved in street sex work. The term 'structure' comprises a system of dispositions, which generate perceptions, appreciations and practises (Bourdieu, 1990: 53).

Grenfell (2014: 50) demonstrates that the 'structuring' concept refers to one's habitus (thoughts, feelings, actions) meaning the lived experience of FSSWs, which help shape, one's present and future practices. Therefore, the three concepts are significant in a framework because they operate in relationship. For instance, 'one's practice results from relations between one's dispositions (habitus) and one's position in a field (capital), within the current state of play of that social arena (field)' (Grenfell, 2012: 50). For the women recruited in this study, their field is the street and the Women's Centre.

While Bourdieu's key concepts are applicable to understanding the complexities of women's lives in street sex work, a methodological approach, which draws on qualitative insights from different methods to produce a rich account of women's experiences in sex work, is necessary. The following section introduces the choice of methods applied to this study.

1.4 Methodological Approach

The research methodology selected was a mixed methods qualitative design consisting of a combination of different qualitative methods. These include sex calling cards, archived oral life histories and in-depth interviews. Applying a mixed methods strategy can reveal multi-faceted social phenomena. 'The argument is that different methods and approaches have distinctive strengths and potential, which, if allowed to flourish, can help us to understand multi-dimensionality and social complexity' (Mason, 2009: 9).

The epistemological position underpinning this study is social constructivism where meaning derives from knowledge generated through the social context within which social interactions and social processes occur (Gergen, 1995). Subsequent analysis of the data was informed by a feminist paradigm, which helped shape my research process in order to see and understand the social world from the vantage points of women (Winkler, 2010). The next section provides an outline and summary of the chapters to be included in this study.

1.5 Thesis Overview

There are six chapters in my thesis, which include references and an appendices section. The following paragraphs illustrate the main chapters embodied in this study in accordance with the research process. Chapter 1 has introduced the background context and the research problem this study is concerned with followed by the research question, aim and objectives.

Chapter 2 is a critical review of the literature on sex work and provides the background to the development of the research question. In this chapter, it will be evident that research is lacking on the wider health status of FSSWs. A review of current UK government policy also reveals that little is known about the health needs of women engaged in street sex work and that they are not identified as a high priority group. This is evident in the *Tackling Health Inequalities Review 2002* and the *Sexual Health and HIV Strategy report 2002*. The theoretical underpinnings identified in the literature review chapter that have informed this thesis include a feminist research ethic (Ackerly et al., 2010) and a Bourdieu-based theoretical framework.

Chapter 3 provides a detailed description of the methodological approach and methods chosen for this qualitative research study. The study consists of three phases in accordance with three data sets. The research design incorporates a mixed methods approach and a detailed account of the data collection and recruitment process. This chapter also discussed the ethical challenges of undertaking research with FSSWs.

Chapter 4 presents the findings from the visual and secondary data consisting of the visual representation of women in sex work and account of three women in sex work's life histories from the late 1990s. The aim of this chapter is to orientate me to the field in preparation for my FSSW participants.

Chapter 5 reveals the views and experiences of 10 contemporary FSSWs through an in-depth account of their lived experience in street sex work in relation to their own health and wellbeing. A feminist paradigm drawing on the work of Ackerly and True (2006), O'Neill (2001), Marshall (2000) and Haraway (1991) provided fundamental insights to understanding the intersections of gendered hierarchies with forms of power and oppression. Another key feature of a feminist approach represented in this chapter is my commitment to exploring and listening to the struggles and experiences of women's lives as sources of knowledge, particularly by privileging the interview accounts (Eschle and Manguashca, 2007: 288).

Chapter 6 focuses on a critical discussion of the findings using a Bourdieu-based approach as the theoretical framework to explore the health inequalities and perceptions that influence the health and wellbeing of FSSWs. Thoughts on best practice for improving health service provision are included in this chapter. A feminist paradigm and a social constructivist approach ensured that women's involvement in street sex work shared meaning through understanding the socioeconomic and political contexts of women's experiences in the sex industry.

The chapter concluded by considering the contribution of my research to knowledge. The limitations and recommendations are also addressed here which specifically focus on the basic health care needs highlighted by the findings in this study. The next section examines the literature on sex work policy and health information in relation to women in the sex industry in order to provide a critical account of the research study under investigation.

Chapter 2 – Literature Review

2.0 Introduction

‘Sex work is the provision of sexual services for money or its equivalent’ (Harcourt and Donovan, 2005: 201) and ‘regarded as a private transaction between two consenting adults’ (Pitcher et al. 2006: 3). While sex work is not illegal in Britain, there are other aspects of the law that seek to regulate and ‘limit certain undesirable effects’ on society (Matthews and O’Neill, 2002: 17). At a national policy level, it is evident that street sex work has been viewed as a problem of public disorder, requiring strict enforcement laws and crack down measures to regulate sex workers, as opposed to protecting and supporting their position of vulnerability on the street.

Research shows street sex workers experience high levels of violence and robbery perpetuated by clients, passers-by, ‘pimps’ or managers and on occasion, local residents who object to the selling of sex in their neighbourhoods (McKeganey and Barnard, 1996; Phoenix, 2002; Hester and Westmarland, 2004). The prevalence of crack cocaine in street drug markets has also led to increased risk-taking and extended working hours for street sex workers, increasing their exposure to violence (May et al. 1999, 2001; Becker and Dufy, 2002). The next sub section explains the literature selection for my study.

2.1.1 Literature Search Strategy

I commenced my literature search in 2011 and the date range of academic material searched spanned from 1992 to 2016. The ‘Oral History of Prostitution’ archive, located at the British Library formed my secondary dataset, hence I commenced the literature search from the 1990’s.

The literature searched initially focused on adult female sex workers and then refined to focus on the health and wellbeing of female street sex workers. My study population was female street sex workers (FSSWs) only. Aspects that

were related to, but outside of the scope of the study and therefore excluded from the search strategy were as follows:

- Male sex workers
- Transvestites
- Legalising sex work
- Decriminalisation of sex work

The search engines used for the literature search included: PubMed, which interfaced with Medline records to provide specific peer-reviewed health literature. I also accessed the CINAHL database that provided nursing and allied health literature. Science Direct and Google Scholar offered a broad range of literature across many sources such as books and articles. Electronic journals sourced through these databases and included articles in the Sociology of Health and Illness journal, the British Medical journal and The Lancet. I also hand-searched for references at the end of some particularly pertinent journal papers and research reports.

Google Scholar also provided access to Government websites for evidence-based research reports and policy documents such as from the Department of Health (DH) as well as well-renowned international organisations: the World Health Organization (WHO), the United Nations Programme on HIV/AIDS (UNAIDS) and the United States AID agency (USAID) that provides humanitarian support to foreign countries.

I then extended my search to explore the historical and cultural contexts of sex work in the UK in order to gain some background knowledge on the general policy perceptions of sex work. The search did not include the legality of sex work or the argument for decriminalisation of sex work but instead focused on the history of sex work legislation in the UK.

I broke the topics down further and searched for literature relating to the physical, mental and social health and wellbeing of women in the sex industry. It was evident at this point in my search that FSSWs belong to a group of

'marginalised women often excluded from the educational, social and employment settings that would enable them to progress further in life' (Cornish, Ghosh & Shukla, 2010: 234). In light of these concerns, it was apparent that there were gaps in the literature and the role of health services in prioritising the health and wellbeing of FSSWs.

The following keywords formed the next phase of the literature search:

- Women and prostitution
- Women's sexuality and sex work
- Female sex workers and stigma
- Whore stigma
- UK sex work policy
- Feminism and sex work
- Health and wellbeing of female sex workers
- Alcohol, Drug use and female sex work
- Sexually transmitted diseases and sex work
- HIV and sex work
- Indoor sex work and outdoor sex work
- The lived experience of female street sex workers in the UK
- Health needs of female street sex workers in the UK
- Physical, mental and social health of female street sex workers in the UK
- Female street sex workers experience of violence and trauma
- Female street sex workers access to healthcare

The literature review presented sets out to firstly, explore the historical context of sex work and health in Britain followed by a review of the criminal justice policy in relation to health. The aim is to provide a background context to the perceptions of sex workers, the impact the regulatory framework has or potentially could have on these women, and their health needs.

This then leads into an introduction outlining the different types of sex work that will shape the research problem this thesis is concerned with in relation to

understanding the health and wellbeing of FSSWs. Also included is a review of empirical studies to explore how the health of female sex workers has been conceptualised and addressed in existing health research studies. Health considerations are viewed through an identifiable framework of health that is relevant to the health needs of women in the sex industry.

The second half of this chapter examines feminist perspectives on female sexuality and women's position in the sex industry. This chapter will not seek to engage in the debate relating to the legalisation or decriminalisation of sex work, neither will this study make any stance for or against a woman's choice to engage in sex work, as this is a contested space in the feminist literature.

In the last part of the literature review, key concepts from a Bourdieu-based theoretical framework are explored to guide an understanding of FSSWs lived experience. The next section conducts a critical exploration of the historical context of sex work and health.

2.2 Historical Context of Sex Work and Health

From both a historical and cultural context, the social construction of women involved in sex work has emphasised the 'whore' image, which has created a negative stereotype. This stereotype portrays sex workers as failed examples of womanhood, defined by immoral sexual behaviours and shunned by mainstream society (Pheterson, 1993). In ancient history, sex workers were highly regarded as temple goddesses worshipped as deities and not just considered immoral women. One of the earliest known deities was Inanna, a female sex worker from Mesopotamia (Bassermann, 1993). Intolerant attitudes towards women in sex work emerged around 1200 BC and were located in Judio-Christian traditions (Sanders, O'Neill and Pitcher, 2009: 2, Esler, 1995).

There has long been a discourse within Christianity of saving the 'fallen woman' and restoring her to purity. For example, 'whores' became 'bad-girls' with the growth of Christianity and later of Protestantism, which contrasted the

ideal of a good wife and mother with the sex workers as bad-girls and sinners (Mazo-Karras, 1989; Roberts, 1992, Kishtainy, 1982). Here, concern was less about the health of the sex worker and more about ensuring the protection and isolation of 'morally bad' women from respectable communities. This consequently led to sex workers being categorised as an outcast group and ostracised from the realms of respectable society.

Alain Corbin's analysis of commercial sex in nineteenth-century France (Corbin, 1990) describes how the interrelated discourses of municipal authorities, hygienists, the police and the judiciary combined to organise the regulation of sex work around three major issues. These were the need to protect the nation's health, the need to protect male prosperity and the need to protect public morality. Again within this context there seems to be little or no concern expressed for the health needs of sex workers but instead an increased focus on thinking about sex work as a social problem, to use Hubbard's words 'polluting the moral order of the community' (Hubbard, 1999: 164).

For Corbin, these three major issues are rooted in five key images of the 'prostitute' who is viewed as:

- the *putain* 'whose body smells bad' (Corbin, 1990: 210);
- the safety valve which 'enables the social body to excrete the excess of seminal fluid that causes her stench and rots her' (Corbin, 1990: 211);
- decay, symbolically associated with the corpse and/or with death;
- disease, symbolically associated with syphilis;
- the submissive female body 'bound to the instinctive physical needs of upper class males' (1990: 213).

Corbin (1990) describes these five key images to reinforce the image of the female body as 'rotten'. These discourses led to a series of principles that structured the regulation of sex work: 'the principle of tolerance, the principle of containment, and the principle of surveillance' (O'Neill, 2001: 131). Zajdow (1992: 177) persists with this frame of thought in mind that with the intention of enforcing compulsory health checks on female sex workers, 'how does

society go about distinguishing a working woman from others without resorting to the extremes of locking her up or indelibly painting the colour red on her face?’ Consequently, both the role of the state and wider society put sex workers under surveillance in one-way or another (Bullough & Bullough, 1987; Ringdal, 1997).

This dominance of surveillance as a concept has the potential to regulate FSSWs or even to marginalise them further. Pitcher et al.’s (2006) study on ‘living and working in areas of street sex work’ identified how community policing of street sex workers has the effect of increasing the surveillance of these women on the streets through ‘lay involvement in patrolling and collecting evidence for Anti-Social Behaviour Orders (ASBOs)’ (p. 24). The view of street sex work is that it is a problem of public disorder where sex workers are served with Anti-Social Behaviour Orders (ASBOs), injunctions or Criminal Anti-Social Behaviour Orders (CRASBOs). The ramifications of these police enforcement measures further increases women’s vulnerability by restricting them to just one geographical location, which limits their access to support services.

The next section explores the UK policy position on sex workers. A review of the criminal justice and health policies in the UK will demonstrate the repressive nature of the current social policy. Social policy relates to the sets of arrangements and structures linked with state policies, ranging from economic policy to specific areas such as crime control (Bunton & Gordon, 2002: 132).

2.3 Criminal Justice Policy and Health

In 2004, the UK Home Office published *Paying the Price*, a consultation paper on commercial sex in the UK, following a review of the Sexual Offences Act (2003). This paper received much criticism about its failure to address the health and human rights of sex workers (Laite, 2006; Boynton & Cusick, 2006; Robinson, 2007; Phoenix, 2007). Instead, it focussed on penalising both sex workers and their clients. The document emphasises a ‘one-size-fits-all’

framework with a criminal justice or nuisance approach. A nuisance approach to legislation concerning sex workers means legislation focusing on deterring sex workers from engaging in sex work or keeping sex workers out of public spaces (Laite, 2006). While focusing on these other approaches, the consultation paper failed to address the needs of women who choose sex work and thereby did not adequately comprehend their unmet health needs.

The methodological approach used to collect the data for the Home Office paper resulted in questionable findings. Instead of visiting or speaking to sex workers, Home Office researchers only spoke to brothel receptionists via telephone (Lipsett, 2008). The methodology, although convenient, is arguably significantly unreliable because it does not recognise the differences between the needs of women selling sex in different settings (Jeal and Salisbury, 2006). There is a lack of accurate evidence in the report concerning the voices of women engaged in sex work.

Consequently, according to Laite (2006: 2) 'the UK Government report took no account of the historical dimension of the laws which have gone largely unaltered for almost two centuries'. Understanding sex work as a product of the world in which women are abused, objectified and economically disadvantaged gives more reason to demand that the Government does not use laws to punish women in the sex industry (Laite, 2006: 9) but instead pays attention to their health needs.

Furthermore, Zatz (1997: 289) argues that the failure to recognise the role of laws in structuring the marginal status of sex work means that, 'how much of what the state identifies as harmful in sex work is a product, not of the inherent character of sex work or sexuality but rather of the specific regimes of criminalisation and denigration. These terms serve to marginalise and oppress sex workers while constraining and distorting sex work's radical potential'. Despite 'vocal and long-standing protest, the discourse on women in sex work as a public nuisance and legal pariahs, has remained the ideology implicit in the UK's sex work control strategy down to the present day' (Laite, 2006: 8). As a result, the health of sex workers remains neglected.

This point reiterates Gilbert's criticism that 'current prostitution and related legislation ignores the realities of sex work, creates few legal options for sex workers and forces most sex workers underground where they must operate illegally and/or with no occupational health and safety measures in place, as in street work' (Gilbert, 1992: 190). While this paper was written in 1992, Sagar (2007, cited in Sanders et al., 2009: 113) finds that the same discourse of 'unruly', 'uncontrollable', 'dangerous' women is echoed in the 21st century through the increasing use of anti-social behaviour legislation and mechanisms to control and contain sex workers.

In recent times, UK government ministers have introduced repressive law and order measures – from Anti-Social Behaviour Orders (ASBOs) to detention without trial. New laws were introduced in England and Wales under the Policing and Crime Act, 2009. Amendments to section 16 of this Act (2009) reinforced police powers to arrest women deemed to be loitering or soliciting for the purposes of offering sexual services as a 'prostitute'.

Laite (2008: 3) demonstrates that labelling women on the street with the term 'prostitute,' for instance by arresting them for loitering and treating them as being 'known to the police', means little street-level change is likely to follow from this contentious term in sex work legislation. In British law, soliciting on the street is an offence. If caught, the charge is a heavy fine, which includes £500 for the first offense and then £1000 for further offences (Street Offences Act 1959). The consequences of this law mean that a woman or man forced to work extra hours to pay the fine, putting their health and wellbeing at further risk. Another challenge relates to the reduced time available to negotiate with the client for fear of police arrest. Potentially, this poses a health risk to street sex workers because they have less time to assess clients and negotiate for safer sex.

Goodyear and Cusick (2007: 52) emphasise that 'the use of ASBOs by the UK Home Office to control sex workers has also forced women into more dangerous locations and isolated them from support services'. This approach

by the UK Government means that there is less focus on protection and more emphasis towards prosecution. This also suggests a 'poor understanding of the complex needs of street sex workers by both services and professionals, particularly a failure to engage with the reality of these women's lives and the factors that maintain them in this work' (Mellor and Lovell 2011: 1).

Consequently, the alienation caused by policing further reinforces the marginalisation of these women in street sex work, potentially creating barriers for them to access health and social care. UK Government documents such as 'The Tackling Health Inequalities Review' (2002) and the 'Sexual Health and HIV Strategy' (2002) give little emphasis to sex workers, particularly street women. There is a need to look at the different types of female sex workers in the UK on a wider frame of reference before narrowing the study focus to a particular group of sex workers that have the greatest health needs.

2.4 Female Sex Workers in the UK

The UK Home Office estimates that there are around 80,000 commercial sex workers in the UK (Home Office, 2004). Women make up the majority of the sex work population, with some estimates suggesting the proportion is around 85-90 per cent (Scambler, 2007). Approximately 85 per cent of these are women working mainly off-street (Dickson, 2004) referred to as 'indoor sex workers'.

Harcourt and Donovan (2005) grouped types of sexual services into two categories; direct and indirect sex work. Direct sex work refers to services such as indoor and outdoor sex work as well as escort services. Indirect sex work connotes services such as lap dancing, stripping and virtual sex services (internet and phone sex) (Balfour and Allen, 2014: 3).

Indoor sex work is typified by women working as sex workers in the following locations: brothels or as escorts in hotel rooms or private residences (which includes working for a madam and privately with an agency). Strippers or bar

patrons who connect with prospective clients in club venues and make dates for later meetings typify indoor sex work too women working in clubs and saunas with special sexualised services also Individuals working in flats (sex work business where women tend to work on their own) (Thukral et al., 2005: 9). In England, it is illegal to keep a brothel (a premise), however it is legal to work as a sex worker in a private location, as is working as an outcall escort.

Spice (2007) revealed that there are differences between indoor sex work and outdoor sex work in terms of harm and risk to health. Low risk sex work activities, such as stripping and non-contact sex work, are less likely to have adverse health problems (Harcourt and Donovan, 2005), while sexual services undertaken on side streets, in vehicles, or short stay premises, known as street sex work, poses a higher risk to sex workers in relation to the nature of their work. 'Clients solicited on the street, park or other public places' (Harcourt et al., 2005: 202) and called 'outdoor sex work' refers to street sex work.

Jeal and Salisbury (2007: 879) mentioned in their study that street sex workers represent a 'much more vulnerable population and were found to 'participate in health risk behaviours such as substance misuse and risky sexual practices'. In addition, Costello (2003) reaffirms that street sex workers are also more likely than many other occupational groups to experience poor health, poverty and social exclusion. Their work often supplements low paid jobs (Elmore-Meegan et al., 2004; Harcourt and Donovan, 2005) and attracts considerable stigma (Barry and Yuill, 2008).

Indoor sex workers have a lower sexual health risk because these women have some security mechanisms in place. Although many work alone, their sexual services occur in places such as massage parlours, brothels or private dwellings where they are able to control their work environment and preselect clients to some extent. However, Harcourt and Donovan (2005: 203) suggest that 'it is difficult to measure the sexual health and welfare parameters of private workers, because, like escorts, they work hidden away'.

Other factors that can potentially lead to poor health outcomes for a sex worker include the number of clients for sexual services. Donovan (1984) reports that high volumes of clients over relatively short periods are linked to high levels of Sexually Transmitted Infections (STIs). The challenges to practice safer sex are perpetuated by the urgent need for money, drug and alcohol abuse, homelessness and ignorance (Donovan, 1984). Thus, it is not possible to separate high and low risk sex workers.

Research also indicates that individuals tend not to fix levels and types of participation in sex work. An individual in the sex industry can change their occupation in sex work depending on their level of need, ranging from 'survival, debt, drug dependency, coercion, and social connection, to desire for wealth and social mobility' (Harcourt and Donovan, 2005: 201). In the table below, Scambler (2007) presents categories that define sex work careers. The table reflects the diversity of the sex industry and different circumstances for entering sex work illustrated as paradigmatic examples. Patterns in health and wellbeing varying from coerced to bohemian careers may also present different health experiences.

Career	Paradigmatic example
Coerced	Abducted, trafficked
Destined	Family, peers in trade
Survivors	Drug users, single parents, debtors
Workers	Permanent job
Opportunists	Project financing
Bohemians	Casual, without need

Figure 1: A Typology of sex work careers (Scambler, 2007: 1080)

The different types of sex work careers can potentially pose a significant issue to public health officials wanting to estimate the number of individuals working as sex workers in a country. This is due to the hidden nature of the sex industry where the laws that govern sex work prohibit or prosecute individuals from engaging in the illegal aspects of sex work. Individuals are subsequently

alienated from accessing health services due to the risk of criminalisation. The emotional health risks of criminal arrest have not yet been recognised (Sanders, 2004).

The sex industry also extends beyond female sex workers to male sex workers. Males who undertake sex work for men rarely have the solicitation and loitering laws applied to them (Sanders et al. 2009: 126). This implies that male workers do not face the same kind of approaches by the law that female sex workers experience therefore their issues are likely to be different. The experiences of male sex workers would benefit from a separate study given there are a number of challenges that male sex workers experience not addressed in this study.

Similarly, there are other groups of sex workers such as transgender sex workers or those individuals undergoing gender transition (both male to female and female to male), but the aim of this study is to keep the focus on the health needs and examine in detail the experiences of a specific and distinct group of female sex workers, FSSWs. It is, therefore, important to consider in more detail some of the ways in which health and wellbeing have been conceptualised in health care.

2.5 Conceptualising Health and Wellbeing for FSSWs

The central principle of the UK's National Health Service (NHS), following its formation in 1948, was that health services would be 'available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender assignment, pregnancy and maternity or marital or civil partnership status' (NHS, 2013: 3). Thus, the NHS has a duty to ensure the services it provides promote equality to different groups found within UK society. Also embedded within the NHS constitution is that it primarily functions to 'improve the health and wellbeing of the people by supporting them to stay mentally and physically well' (2013: 3). These values when applied to FSSWs are significant in justifying a non-judgmental approach by NHS health service provision.

In 1948, the World Health Organization (WHO) established a key definition of health but it has been questioned for its relevance in an era marked by new understandings of disease at molecular, individual and societal levels (Lancet, 2009: 781). It does however still frame health into three broad aspects: physical, mental and social health and wellbeing.

The Ottawa Charter (WHO, 1986) changed thinking about how health can be understood in terms of broad structural factors consistent with a belief that 'health requires peace, shelter, education, food, income, a stable ecosystem, social justice and equity as prerequisites' (Baum, 2002: 35). In 2004, Derek Wanless completed a review of the issues involved in maximising the health of the population in the UK, emphasising the need to address old problems in new and more imaginative ways and to act in the right manner on emerging problems. He reported that health and wellbeing are influenced by many factors including past and present behaviour, healthcare provision and 'wider determinants', such as social, cultural and environmental factors (Wanless, 2004).

The UK government also published a report called *Choosing health: making health choices easier* (Department of Health, 2004). This is concerned with ensuring informed choice for all and supporting individuals and communities in making healthy choices. White (2009: 82-84) identified that the most significant material influences on health are 'diet, housing, working conditions, exposure to pollution and organisation of the urban landscape' and 'poor provision of services' (Bartley, 2004: 130).

Marmot et al. (2010) note that there is an 'established link between low income and poor health, and a definitive correlation between health and occupation with insecure, poorly paid work having a detrimental impact on health and wellbeing'. While there has been no thorough research into the impact of these conditions on sex worker health, the poor socio-economic conditions of many sex workers, specified in the literature, suggests that

health and life expectancy among this group is likely to be extremely poor (Balfour and Allen, 2004: 7).

There are three views of health described in previous research studies. The first is the 'medical' model of health, which refers to health as the absence of disease processes or pathogens. The second relates to a 'functional' model of health. Parsons (1951) described the notion of the 'sick role', which required an individual to take appropriate action to get better when ill. This idea also relates to 'social health in relation to an ability to fulfil social roles (Cowley, 2008: 214). The third view suggests that how people feel about themselves is more important than a disease process (Cowley, 2008: 214). The WHO is able to integrate these three views on health in relation to an individual's physical, mental and social health and wellbeing. A definition of these key concepts of health and wellbeing is presented in the next paragraphs.

Nordqvist (2015: 2) states that 'physical health relates to anything concerning our bodies as physical entities' while 'physical wellbeing is defined as something a person can achieve by developing all health-related components of his/her lifestyle'. Examples include maintaining good nutrition, bodyweight management, avoiding drug and alcohol misuse, engaging in responsible sexual health, good hygiene and getting the right amount of sleep.

According to the WHO, mental health is 'a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (WHO, 2001). This definition does not advocate the absence of mental illness/disorder. It represents the positive side of mental health by those individuals with a diagnosis of a mental health issue (Ewles, 2005).

Mental health is rooted in links between the individual and their social contexts. For example, risk factors for mental health include a family history of psychiatric disorders, violence, childhood neglect, family breakdown and

unemployment (Ewles, 2005: 223). Psychological protective factors for mental wellbeing include feeling respected, valued and supported together with a sense of hopefulness about the future (Williams and Pollock, 2001). Reducing the risk factors that undermine positive mental health such as social alienation is linked to social wellbeing.

Social wellbeing is the ability for individuals to be involved with other people and with the community at large (Kuh, Cooper, Hardy, Richards and Ben-Shlomo, 2014). The UK's Faculty of Public Health (2010: 2) mentions that 'social and income equality, social capital, social trust, social connectedness and social networks as opposed to racism, stigma, violence and crime' contribute to social wellbeing.

A strong link exists between the definitions of physical and mental, health to emotional and social wellbeing. They exist to achieve optimum wellbeing aimed at maximising an individual's potential, of which the NHS reaffirms, 'to stay as well as we can to the end of our lives' (NHS, 2013). Policy created to advance the health of street sex workers should therefore be expected to include these attributes of health with key priorities based on the NHS constitutional values (2013), the WHO definition of health (1948) and the Ottawa Charter for Health Promotion (1986).

The next section explores the general health of street sex workers and implications of sex work on workers' health.

2.5.1 The Health and Wellbeing of FSSWs in the UK

This section will assess a number of peer-reviewed health studies to reveal aspects of the physical, mental and social health issues of women involved in sex work in accordance with the WHO (1948) definition of health and wellbeing as mentioned previously. This section will also explore the literature for evidence on the access of women involved in sex work to health services and agencies in addressing their health needs.

Mellor and Lovell's (2011) exploratory study undertaken in the northwest of England examined nine street sex workers' experiences of health and health-related services. A thematic analysis approach highlighted complex life experiences of FSSWs consisting of violence, drugs, and alcohol and housing problems. These factors added to the likelihood of the women's social exclusion and ill effects of having their children taken into care.

The study also revealed that the women interviewed were ambivalent about their own perception of health as there was not much depth in their responses. Depression was the only aspect of health mentioned in the findings. The women also mentioned poor experiences of health services in meeting their own health needs. 'This study suggested a poor understanding of the complex needs of street sex workers by both health services and professionals, particularly a failure to engage with the reality of these women's lives and the factors that maintain them in this work' (Mellor and Lovell, 2011:1).

An earlier study conducted in 1996 by McKeganey and Barnard undertook research directly with sex workers on the street. The aim of the research was to 'identify the extent of HIV infection among street-based prostitutes'. Fieldwork entailed walking along the streets in the red-light areas of Glasgow over a period of 800 hours handing out condoms, sterile injection equipment and information on Human Immunodeficiency Virus (HIV) risk reduction. Before the research began, the researcher gave information to the local health board in the area and local police about the research carried out.

Data collection consisted of obtaining a sample of saliva for testing for signs of HIV infection amongst 361 women. Results revealed that the risk of HIV transmission was relatively low and rare among the sex workers in Glasgow. Additionally, informal street interviews with the women provided information on the views of their experiences in selling sex and the kind of sexual services they provided. The majority of the women engaged in oral and vaginal sex but not anal sex. The women stated that they used condoms and therefore practised safe sex.

70 per cent of the women interviewed confirmed that they engaged in drug use and injected heroin. The study findings outlined that all the women interviewed had experienced violence. McKeganey et al. (1996: 71) stated that 'street sex workers have to contend with a whole spectrum of behaviours, ranging from name-calling to physical assault, rape and murder'. The literature revealed that little has changed since McKeganey et al.'s book. Male violence against women is still prevalent in current times with men, acting as pimps, largely controlling street sex work (O'Neill cited in Scambler et al., 1997: 17). The stigma attached to women's work in the sex industry remains a key feature of their lived reality.

Sociological work has provided important theoretical constructs for the exploration of aspects of social exclusion and health-related stigma. Social exclusion recognises that issues of substance misuse, mental health, inadequate housing, low income and poor access to services are dynamic, interrelated and frequently result in exclusion from community participation (Room, 1995). The literature has mentioned the processes of exclusion such as stigma.

Stigma has to do with a person's attributes that are socially undesirable and that taint the person's social identity (Goffman, 1963: 167). Existing research suggests that women in sex work experience a great deal of social stigma (Bradley, 2007) that is detrimental to their health and wellbeing (Tomura, 2009: 54). This social stigma linked to inequality and exclusion (Scambler, 2007: 1087) can potentially lead to loss of status. Link & Phelan (2001: 379) propose that 'when this occurs, we can expect members of stigmatised groups to accrue all manner of untoward outcomes associated with lower placement in a status hierarchy, ranging from selection of sexual partners to longevity'.

Despite this recognised stigmatised status of sex workers in the literature, there is a lack of empirical data on their self-perceived stigma and its association with mental health (Hong et al., 2010), as well as emotional and

physical health. The literature on sex work has focused on issues relating to the transmission of STIs and HIV and comparatively little attention to sex workers' psychosocial health (Church et al., 2001, cited in Wong et al., 2011). It is evident that FSSWs' poor mental health is associated with the stigma and discrimination they experience (Inciardi et al., 2005).

Tomura (2009) undertook a research study in Oakland, California to investigate a female prostitute's experience of stigma associated with her work, which revealed that 'severe stigmatisation of sex workers is a real phenomenon' (p. 77). Researchers have discussed how the social stigmatisation of sex work is detrimental to their health and wellbeing, but sex workers' subjective experience of stigma is relatively unknown (p. 54).

Wong, Holroyd and Bingham (2011) used a grounded theory approach to interview the women in their study. The gap explored in this piece of research was the idea that stigma research has tended to be strongly theoretical. This stigma research privileges the opinions and theories of researchers without paying due attention to the words and perceptions of those who are stigmatised (Link and Phelan, 2001). It would therefore be necessary to take a feminist research approach, which is concerned with the ways in which social, political, and economic actions are interrelated with the actions and lives of women, including those insights on stigma from research participants. This point requires clarification by FSSWs on their own lived experience of stigma.

Link et al. (2001) advance a conceptual model of stigma. This model acknowledges that the labelling, stereotyping, distancing from others and loss of status that characterise stigma are made possible only by the differential distribution of social, economic and political power. Thus these relations of stigma can be grasped sociologically only as part of a nexus of social structures including those of the law and police. The next section examines further health studies for their relevance to understanding research to explore the health and wellbeing of sex workers and their access to health services.

2.5.2 The Physical and Mental Health of FSSWs

Jeal and Salisbury's (2004: 147-148) qualitative study found that 'the health and social inequalities experienced by street sex workers are much worse than the general population'. The results of this comparison study demonstrate reports that for all the women who are street sex workers, they suffer from chronic health problems such as a 'longstanding illness or disability, anxiety/depression, recurrent chest infections, skin conditions and Hepatitis C and B'.

Other results demonstrate that the women all had a current drug or alcohol dependency problem and experienced violence such as assault, including rape and use of weapons (p.149). Two-thirds of the women interviewed were homeless (p.148). Jeal et al. (2004) further reiterate the nature and pattern of alcohol and drug misuse in women who choose sex work. However, documents in the academic literature are not complete on the associated psychological and physical co-morbidity. The UK Home Office (2004) estimates that nearly all (95%) of street sex workers regularly use heroin and/or crack cocaine.

A longitudinal study conducted by Ward and Day (2006) recruited sex workers from an inner London genito-urinary medicine department with a clinical and outreach service called the Praed Street Project for sex workers. A cohort of sex workers enrolled from 1986 and followed for 15 years. Findings revealed information on health status, occupational mobility, STIs and health problems. These results identified with women who sold sex over a long period.

The data collection methods included data from interviews, questionnaires, clinic records or third parties (another sex worker or relative). One of the strengths of the methodological approach used was being able to validate the health issues with clinical records. For instance, disclosure of STIs during the interviews were confirmed by the clinical notes where pathology results were documented thus adding to the validity of findings.

While this study was able to identify the major health problems expressed by women who sell sex, which is relevant to understanding the health and wellbeing of women in this industry, it did not explore the experiences of these women receiving health services. The significance of this study to major health problems experienced by the women could be characterised by a diagnosis of 'mental illness such as depression, psychosis, eating disorders and addictions to substance misuse' (Ward and Day, 2006: 415). The most reported issue was mental health followed by STIs.

2.5.3 Health Service Use and Sex Work

Existing studies on FSSWs use of health services tend to focus on access to sexual health services (Jeal and Salisbury, 2007; Grath-Lone et al. 2013). Jeal and Salisbury's (2007) study of women selling sex in Bristol compared the health needs of sex workers working in massage parlours with those of women working on the streets. It indicated that 'parlour sex workers want a discreet sexual health service while street sex workers want a health service for all aspects of health and basic living needs' (p.879). The finding reflects the relative social stability of parlour sex workers compared with the absence of basic health needs in the lives of street sex workers.

A number of authors have suggested that marginalisation from mainstream public health services exists complicated by voluntary withdrawal because of the fear of being judged, humiliated and discriminated against (National Aids Trust 2003, Rekart 2005 and Surratt et al., 2005). The NHS constitution (2013: 3) states 'it has a duty to each and every individual that it serves and must respect their human rights but also a wider duty to promote equality'.

A more recent study (McGrath-Lone, Marsh, Hughes and Ward, 2014), analysing cross-sectional data from genito-urinary medicine (GUM) was able to relate sex worker demographic characteristics and their use of sexual health services and sexual health outcomes. This information collected and

reported on from a patient-level electronic data set called Genito-Urinary Medicine Clinic Activity Dataset.

This data collection method was useful in locating whether sexual health services tailored to the needs of the population group were adequate. For instance, results revealed that there is evidence of geographical inequality in females sex workers (FSWs) access to sexual health services (McGrath-Lone et al., 2014: 344) but that FSWs have access to high-quality sexual health care through the GUM clinic network. This network consists of 40 clinics in London that offer a walk-in facility for sexual health screening (CityDoc, 2015). Data on whether patients are sex workers was indicated in the surveillance of the attendees to the GUM clinic.

Other aspects of health that do not focus solely on sexual health were not included in the data collection for the above study such as data on sexual and drug-injecting behaviours. The study also outlined that FSSWs are not likely to be representative of all female sex workers attending GUM clinics because they are a higher risk group (McGrath-Lone et al., 2014: 349) in relation to inconsistent condom use, intravenous drug use and violence (Jeal and Salisbury, 2004: 150). This provides more justification to explore the wider health and wellbeing of FSSWs because there is limited information on their specific health needs.

Eaves Poppy Project was set up in 2003 to provide intermediate help and accommodation for trafficked women many of whom had been subject to sexual exploitation on the streets of London. The organisation published one relatively well-known report called *Sex in the city: mapping commercial sex across London*' (Dickson, 2004). The document's research findings identify the magnitude and range of venues there are for selling sex and the numbers of women working in sex work across London.

As the research focused on identifying the magnitude of the sex industry, there were no interviews conducted with women working as sex workers. The

only interviews undertaken consisted of rescued women already receiving support services from the Poppy Project. There was no evidence about their health and wellbeing status at this point, only about “where they had worked, if they had received sexual health or outreach services, and whether they felt able to estimate the degree of trafficking amongst other women selling sex in flats, parlours and saunas” (Dickson, 2004: 8).

In addition, the methodological approach chosen to gather data about sex workers’ access to sexual health outreach services was from outreach services rather than due to evidence from in-depth interviews with women involved in sex work. Thus, whilst the findings highlight a need for further sexual health outreach services across London, there is no evidence to suggest what impact the lack of services has had on these women. Consequently, the majority of these services focus on harm minimisation or reduction that is helping women to be safer (Dickson, 2004: 48), rather than addressing the women’s health needs. This is a service deficiency compared to interviewing women on how they perceive current health service provision and how this affects their health and wellbeing needs.

The second half of this chapter will explore feminist perspectives on sex work and the social construction of women’s sexuality in society. The aim of this section is to understand the social position of women in the sex industry and their voice in the literature. This will be followed by a theoretical framework that considers the range of factors mentioned in this review that play a major role in understanding the health and wellbeing of FSSWs.

2.6 Feminist Perspectives and Sex Work

Different feminist theorists have assumed a plethora of positions on the subject of sex work. These range from a local to a global context of women’s lives in the sex industry. Topics explored include interpersonal issues, such as body and health (Dworkin & Wachs, 1990) or health and illness (Schulz & Mullings, 2006) and domestic violence (Jiwani, 2005; Renzetti, 2005). Others have examined women’s lives and working conditions in diverse international

contexts (Gulcar and Ilkcaracan, 2002; Katsulis, 2009) and the international sex trade (Dewey, 2008; Hanochi, 2001). Transnational feminists also examine sex trafficking (DeRiviere, 2006; Firdous, 2005; Stout, 2008), violence against women (Jiwani, 2005) and reproductive technologies (Gupta, 2006). These studies provide background knowledge on the diversity of women's experiences in the sex industry, which may also include some of the experiences of street sex workers.

Maggie O'Neill (2001), in her book *Prostitution and Feminism*, presents an exploration of feminist theory and socio-cultural research. The book advocates a theoretical critique of the use of language to describe sex work and a shift in the way it is currently conceptualised. She explores renewed methodologies for social research, which seek to speak in empathic ways with women in social research (O'Neill, 2001: 14). This is a text acknowledging the importance of sex workers' voices and their own personal accounts of their lived experiences. This has implications for understanding women's health by locating the life stories of women who sell sex within academic literature and health studies.

Another feminist researcher called Katsulis (2009) uses her feminist theoretical background to inform the research question and methods on the lived experiences of women who work in Mexico's sex industry. She seeks to uncover knowledge about the women's day-to-day experience through a feminist approach to mixed methods research. Her data is from both qualitative (interviews) and quantitative (surveys) methods and provides a dual perspective that 'combines women's voices with broader findings. She uses this information to argue for social change and policy initiatives' (Hesse-Biber, 2014: 375). Weldon (2001) reports that some feminists addressing sex work typically do not want to hear from sex workers unless they tell tales of abuse and oppression, even going so far as to prevent those sex workers from speaking who do not share their opinion.

More general feminist enquiries into sex work include feminist debates, reminiscent of the earlier 'pornography wars' which consisted of arguments for

or against sexual material and sex work (Bell, 1987). The debate suggested that some men and women make a rational choice to sell sex while radical feminists such as Kathleen Barry (1995) see sex work as a form of violence against all women. In this context, a woman can never be a 'sex worker' because she becomes a 'sex object' by structural and power inequalities between men and women (Barry, 1979; Dworkin, 1996, cited in Sanders et al., 2009). This is a patriarchal view that sex work affects all women and gendered relationships or the assertion that 'all women are oppressed' and lack choices (Hooks, 1984: 5).

Rogers (2006: 351) states that feminism is concerned with equity, oppression, and justice. It is interesting to explore in feminist literature how a shift in thinking or a 'renewed methodology' on sex work, policy and politics is required at the intersection with discourses on health, the law and sex workers' rights (O'Neil 2001; Sanders et al., 2009; Campbell et al., 2006). A feminist approach has the potential to examine not only these connections but also an enquiry into gender (Marshall, 2000), disadvantage and health in accordance with the distribution of power in the processes of public health, from policy making through to programme delivery (Rogers, 2006: 351).

In the next section, a review of the literature on the social construction of sexuality is presented to assist in providing insights into understanding the cultural identities of women's lives in sex work.

2.6.1 The Social Construction of Sexuality

Foucault's work *The History of Sexuality* (1980) raises a question on sexuality and western governance (Foucault, 1980: 45). What Foucault is suggesting is that individuals are not simply constrained by external structures, but by the regulation of disciplinary structures and discourses (Foucault, 1980). This alludes to the point of how people position themselves according to discourses and how they produce themselves through particular practices (Woodward, 2003: 97-98). For example, in Hooks' (1992) paper, Tina Turner describes 'the way her public persona as singer was shaped by Ike Turner's

pornographic fantasy of the black female as wild sexual savage and this is said to have emerged from the impact of a white patriarchal controlled media shaping his perceptions of reality' (Hooks, 1992: 126).

Additionally, media messages inevitably feed into the local imagination and provide powerful symbolic stereotypes of sex workers and sex work. This can include labels such as 'woman of the night', or 'vice girls', who work in 'the vice-ridden area' (Campbell & O'Neill, 2009: 39). Women's sexuality is perceived as 'dirty' and their work representing 'bad girls' thus contravening norms of acceptable femininity and suffering 'whore stigma' (Pheterson, 1986). In managing this 'spoiled identity' (Goffman, 1963), individuals must manage the stigma associated with the work, and in turn the stigma associated with them as the 'dirty workers' who perform the work (Ashforth and Kriener, 1999).

In the literature, the portrayal of a female sex worker presents as an object 'other', a body object of fascination to some and of disgust to others (Campbell et al., 2009: 39). Hochschild (1983: 37) states 'prostitutes' bodies are similarly a resource to make money'. In both cases, 'the body, not the soul, is the main tool of the trade'. McKeganey and Barnard (1996) on objectification of the human body suggest that for the purposes of commercial sex, the body is actually, emptied of meaning. McDowell (1997, cited in West et al., 2002: 486) stresses the 'othering' of women – indeed, the terms used by men to mark women as 'illegitimate' outsiders are synonyms for sex workers – 'skirts', 'slags', 'brasses', 'tarts' – women are marked as the ultimate 'other', 'the whore'. This marking or labelling signals a point of no return as the whole notion in society 'once a 'whore', always a 'whore' or once you are objectified, always objectified no matter the circumstances of how you entered, lived or left that life.

These constructions based on symbolic ideologies about sex workers, reveal the challenges sex work poses to the nature of women's work in the sex industry. This is because images of stereotypical femininity in contemporary culture are associated with the respectable, decent and virtuous wife and

mother. Therefore, sex work and sex workers reveal inequalities within traditional heterosexual gender relations and the interrelated structures of work, sexuality and power (Connell, 1987).

This calls for Bourdieu's (1930-2002) theoretical framework that encourages the social structures and symbolic representation of women in the sex industry to be reconciled with a few closely interrelated generative principles. The next section explores the literature on a Bourdieu-based theoretical framework.

2.7 A Bourdieu-based Theoretical Framework

Bourdieu (1984) offers a theoretical framework as a means to understand and conceptualise how social groups maintain their distinction from other groups through the lifestyles they adopt. This suggests that individuals are socialised by their environment and by people living in similar life conditions that is, people occupying a similar position in social settings tend to develop a similar habitus, thus sharing similar lifestyles. These lifestyles could mean a marker of social position, which may have an influence on health behaviours, health beliefs and health inequalities. Therefore, lifestyle explored through Bourdieu's key concepts of 'habitus', 'field' and 'capital' assists in understanding the health behaviours of FSSWs.

Habitus, according to Bourdieu, is a system of dispositions which integrates past experiences and enables individuals to cope with diverse unforeseen situations – dispositions which the women, known as agents, acquire either individually, through family and the education system or as a group through organisational socialisation (Bourdieu, 1984: 170). Exploring the concept of 'field', also referred to as a 'social space', increases knowledge on the strategies of survival women use on the street where specific interactions take place. The field is therefore 'competitive with various agents using different strategies to maintain or improve their position' (Grenfell, 2012: 67).

According to Bourdieu, the relationship between field and habitus operates in two ways. On the one hand, the field conditions the habitus, which is the product of the embodiment of the imminent necessity of a field. On the other hand, habitus constitutes the field as it provides the cultural frames for making sense of the field (Bourdieu & Wacquant, 1992). Grenfell (2012) identifies that 'at stake in the field is the accumulation of capitals: they are both the process in and product of a field'. Bourdieu nominated four forms of capital: economic (money and assets); cultural (forms of knowledge, language, taste, and narrative); social (networks, family and cultural heritage) and symbolic capital (things, which stand for all of the other forms of capital)' (p.67).

Bourdieu did not conduct empirical research on health, but the theory on the forms of capital can be applied to the study of health inequalities (Pinxten & Lievens, 2014: 1097). Economic capital refers to material assets that are 'immediately and directly convertible into money and may be institutionalised in the form of property rights' (Bourdieu, 1986: 242).

Economic capital includes all kinds of material resources used to acquire or maintain better health. There are two ways to explain the impact of economic capital on health (Mirowsky & Ross, 2003). In the materialist interpretation, the amount of material resources positively relates to health outcomes. Following this interpretation, actual differences in material resources determine the probability of an individual encountering health problems or stress and which health behaviours they adopt.

The section on exploring the typology of sex workers in relation to harms and risks to health included in this chapter revealed that 'the health and social inequalities experienced by this group are much worse than any other group of women involved in sex work' (Jeal et al., 2004: 147). In relation to economic capital, Feucht (1993) acknowledges that street sex workers have a role within drug marketplace economies (especially crack cocaine markets), which includes distributing and the carrying of drugs, and selling sexual services for drugs. Therefore, the economic capital they acquire is often for the purchase of illicit substance use.

In Bourdieu and Wacquant (1992: 119), social capital refers to ‘the aggregate of the actual or potential resources which are linked to the possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition’. This key concept explores the realities of the social inequalities that exist amongst women in street sex work in accordance with the structuring role of the law, as in the presentation of the UK documents on sex work presented in the government policy section. Social capital as applied to a feminist perspective seeks to understand women’s position in sex work through exploring social networks and the working environment of the sex industry.

Bourdieu (1986) distinguishes between three forms of cultural capital. Cultural capital in the institutionalised state refers to educational attainment. Objectified cultural capital concerns the possession of cultural goods. The embodied state refers to people’s values, skills, knowledge and tastes. Cultural capital becomes a ‘key component that links people’s social position with the behavioural aspects of health inequality’ (Abel, 2008: 2). Bourdieu argues that the social space based upon the possession of capitals serves to frame cultural tastes and practices, and that these tastes then serve to manifest social class inequalities (Veenstra, 2005: 3). In the literature section on sexuality and identity, women in sex work seen to lack cultural capital due to the way the media constructed them. The stereotypes that continued the ‘othering’ of these women framed their identities as sex workers.

Another concept of Bourdieu relates to symbolic violence, which occurs when ‘contemporary social hierarchies and social inequality are produced and maintained by forms of symbolic domination more than physical force’ (Bourdieu, 1993: 60). This concept is of value to the study of women in street sex work. It can explain the way in which symbolic violence leads to socially distributed suffering due to the lack of attention given to these women’s lives.

2.8 Summary of Literature Review

This literature review chapter has provided a historical background context to the laws on sex work and their application in the UK that favour legislation designed to regulate and control sex workers. Although some empirical research has considered the health issues of sex workers as emphasised previously, unmet health needs continue for this group of women. This led to the conclusion that the voice of women in street sex work on their own health needs is lacking in research studies.

In contributing to a feminist research ethic, any attempt to understand sex work in contemporary times must be very 'clear about the socio-economic and historical contexts to sex work' (O'Neill, 2001: 184). In particular, understanding the 'humanly constructed boundaries that can potentially lead to marginalization, exclusion and silencing in the research process' (Ackerly et al., 2010: 31) is essential. With reference to undertaking a study on women's lives in street sex work, as in the research for this thesis, exploring the lived experience of these women through a feminist standpoint means reflecting on the social processes and power relations within their social context.

The chapter concludes by providing a Bourdieu-based theoretical framework to understand women's involvement in street sex work through the three key concepts: field, capital and habitus. This framework not only extends the application of Bourdieu's concepts but also can potentially provide insight into the perspectives of women's narrative accounts in street sex work. The next chapter on methodology and methods discusses the data collection and analysis of this study.

Chapter 3 – Methodology and Methods

3.0 Introduction

The literature review in chapter 2 revealed that UK government laws enacted to regulate and control the sex industry show less concern for the health needs of sex workers (Day & Ward, 2007; Boynton & Cusick, 2006; Robinson, 2007; Phoenix, 2007). In seeking to understand the health issues of women in the sex industry, a study that explored their own personal constructions of health and wellbeing would provide new meaning for the lived experience of female street sex workers (FSSWs).

This chapter describes the methodology and methods used in the research process for this study. Section 3.1 presents the research methodology that this study is concerned with, which is a feminist qualitative methodology. Section 3.2 provides the research philosophy to demonstrate the nature of qualitative inquiry including the research question, aim and objectives to the study. Section 3.3 describes the mixed methods approach used in this research.

The mixed methods research design incorporated semiotic analysis of sex calling cards from telephone booths in central London (Phase 1); framework analysis of secondary data (Phase 2) which included archived in-depth interviews made with sex workers in the late 1990s and thematic analysis of in-depth interviews made with FSSWs in the primary data set (Phase 3). The methods chosen were the most appropriate analysis strategy to capture a complex and difficult area to undertake research, which required time and consideration of the data (Dunbar, Rodriguez and Parker, 2002).

Section 3.4 describes the process of collecting visual data in accordance with Phase 1. Section 3.5 explains the immersion and familiarisation of secondary data in Phase 2 of this study. Section 3.6 presents the fieldwork in relation to Phase 3 that provides the target population, demographics characteristics of the participants, the setting for recruitment including the specific sampling

techniques used, interview process and analysis strategy. Ethical considerations and challenges are emphasised here too including my emotional labour and reflexivity in conducting this phase of the study. The next section describes the research methodology most appropriate to explore and understand the research phenomenon of this study.

3.1 Research Methodology

Studying non-mainstream groups in society such as marginalised and stigmatised communities, researchers must tailor their data collection methods to both the sensitivity of the research topic and the vulnerability of the research subjects (Goffman, 1963; Hobbs, 2002; Lee, 1993). This consideration is not to further victimise the participants but to allow strategies aimed at reducing data invalidity, while still maintaining respect for vulnerable participants for instance, by incorporating a 'feminist research ethic'. Ackerly and True (2010: 22) state that a 'feminist research ethic is a commitment to the question of how we enquire. It requires being attentive to the power of knowledge, epistemology, boundaries, marginalisation, silences and intersections, as well as relationships and a researcher's own socio-political position and belief system'.

The previous chapter also identified that a feminist perspective that seeks to understand the subjective realities of women's narrative accounts in sex work can provide a richer level of meaning around interpretations of their health needs. A feminist view aims to understand the nature of gender inequality, and examines women's social roles, experiences and interests (Marshall, 2000 and Campbell & O'Neill, 2006). Feminist social researchers in the early 1980s proposed that the prevalent principles and practices associated with quantitative research were incompatible with feminist research on women (Bryman, 2012: 40).

While Oakley (1981) states that in quantitative research, male values of control in the general orientation of the research strategy, control of the research subject and control of the research context and situation exist.

Feminist qualitative research aims to reflectively and critically reveal 'the silences and oppressions women experience and to understand the conditions, processes, and institutions that cause and sustain them' (Ackerly and True, 2010: 7).

In addition, a qualitative research methodology can provide an understanding of the meanings and experiences people have of health and illness (Green & Britten, 1998), which is fitting for this study. This process to understand a phenomenon is reliable because it 'documents the world from the point of view of the people studied rather than presenting it from the perspective of the researcher' (Hammersley 1992a: 45). The research usually involves exploring people's personal experiences, life stories, interviews, cultural texts, introspection, case research and productions, along with observational, historical, interactional and visual texts that describe routine and problematic moments and meanings in individuals' lives (Denzin and Lincoln, 2011).

On the contrary, quantitative researchers study individuals indirectly, 'replacing' them with abstract models, exploring a nomothetic science based on probabilities (Denzin and Lincoln, 2005). This methodology underpins the scientific enquiry of a deductive process such as hypothesis testing. However, a qualitative approach considers the inductive process, which attempts to establish patterns, consistencies and meanings towards a connected view of the research focus (Gray, 2014: 18).

Unlike quantitative research, which seeks to apply some form of statistical data analysis (Cresswell, 2003: 18), qualitative research has the potential to add richness and depth to our understandings of socially constructed phenomena, whereas a positivist paradigm cannot achieve this. In positivism, there are no provisions for human interests within the study and explanations tend to focus on demonstrating causality (Ramanathan, 2008). Qualitative inquiry documents 'what happens among real people in the real world in their own words, from their own perspectives, and within their own contexts to illuminate meaning by discovering patterns and themes across the data' (Patton, 2015: 12- 13).

As a result of the evidence presented in the preceding paragraph, my study will adopt a qualitative methodology, which includes a feminist paradigm that privileges women's perspectives and experiences but also seeks to prevent further oppression by minimising power differences between the researcher and the participants in the study (Ackerly and True, 2010). The methodological assumptions adopted for the research process discovered in Cresswell (2007) specify five types of assumptions: ontological, epistemological, axiological, rhetorical and methodological (2007).

3.2 Research Philosophy

Qualitative research begins with assumptions, a worldview, the possible use of a theoretical lens, and the study of research problems looking into the meaning individuals or groups assign to a social phenomenon (Cresswell, 2007: 37). Ontological assumptions are concerned with what we believe constitutes social reality (Blaikie, 2001). Adam (2014) emphasises that in dealing with opinions and perceptions one takes on the ontological position of a subjective reality, otherwise known as interpretivist ontology. Here, meaning is derived from a naturalistic approach to data collection that may employ more than one method in order to reflect different aspects of the issue under study. This emphasises an inductive logic where patterns, categories and themes form from the "bottom-up" (Cresswell, 2007: 39), which is in line with qualitative research.

Examining the perceptions of what women in sex work believe their health needs entail requires an epistemological position that privileges social constructivism. Social constructivism refers to the way in which groups co-construct knowledge for each other to create a culture of shared meaning (Crotty, 2003). It maintains that human development is socially situated and knowledge constructed through interaction with others (McKinley, 2015: 184). This position gives attention to the construction of social and psychological worlds through human and cognitive processes (Young and Collin, 2003).

Social constructivism also has the potential to allow me to embrace my own

subjectivity in the research process (Thomas and Davies, 2005); Thomas and Linstead, 2002). For example, my engagement with participants involved in this study means I co-construct and represent their historical and institutional processes and accounts intertwined with my own lived experiences (gender, culture, age, education) (Alvesson and Deetz, 2000). In particular, my exploration of sex work makes me sensitive to the experiences of such work for the participants involved in this study.

Cresswell (2009) asserts that social constructivism is a useful theoretical approach by way of the following knowledge claims:

- Individuals construct meanings as they engage with the world they are interpreting.
- Individuals engage with their world and make sense of it based on their historical and social perspective.
- The basic generation of meaning is always social, arising from interaction with a human community.

This approach when adopted can provide guidance to make deeper meaningful knowledge constructions of how individuals make sense of their context and environments. In order to produce what Geertz (1973) calls “thick description” that is, rich accounts of the details of people’s social lives, the following research question was identified to explore women in street sex works own perspectives on their health and wellbeing within their social context:

What is the lived experience of female street sex workers in relation to their own health and wellbeing?

This question uses an inductive logic that seeks the subjective accounts and interpretations of participants on their own social reality. It relies on a feminist qualitative methodology adopted to understand women’s lived experience in the sex industry through exploring from a feminist stance, ‘the silences and oppressions women experience and to understand the conditions, processes, and institutions that cause and sustain them’ (Ackerly and True, 2010: 7).

The aim was to explore what the perceptions and needs of FSSWs are in relation to their own health and wellbeing. The key objectives identified to address this research question included the following:

1. To examine the key health and wellbeing needs of FSSWs.
2. To identify their experiences of health services and agencies in addressing their health needs.
3. To investigate how FSSWs construct their experiences and understandings of health needs.

3.3 Methods and Rationale

A range of qualitative methods guided by a 'feminist research ethic' reveals knowledge and understanding about the experiences of women involved in the sex industry. My methods included semiotic analysis of visual images that included sex calling cards, framework analysis of oral archived interviews with sex workers in the late 1990's and thematic analysis of in-depth interviews with FSSWs. These three methods when incorporated into my study are consistent with a mixed methods approach.

A mixed methods approach means 'adopting a research strategy employing more than one type of research method' (Brannen, 2005: 4). While the concept of a 'mixed methods' approach to research discussed in the context of combining qualitative and quantitative methods, the same principles apply to using more than one qualitative method to carry out an investigation (Ritchie & Lewis, 2003). The rationale for the use of a mixed methods approach was to find answers to the research question and objectives. This involved thinking 'outside the box' that is, exploring different options for engaging with the research population. Therefore, I used more than one qualitative approach to capture phenomena.

The notion of thinking 'outside the box' derives from concerns about the nature of the research population because of the illegal aspects of the sex

work. Soliciting on the street is one such example. The women therefore may have concerns regarding privacy and confidentiality and could be reluctant to participate in a research study. As a result, due to the feasibility of accessing relevant data, consideration for different methods ensued. My rationale for each data collection method used in this study will be outlined in the following three phases of the fieldwork.

Phase 1 of the fieldwork relates to a time in April 2010 when I was walking in Soho, central London. I noticed the sheer volume of sex calling cards lying on the ground next to the iconic London telephone booths and plastered on the booth walls. This led to the idea of collecting visual data on the representation of women in sex work who are advertising sexual services and the prospect that this data could contribute to understanding how female bodies socially constructed their identities within the context of sex calling cards. I decided to use visual data, such as sex calling cards, because of their relative availability at the time of conceptualising the study topic.

Three months later, I found in-depth interviews of sex workers archived at the British Library and called this Phase 2. The research process involved locating, accessing and immersing myself in the secondary data. Selecting the archived oral narrative accounts of women in sex work in this data set enabled me to learn about the background context of women engaged in sex work. It was also to understand their health needs before having actual contact with contemporary street sex workers. Moreover, with no exposure to street sex work or the sex industry, engaging with archived in-depth accounts from the late 1990s provided insight into the lived experiences of this group of women sex workers.

Phase 3 consisted of primary data and involved the process of recruiting FSSWs. At the time, uncertainty about recruiting my participants meant that the secondary data was key to providing an understanding about the background data on women's lives in sex work. Familiarisation through the secondary archived data also meant the development of an appropriate

interview schedule for Phase 3 in line with my feminist paradigm geared to demonstrating a sensitive approach to my participants.

Thus, a pragmatic rationale for the use of a mixed methods approach was to establish contextual insight into the visual and historical background of women in sex work through Phase 1 and 2 in order to orientate me to the field as in Phase 3. Therefore, Phase 1 and Phase 2 are part of the research process and presented as a way of developing Phase 3.

The three phases of the study carried out over a three-year period from 2010 to 2013 are presented in the timeline (Table 1). Key dates outlining when immersion and data collection commenced, location of the data sets, sample size and ethics approval dates appear in this table too.

Table 1: Timeline of Phases 1, 2 and 3

Phase 1: Visual Data Collection (Semiotic Analysis)	Phase 2: Secondary Data Immersion (Framework Analysis)	Phase 3: Primary Data Collection (Thematic Analysis)
<p>When: 1st April to 29th of August 2010</p> <p>Where: Telephone booths in central London:</p> <ul style="list-style-type: none"> • Edgware Road • Soho • Marylebone Road <p>Sample Size: 50 sex calling cards</p>	<p>When: 11th December 2011 to 18th January 2012</p> <p>Where: The British Library: 'Oral History Collection on Prostitution'</p> <p>Sample Size: Archived in-depth interviews on the life histories of three women involved in sex work from the year 1997.</p>	<p>When: 1st July 2012 to March 2013</p> <p>Ethics approval: 12/5/12 - 12/12/12</p> <p>Ethics extension: 31/3/13</p> <p>Where: Women's Centre in central London</p> <ul style="list-style-type: none"> • 3 pilot studies conducted January 2013 • Recruitment 22nd of February to 31st of March 2013 <p>Sample Size: 10 FSSWs</p>

3.3.1 Mixed Methods Design and Analysis Strategy: Semiotic analysis, Framework analysis and Thematic analysis

This section identifies the definitions of each of the methods used in relation to a mixed method design followed by the process in undertaking data collection and analysis. The first method of analysis discussed is the use of visual images through the process of semiotic analysis. Semiotic analysis 'entails the deployment of a highly refined set of concepts which produce detailed accounts of the exact ways the meanings of an image are produced through that representation' (Rose, 2007: 75). This method when applied to analysing sex calling cards has the potential to enhance meaning on the social construction of female bodies for the purposes of advertising sexual services.

Secondly, the process of framework analysis applied to the archived interviews on the "Oral History Collection of Prostitution" identifies patterns and relationships between and across the secondary data. Framework analysis as described by Ritchie and Spencer (1994) is an approach used to interrogate and organise data. This was essential to understand the historical accounts of women's lives in sex work in relation to their health and wellbeing in order to easily manage and add or contrast knowledge with the other forms of data.

The analytical approach chosen to examine the primary data is through Braun and Clarke's (2006) process of thematic analysis. This method involves the identification of key themes through 'careful reading and re-reading of the data' (Rice & Ezzy, 1999: 258) in order to generate initial codes and their contribution to overarching themes. This means that the themes were constructed and emerged as being important to the description of the phenomenon (Daly, Kelleher & Gliksman, 1997). This method of analysis is compatible with a social constructivist epistemology where 'patterns (themes) are identified as socially produced within data' (Braun and Clarke, 2006: 8).

3.3.2 Combining the Methods: Iterative Development for Fieldwork

According to the three phases of this study, Phase 1 and Phase 2 provide some understanding about women's physical bodies used to promote sex work. While secondary data in Phase 2 contributed to knowledge and insight into the actual life stories of female sex workers background context, entry and involvement in the sex industry. This approach prepared me for primary research in the field (Phase 3).

There are methodological considerations concerning the relevance of a mixed methods research approach in relation to combining the different types of data. The impetus is 'not to produce a unitary rounded reality' (Brannen, 2005: 12) but to understand social phenomena from different methods (Denzin, 1970). Greener (2007: 43) states that "when two or more methods that have offsetting biases are used to assess a given phenomenon, and the results of these methods converge or corroborate one another, then the validity or credibility of inquiry findings are enhanced". This means that data analysis from one phase to another phase can provide a deeper understanding of the data and methods used to increase transparency of a mixed methods approach.

The potential of a staged process for my preparation to the field was seen when combining the visual and secondary data results in order 'to add to an understanding being gained' (Brannen, 2005: 12) with the primary data set. For instance, the follow-up questions used in the secondary data proved useful in the design of the interview schedule for Phase 3. The interview schedule in Phase 2 of the secondary data set illustrated good use of open-ended questions such as 'tell me about your upbringing'. The use of this life history approach in the interviews allowed the participants to talk freely about major events regarding their family upbringing and entry into sex work.

Some closed-ended questions were also used in the interviews for example, 'when you go the clinic, are you open about being a 'prostitute', (this was the terminology used in the secondary data set), in order to understand how the

women navigated key elements of their health experience. The language used and the questioning strategies attempted to adopt an empowering position from a feminist ethics perspective. In particular, the questioning strategies checked and confirmed the permission the women gave. So for example, 'can we talk about' as opposed to 'tell me about', provided the women with the option to speak or not by way of invitation.

These types of questioning strategies enabled me to structure and shape the interviewing strategies adopted for the in-depth interviews with FSSWs in the primary data set (Phase 3). The responses from the sex workers in the archived interviews indicated that they felt able to talk openly and provide important insight into their own health and wellbeing.

The guiding feminist principle for the interviews was to 'report what women said, treating it as a true and representative account of their experience, and thereby to break the silence' (Kitzinger cited in Seale et al. 2007: 117) about how women in sex work experience health and wellbeing. It also helped to 'give voice' to those experiences. It is important to illustrate that the women's accounts remain situated and shaped by the context of the Women's Centre

Another advantage of the iterative process was the illustration of the sex calling card portfolio presented to the FSSWs to elicit responses on the representation of women in advertising for sexual services. Although the sex calling cards do not represent the street sex workers, they can shed light on the terminology used in the cards. The following is one key question presented to the participants:

- What do you think about these photographs?

Prompts included:

- How do they make you feel?
- What about the words used?
- What do they mean to you?

I then transcribed data and analysed it using a thematic analysis approach. The coding categories included personal views on sex calling cards and some of the definitions of the types of services provided by sex workers. Appendix six represents a display of these views to illustrate the perspectives of FSSWs on the visual representation of women posing as glamour models for the sale of sexual services. The method chosen to explore the visual data presents as Phase 1.

3.4 Phase 1: Visual Data Collection

In London, sex calling cards found in telephone booths are one of the few visible signs of a productive indoor sex market (Swirsky & Jenkins, 2000). The cards promote women for sex in glossy postcard-size prints. Sanders et al. (2009: 28) report that 'placing cards with brief details and images in telephone booths is a key medium employed to signal to the tourist and local customer that "sex in the city" is available'.

A selection of 50 sex calling cards collected in 2010 from parts of central London – namely Soho, Marylebone and Edgware Road – for the purpose of semiotic analysis. Cultural stereotypes grouped together include European, Italian, Latino, Black, Blonde and Schoolgirl to name a few, and then placed in a portfolio for further analysis. This established a cross-sectional representation of all the cards collected for the visual data component to this study.

Obtaining the visual data from locations such as Soho and Edgware Road was challenging because sometimes the telephone booths smelled of urine and collecting the cards meant risking the possibility of picking up urine-stained cards. I used disposable gloves for picking up these cards. Similarly, collecting the cards made me feel uncomfortable at the prospect that passers-by could judge me as a 'pervert' or 'deviant'.

I was also afraid of the confrontation or harassment for taking the cards from the booths by those who had put them there in the first place. I also feared the police seeing me and mistaking me for a sex worker or person employed to place the cards in the telephone booths. However, none of these experiences occurred, despite my fears. In fact, people passing by rarely glanced at me as I was in the booths. My expectations were I would receive greater scrutiny but this may reflect urban anonymity, in what I was doing.

The next section demonstrates the analytical strategy employed to explore the visual analysis of the sex calling cards through a process of semiology. The fundamental process through which this can occur is by investigating the encoded message in the card advertisement.

3.4.1 Semiotic Analysis Strategy to Understanding the Visual Meaning of Sex Calling Cards

Sex calling cards represent women advertising sexual services which makes this data a feminist concern. Knowledge of how female bodies are socially constructed within the context of men's roles as consumers of the calling cards, over which sex workers have little or no control, has the potential to unearth the invisible aspects of women's identity in the sex industry. Therefore, the value of semiotic analysis to these calling cards is central to the feminist paradigm maintained in this study through decoding the visual representation of women's bodies in the sex calling cards and understanding the meaning of the text used to advertise for sexual services.

Applying social constructivism to decode meaning in sex calling card adverts is another way of examining hidden messages used as advertising techniques to get desired results by tracing how the media conveys a visual image, in order to attract attention from the public. Potter (1996) suggests that to deconstruct or decode is to uncover the hidden messages and themes behind the obvious up-front message, which in this phase, is through the analytical strategy of semiotic analysis.

Rose, in *Visual Methodologies* (2007: 79), identified that the fundamental unit of semiology is a sign. In semiotics, the sign is made up of two parts which include the 'signified' and the 'signifier'. The 'signified' represents the image or woman in the sex calling cards. Conversely, the signifier is the content of the calling cards such as the language used to advertise for sexual services. In semiotic analysis, the following approach to analyse and understand intent of the visual data presents as follows:

- 1) The image of the women coexists with a stereotype. The stereotype is the concept the woman in the calling cards is offering which refers to a particular nationality, ethnic or sexual preference and fantasy. The images fall together under the heading 'Stereotype'. Please see Table 2 in chapter 4 of the findings chapter for a presentation of this column.
- 2) The signifier consists of the characteristic features attached to the image, which symbolise particular qualities about a woman's body. For example, an image of a black woman is characterised with the signifier, 'sexy booty', which is a cliché description used to describe a black woman's posterior. Table 2 in chapter 4 of the findings represents this data.

Therefore, the signified shifts in the advertisements from the signifiers (language used to describe the woman in the calling card) and on to the sign, which is the sex calling card. The meaning explored exists within this relationship.

Goffman's theory on the analysis of *Gender Advertisements* (1979) is another useful approach to analysing what the position of the women in the images might symbolise. By classifying the images according to everyday rituals demonstrated in commercial advertising, (Goffman, 1979) the following two approaches when applied to the calling cards, explore the images further (see Table 3 of Chapter 4).

- 1) The ritualisation of subordination - the tendency for women presented in inferior positions and poses by observing how the women perform 'submissive gestures - bending one knee in (bashful knee bend), smiling or body canting' (Bell and Milic, 2002: 205).

- 2) Licensed withdrawal refers to the way 'women withdraw from the scene around them because they are implicitly or explicitly under the care of a male protector' (Bell et al., 2002: 205). This withdrawal is symbolised by certain types of gaze, for instance, gazing in an undirected way.

Table 4 of Chapter 4 presents the services mentioned in the sex calling cards. The street sex workers recruited in Phase 3 verified the definition of the sexual services and fantasies mentioned in the calling cards. This established the validity of the meanings of these services. The next section discusses the ethical issues inherent in analysing visual data.

3.4.2 Ethical Issues

In terms of incorporating potentially sensitive or provocative visual data such as sex calling cards into the research, the British Sociological Association (BSA) had no ethical concerns about the use of this data when contacted. The BSA (2002) states that researchers should consider the potential risk of the dissemination of their results to themselves, the discipline and the individuals portrayed (BSA, 2002). While the imagery displayed in the cards may include the exposure of body parts such as breasts, there is no physical, social and psychological harm caused to research participants who are anonymous (that is, their names are not known and their images are more or less generic), as are the photographers. The next section will examine the re-use of qualitative data, known as secondary data, to explore and understand the life histories of different categories of three women in sex work.

3.5 Phase 2: Secondary Data Collection

In relation to the iterative process, semiotic analysis of sex calling cards in Phase 1 provided an understanding of the visual representation of women involved in sex work and the sexual services they provided. This starting point led to Phase 2. To further increase understanding of the sex worker's lived experience, archived in-depth interviews from 1996 to 1997 are stored at the British Library in a collection of narrative accounts called *Oral History of Prostitution* by Wendy Rickard. Rickard had an interest in the life histories of sex workers and conducted face-to-face interviews with different types of sex workers, which were included as part of a collection. The British Library received this information for public use and data is stored in the reading room section of the Library, in cassette tapes.

The use of secondary data sources is an ethically sound approach to examining the accounts of these women prior to contact with FSSWs. Secondary analysis of qualitative data, involves 'the use of pre-existing data derived from previous research studies for the process of formal data sharing' (Heaton, 2004: 5). A number of authors have been reflexive about their use of secondary analysis (Corti & Thompson, 2004; Hinds et al., 1997; Mauthner et al., 1998; Szabo & Strang, 1997). However, most of these researchers were reusing their own data. Heaton (2004: 121) suggests 'a need to document in more detail what the process of doing qualitative secondary analysis involves in practice, including methods for re-using different types and sources of data for different purposes, and whether and how informed consent has been obtained for secondary studies'.

There are various arguments in favour of developing secondary analysis of qualitative studies (Hinds, Vogel & Clarke-Steffen, 1997; Sandelowski, 1997; Szabo & Strang, 1997; Thorne, 1994, cited in Heaton, 1998:3). For example, it has been contended that the approach can be used to generate new knowledge, new hypotheses, or support for existing theories; that it reduces the burden placed on respondents by negating the need to recruit further subjects, and that it allows wider use of data from rare or inaccessible

respondents (Heaton, 1998). For instance, Bishop (2007) offers a reflexive account of a secondary analysis project that was designed to 'explore historical changes in attitudes and practices' (Bishop, 2007: 2), which made use of existing data plausible (Savage, 2005).

However, Heaton (1998: 5) states that, 'where sensitive data is involved, informed consent cannot be presumed'. Growing interest in re-using data makes it imperative that researchers in general now consider obtaining consent, which covers the possibility of secondary analysis as well as the research in hand. This is consistent with professional guidelines on ethical practice (British Sociological Association, 1996, cited in Heaton, 1998: 5).

In relation to the secondary data, the participants recruited for the *Oral History of Prostitution* collection (Rickard, 1996, 1997) conducted a face-to-face conversation between the participant and the researcher (Gubrium & Holstein, 2002). All cassettes include the interview date, name of respondent and date of birth. The interviews were continuous and followed a life story format. In the recordings, the respondents communicated verbally to Rickard that they felt a sense of pride in talking about their lives and the women often made mention of wanting the interviews to help other women. The next section will demonstrate the data collection method employed in the field and the sampling criteria used to select the archived data.

3.5.1 Fieldwork

Fieldwork for Phase 2 commenced in December 2011 to January 2012. There are 15 interviews in the archived collection but only three were chosen, the criteria being that the participants were adult heterosexual women involved in sex work with no restrictions to public listening. Other interviews related to rent boys, transsexual sex workers or the tapes had embargoes to consider and did not fit the criteria for this study. Each in-depth interview consisted of 10-12 cassettes. This took approximately 30 hours of listening over one month. The next paragraph outlines the process of data collection for this secondary data.

Firstly, an appointment to book a listening booth in the reading rooms had to be made in advance, usually giving one weeks' notice. This was due to the high demand for the single rooms. Negotiating the appointment also involved stating what collection of data was required so that the library assistant could locate the material requested before my visit. The listening booths were only open at certain times of the day, which meant that only a few hours of listening time could be allocated at a sitting. This meant working efficiently with the data sets in order to maximise the time given to listening and transcribing the data.

However, because the interviews were recorded on tape cassettes, transcribing the interviews meant frequently stopping the tape, rewinding it and playing back. This process took a significant amount of time. The reading rooms only allow for pencil and not a pen, which meant making sure that, the right stationery was at hand. The notes taken included direct quotes, paraphrased remarks and the types of questions used in the in-depth interviews.

In the paragraphs below, I include the interviews selected for analysis. The names of the sex workers have been changed and replaced with pseudonyms to protect the participants involved in line with an ethical approach. In the bullet points that follow, the participants' demographics and typologies of the sex work the women were involved in is mentioned. These women met the inclusion and exclusion criteria mentioned previously.

Interview 1: recorded Nov 1997: 12 Cassettes

- 'Violet' – 'Street Sex Worker' – D.O.B. 1961
- Born in Dorset

Interview 2: recorded Nov 1997: 8 Cassettes

- 'Cherry' – 'Working girl', 'Milkmaid' – D.O.B. 1960
- Born in Zimbabwe

Interview 3: recorded June 1998: 6 Cassettes

- 'Rose' – 'High class prostitute' – D.O.B. 1961
- Born in South Kensington, London

The interviewer used open-ended questions with a calm and patient voice in order to draw a rich response from the participants. This approach is consistent with semi-structured interviews where the questions are open-ended, thus not limiting the women's choice of answers (Gubrium & Holstein, 2002; McCracken, 1988). For example, each interview commenced with the question, 'When did you first become aware of prostitution?' Here the participant shared a detailed life history of her journey to becoming a sex worker. However, because the interview structure allows for an in-depth account given over a few days, there were interruptions. The phone would ring and usually the calls related to 'punters' (clients of the sex workers) requesting to make appointments.

Similarly, one of the participants, 'Rose', would often become very emotional throughout the interview process, necessitating stops in the recordings. While this background activity gives the listener an impression of the emotional state of the participant in the interview, it also raises a number of concerns about the re-use of the data and whether or not some data was lost in the interview process. This has the potential to lead to a limitation in the secondary data, which is 'the problem of not having been there' (Heaton, 2004: 54). In spite of this, it was necessary to persist with this data since access to FSSWs was not apparent at this stage. The archived life stories of the women in the secondary data set were valuable in gaining insight into the women's perceptions and experiences of health and wellbeing. The next section outlines the method used to analyse the secondary data.

3.5.2 Framework Analysis

The framework method was developed in the 1980s for use in policy research. It is now used in health research as a structured approach to produce thematic summaries of data (Richie and Lewis, 2003). In order to

manage and organise the archive accounts from the secondary interview data set, the framework approach enabled me to summarise the data in a way that supported the research question and the development of a framework on the health and wellbeing of the three different types of sex worker's included in the secondary dataset.

I developed the framework into a structure that consisted of categories or 'codes grouped together into clusters around similar ideas' (Gale et al. 2013: 1) from the transcripts. Concepts referring to the women's perceptions of their health needs were used. This is similar to thematic analysis where repeated reading of the transcripts resulted in the formation of categories that were evident in each of the three life histories (Braun and Clarke, 2006). (Please see appendix seven for a summary of the framework). A demonstration of the framework analysis employed is provided in the paragraphs that follow.

I drew on the framework process developed by Ritchie & Spencer (1994), which they state involves the following interconnected stages:

1. Familiarisation – becoming familiar with the range and diversity of the data
2. Identification of a thematic framework
3. Indexing – applying the thematic framework systematically to all the data
4. Charting – reorganising the data according to appropriate thematic references
5. Mapping and interpretation – identifying a structure that illustrates the dynamics of the phenomena under investigation (p. 186).

Stage One, Familiarisation: The transcribed interviews consisted of field notes under anonymised interviewee names to protect the women. Familiarisation with the transcribed interviews involved reading through the transcribed notes and creating indicative notes on the themes in the data.

Stage Two, identification of a thematic framework: This involved identifying the main themes in relation to the objectives of this study. The themes selected according to the information that would elicit a greater understanding of the lived experience of women in sex work in relation to their health and wellbeing.

Stage Three, Indexing: The themes were grouped together, placed under headings, and then expanded on with key phrases across the entire data set.

Stage Four, Charting: Key themes from stage 3 were then reorganised according to the data generated from the three participants with references matched to the themes. Detailed coding pertained to the health and wellbeing of the interviewees in response to the questions set out in the aims and objectives of this study.

Stage Five, Mapping: A thematic chart was created that mapped the analysis of the data into a structure that would manage the data efficiently. A display of the core themes emerging from the framework analysis of the secondary data consists of the following categories:

- Typology
- Family background
- Reason for entry into the sex industry
- Perception and behaviour of work in the sex industry
- Health diagnosis
- Health beliefs
- Mental wellbeing
- Stigma
- Advice about entry into sex work
- Identity as a mother
- The issue of choice in the sex industry
- Attitudes towards 'sex as work'

The choice of engaging with the secondary data fulfilled two main aims that is, addressing a sensitive area of research and, accessing a research population that is elusive (Long-Sutehall, Sque and Addington-Hall, 2010: 335). Hesse-Biber (2014: 190) states that 'feminists are particularly concerned with getting at experiences that are often hidden'. Therefore, framework analysis using archived data ensured I could explore the topic of women in sex work's health and wellbeing which is a goal of feminist inquiry (Liamputtong, 2007: 185). I achieved this goal by focusing on relationships with different parts of the three data sets, thereby seeking to draw explanatory conclusions clustered around the key themes related to the health perceptions of the three women in the sex industry.

The approach I employed was aligned with my epistemological stance of social constructivism, which seeks to understand (rather than judge) the personal accounts of the women in sex work. This was achieved by documenting their perspectives, that is, how they constructed their social world, both through their interpretations of it and through the actions based on the interactions with those in those worlds (Huberman and Miles, 2002: 67). Another key emphasis of social constructivism is that every human being develops in the context of their culture that includes family upbringing, which gives the individual much of their knowledge (Bruner, 1996). This phase of my study is in support of the next phase, which is to conduct in-depth interviews with FSSWs.

3.6 Phase 3: Primary Data

The purpose of this phase was to recruit a sample of women working as street sex workers for an in-depth interview. The aim is to provide fresh insights into the conditions that street sex workers face today and a fuller understanding of their health and wellbeing needs. The inclusion criteria were women aged 18 years and over who were working as sex workers, with their main place of work being on the streets in central London. My research participants from the women's shelter met those criteria. An account of the journey to finding the field and recruiting participants for the in-depth interviews now follows.

In-depth interviews offer a 'tell it like it is' narrative approach to social science research. This approach is committed to representing interviewees' voices, which eliminates any meaningful distinction between description and theoretical interpretation (Hollway et al., 2012). In this respect, conducting a focus group discussion with the sensitive nature of this research topic would not be the method of choice. This is because the purpose of this study is not to collectively study group interactions and group meaning (Barbour, 2014: 135). Rather, it is to have in-depth one-to-one interviews with participants in street sex work in order to gain an intimate understanding of their health experiences.

Discussing health can be a sensitive topic for many people generally, and more specifically for sex workers. Female sex workers' sexual, reproductive and other health and wellbeing issues have been controversial and subject to stigma in society. Therefore, a group forum is likely to prove problematic in openly discussing the health needs of these women because the nature of this type of sex work is often secretive. Liamputtong et al. (2005: 79) reports that several researchers have used focus groups to study sensitive issues such as HIV/AIDS, so there are also advantages to this method, depending on the research aims of a study. The next section will discuss the fieldwork strategy. This strategy involved four stages: finding the field, volunteering, recruiting participants and leaving the field.

3.6.1 Finding the Field

At a conference on *Sex Workers: Stigma and Barriers to Health* at University College London, I met, for the very first time, a sex worker employed by the International Union of Sex Workers (IUSW). The IUSW is a grass-roots organisation that brings together people who sell sexual contact and gives voice to current, active sex workers in the sex industry (IUSW, 2009). I explained my research interest and the sex worker agreed to meet up for coffee. At the meeting, the woman agreed to act as a gatekeeper to recruit other sex workers for the study. The University of Hertfordshire Health and

Human Sciences Ethics Committee granted ethics approval on the 12th May 2012 for fieldwork to start.

After establishing a second interview, the gatekeeper did not respond despite several attempts of trying to make contact again. As a result, the idea of pursuing fieldwork at the Union stopped. Negotiating access in the first instance led to a change in research plans leading to a new ethics application form with change of venue.

Another opportunity arose in a discussion with one of the Sister's of Mercy. She mentioned her voluntary work at a Women's Centre with vulnerable women. After probing further, I established that women in the sex industry are service users of the Centre. I made an appointment to visit the central London-based Centre on July 2012 and meet the director.

3.6.2 Background Context to the Women's Centre

It is imperative to understand the setting in which participants are recruited in a study. Cresswell (2007: 41) states, 'we cannot separate what people say from the context in which they say it'. The Women's Centre is a registered charity, dedicated to supporting vulnerable women caught in cycles of abuse and social exclusion. There is a particular focus on the needs of women involved in street sex work, trafficking and the criminal justice system. The women-only Centre is located in one of London's main red-light districts and is open from Monday to Friday between the hours of 12 to 4pm. From 12pm, a hot nutritious meal is served followed by activities for the women to get involved in as they wish.

The Centre is located in a two-storey terraced Victorian building. Before entering the house, there is a security intercom system and once verified, you enter into a reception area followed by a few offices for the support workers including a private counselling room. As you walk down stairs to the basement, a canteen area is available with dining tables and chairs and this

area opens up into a garden. This space is a communal area for women to interact with one another, if they wish too.

The Institute of Our Lady of Mercy founded by a Catholic denomination, supports the Centre. Grants are also received from statutory and non-statutory funders with close links to many local agencies and initiatives in order to provide sexual health services, counselling, probation support and domestic violence services to name but a few. An Annual Review report by the Women's Centre (2013) states that by working in partnership with other support agencies, it aims to provide a holistic, flexible range of services within a supportive environment, with the goals of diverting women from the criminal justice system, improving the quality of their lives, and working towards meaningful and rewarding social participation. I felt these incentives fitted in well with a feminist approach that is concerned with promoting social change.

The Centre aims to view women in sex work with compassion and care through the practical and emotional support it provides. The women can receive counselling from a professional psychologist, assistance in finding accommodation, and the women have access to showers, clothing and toiletries. The purpose is for the women to have a holistic, woman-centred service where they feel safe, valued, looked after and cared for. The Centre adopts a trauma-informed approach to supporting the women. According to Harris and Falot (2001), trauma-informed services place priority on the individual's safety, choice and control. However, the significance of the Women's Centre for this study is that the nuns share my feminist stance, which is to have a caring and non-judgmental approach toward the women that access the Centre.

The concept behind the Centre is underpinned broadly by Christian principles and especially the concept of the "good Samaritan" (John 4: 1-42). However, during my eight months at the Centre, I did not see any attempts to impose or provide guidance based on the adoption of religious systems of belief for the women that accessed the support services of the Centre. Nor did the women have to conform to any religious beliefs to use the Centre. The mission of the

Centre is to provide support and a place of refuge. Had they felt judged or persuaded to conform to a religious standard, perhaps they would feel less inclined to return.

There are also no religious symbols or artefacts in the reception and dining area although on the floor above the reception area, there is a quiet room for prayer and reflection. The women are welcome to access the prayer room if they want too. There are other single rooms available for one-to-one support and they are secluded from the public areas, which create a private space for maintaining confidentiality and privacy during meetings. This is where I would later carry out my interviews. From what I can recall, there were no religious symbols in these rooms but religion does ground the Centre's existence.

The nuns are Irish and do not dress in traditional religious attire but instead wear casual comfortable clothes. Previously, the sisters worked as either teachers or nurses before coming to live and work at the Centre. From my observations, the women are very comfortable with the nuns who show commitment and consistency with their roles in ensuring a supportive environment prevails. The nuns greet each woman by name unless they are new to the Centre. They are always welcomed to engage in activities as they wish. One of the nuns offers a manicure, which the women enjoy.

The next section will examine my own reflections as a volunteer and the transition to a student researcher.

3.6.3 Reflections on Voluntary Work: 'This is Not a Zoo'

'This is not a zoo' reported the Director of the Centre when asked about the opportunity to recruit participants for my research study. Upon reflection, this reaction to my research interest is understandable given that the Director is a strong advocate for the women that access the Centre and I was naive to think that I could negotiate access immediately. The Director's protective stance ensured a non-exploitative research focus would prevail which is line with my feminist approach to respect and establish rapport before undertaking

any research. In order to be able to approach the women about my research I had to be prepared to invest my time into building relationships and gaining trust with the women who frequent the Centre, as well as the support staff who provide a service for these women. I also had to undertake 'work' for the centre and the women before engaging in voluntary work. The voluntary work with the women involved supporting the women with art and craft activities. This drew me closer to the world of the women who frequented the Centre.

While no data was collected or recorded at this time as at this stage, the women did not know that I was a student researcher (a requirement of the head of the centre). This period did shape my thinking and enhanced my understanding of the women's day-to-day lives as well as their interactions with each other. The time allowed me insight so that I could appropriately bound my questioning strategy, based on greater understanding into what was appropriate or not to ask the women.

In addition, my role as a volunteer first rather than as a student researcher helped to potentially 'eliminate the power imbalance' (Koch and Harrington, 1998; Maxey, 1999) in the research relationship. This meant I was accepted in a way similar to the nuns, as someone who would not judge them. Feminist researchers have long advocated that feminist research should not just be 'on women', but 'for women' and, where possible, 'with women' (DeVault 1990, 1996; Edwards 1990; Fonnow and Cook 1991, 2005; Neilsen 1990; Ramazangolu and Holland 2002). I believe my age, as a woman in her mid thirties was also an advantage to the interactions I had with the FSSWs since they were in the same age group. (See Table 5 for a breakdown of the demographic characteristics of the women interviewed in this study).

It was also during these activities that I challenged my social constructions about women in street sex work. I discovered that the lives of these women are complex and in some ways different from what the media and literature presented. For example, women's drug and alcohol addiction should take into account the socio-economic and personal circumstances in which these women's lives evolve.

Another important recognition is that while my own perceptions of FSSWs were challenged, my empathy towards these women was increasing also. I felt that the volunteering phase gave me valuable insight into an understanding of the realities of these women's lives before I formally entered into the field as a student researcher. However, working as a non-researcher and not disclosing the research purpose and my researcher identity to my potential participants presented a challenge to standardised research practices relating to covert and overt fieldwork. Dunbar et al. (2002: 291) suggests that 'it is important to the success of the interview for the researcher to disclose something about him or herself to the interviewees'.

Then again, until the Centre agreed that research could begin and I could inform the women users of the centre that I would like to do research, I had to confirm to the centres informal 'code of ethics'. I was prepared to contribute to the women's lives and not just see them as participants in my research. Immediate disclosure of my researcher identity was not possible at the start as the centre staff felt I needed to demonstrate to the women that I was prepared to '*work for them*' by volunteering and was therefore trustworthy. Hence, I did not reveal research intentions at an early stage that could potentially jeopardise data collection Li (2008: 103).

After disclosing my identity, I did not feel any awkwardness as a volunteer. It actually gave me a sense of relief that I could finally be transparent as a student researcher. While the volunteering phase could be seen to be at odds with a feminist stance, as a volunteer I was still concerned with the women and their lives, just in a different way to when I revealed myself as a student researcher. The feminist ethic was there throughout my time at the Women's Centre.

In total, before starting the research, I volunteered for eight months from July 2012 to March 2013. For seven months, I volunteered one day a week until the Centre manager agreed for me to undertake my research assignment. At a team brief, which happens twice a day at the Centre, the manager

introduced me to the staff as a research student during my last month of volunteering. She explained that some time would be given for me to introduce the research topic of which I did. I explained the nature of my research question, the participants I was seeking to recruit and that I would appreciate their co-operation in identifying women in street sex work for my study.

In this way, the support workers and other volunteers were aware of my intention to commence fieldwork. The women at the team brief meeting came up to me after the introduction to my research focus and encouraged me with the importance of the topic. They showed signs of willingness to support me.

The Centre agreed to the display of a poster to make participants aware of the aims and purpose of the study (see appendix two). These areas included the activity room, entrance doors and on the notice board at the Centre. The poster outlined the eligibility criteria for participation in the interviews. A token of appreciation gesture was evident in the poster and constituted a £10 gift voucher from Sainsbury's shopping Centre (this was the closest shopping centre in the area). Hollway et al. (2012: 78) suggest that payment can be seen as a means of inducement, which undermines the free choice of a person to participate in research. However, for women who are unemployed, appreciation for their time was important, and a mark of respect for their participation.

3.6.4 Sampling Techniques

I recruited my participants using three forms of sampling: targeted sampling, snowball sampling and key informant sampling. Atkinson and Flint (2001) advocate the use of snowball sampling to locate hard-to-reach populations. In this approach, an 'initial respondent is asked to suggest other people who may be willing to participate in the research' (Biernacki and Waldorf, 1981). They argue that the use of snowball sampling strategies provides a means of accessing vulnerable and more impenetrable social groupings.

- Firstly, I recruited participants by engaging with the women during the activities at the Women's Centre, which included sewing, knitting, crocheting and playing Monopoly. Here, trust and rapport was built over the eight-month voluntary time and it was easier to identify those women involved in street sex work through one-to-one discussion with the women, and hearing the women in conversation talk about what their night was like on the street. This is a form of targeted sampling.
- Secondly, a known street sex worker at the Centre who I had developed a sense of trust and rapport with over my weekly voluntary work activities was informed of my research topic. She volunteered to be my first participant but was also interested in helping me find other women for the study. She acted as a gatekeeper and 'spotted' women in street sex work who were service users of the Centre. She was familiar with all the women who access the Centre and would inform potential participants about the purpose of the research study and their potential involvement in the in-depth interviews. As a gatekeeper, she could also screen participants who would meet the criteria for the interviews.

This was very helpful to my study as there were often new faces visiting the Centre. The gatekeeper confirmed whether a participant was a street sex worker giving me confidence to work with this person in order to recruit other participants. Snowball sampling refers to an initial participant asked to suggest other people who may be willing to participate in the research who would otherwise be difficult to approach directly (Biernacki & Waldorf, 1981; Bernard, 1988: 98).

- Thirdly, women involved in sex work who were interested in participating in the interviews approached the support workers; potential participants had seen the poster displayed. Interested women came forward by placing their contact details at the reception desk. When I made contact, I informed the participants of the nature of the study, asked whether they were over the age of 18 and involved in

street sex work. This method is a form of key informant sampling where gatekeepers are able to be helpful in identifying the right informants for the study. For instance, sometimes a potential participant would not meet the criteria and were perhaps motivated to take part because of the offer of a gift voucher of £10. However, the support workers at the Centre were able to verify the age of the participants, identify which women were engaged in street sex work or which service users accessing the Centre with various other needs.

The following section outlines the recruitment of my participants for the primary data sample.

3.6.5 Recruiting Participants

Recruitment commenced from 22nd February 2013 through to 31st March 2013. I recruited the first participant while engaging in an art and craft activity. I conveyed the research interest to the participant who then agreed to participate in the interview. The psychologist at the Centre who looks after the participant's case history confirmed the participant's involvement in street sex work.

The second participant came forward willingly after hearing from the program manager about the research study. However, the willingness of this participant to come forward was due to her seeing me interact with the women at the Centre while volunteering and engaging in various activities. I did not know that this participant was involved in sex work until the woman talked about her work as a street sex worker. She was well networked in the Centre.

The third participant was also well known to the Centre as a street sex worker and homeless at the time of her recruitment for the interview. I was informed that this woman had a history of violent outbursts towards other service users, of which, the support and voluntary workers were aware.

The fourth participant I recruited over lunch. The participant asked me about my role at the Centre and it was here that the purpose of my research focus was conveyed. The woman shared very discreetly that she had been involved in street sex work and, if it was kept confidential, she could participate in the research study. The gatekeeper mentioned in section 3.6.4 (second point) approached five participants that all came forward for my study.

The tenth participant was an older street sex worker who had observed me throughout my voluntary time and we both gained a sense of mutual trust and respect for each other. She came forward to the interview voluntarily and shared her story with me. It was a very moving interview where a number of tragic events in her life were disclosed.

The final number of participants recruited for the primary data set was 10. I recruited my participants over a four-week period. Table 5 of Chapter 5 presents my participants' demographics illustrating the interviewee's name, status, number of children, age and age of entry, type of accommodation and ethnic origin. No actual names of the participants have been used to maintain the privacy and confidentiality of the women recruited in this study. The interviews took place at the Centre over a one-month period. The next section outlines the topic guide for undertaking the in-depth interviews.

3.6.6 Developing the Interview Schedule

Chase (1995: 2) argues, 'attending to another's story in the interview context requires an altered conception of what interviews are and how we should conduct them'. It was not my intention to trigger any negative emotional reactions; therefore, careful consideration was given to the topic guide. For instance, I initially undertook three pilot studies with the volunteers at the Women's Centre in order to modify the interview schedule so that greater sensitivity was given to the way I designed the questions. Thus, several attempts at revising an interview schedule were made to act with integrity,

which is, shaped through an ethics of care approach towards the sensitivity of the research participants (Gabb, 2010).

In this mode, the interviewer is imposing on the information in three ways: 'by selecting the theme and topics, by ordering the questions and by wording questions in an appropriate language' (Bauer, 1996). Bauer (1996) states that all structured interviews and most aspects of semi-structured interviews come under the question-and-answer approach, where the interviewer sets the agenda and in principle remains in control of what information is produced. (See appendix five for an illustration of the interview schedule where the questions were specific to their life story, working life, health issues, relationships, family, living arrangements, the experience of health services and impression of the sex calling cards). I constructed the questions in a clear and simple way and avoided complicated terminology in order to accommodate the participants' level of literacy. The next section discusses my reflections on the interview process.

3.6.7 The Interview Process

Once I recruited the participants for the interviews, a time was established with the Women's Centre and a quiet room provided. The women gave informed consent for the interviews. 'Informed consent implies that potential participants need to be given sufficient information about the project and what will be required of them in advance' (Hesse-Biber, 2014: 91).

With regard to obtaining informed consent, I read out the consent forms to the participants to make sure of an understanding about the content in advance of commencing the interviews. The majority of women interviewed had low literacy levels. Most asked for the general information sheet (see appendix three) and consent form (see appendix four) to be read out to them.

Furthermore, in gathering consent in relation to vulnerable groups such as FSSWs, it is suggested in the literature that 'special sensitivity' is required (Liamuputtong et al., 2005: 21). Booth (1999: 78) states that 'the language

used needs to be extremely clear and simple so that people know exactly what they are agreeing to participate in'. This is to ensure that the women are truly giving informed consent.

In addition, due to the sensitivity of the research topic, I gave careful attention to emphasising that confidentiality would be strictly maintained at all times. I signed a confidentiality agreement upon commencement with the Women's Centre under the Data Protection Act 1998, which governs the use of personal information. I took precautions to safeguard the research participants by keeping all information secure on a password-protected computer. Actual names were not used and specific identifiers such as home addresses, criminal offences or any family-identifying feature were not included in the data.

I also verbally informed the women that at any time during the interview process, they had the right to terminate the interview, not to discuss specific questions and the right to put restrictions on how the information is used. I then sought permission to record the interviews on a Dictaphone, which was granted.

The next section will outline the ethical considerations and challenges to undertake this phase of the research study.

3.6.8 Ethical Considerations and Challenges

Ethics approval to undertake this phase of study was sought from the University of Hertfordshire Faculty of Health and Human Sciences, Nursing, Midwifery, Social Work, Criminal Justice and Counselling Ethics Committee on 12th May 2011. Protocol number NMSCC/05/11/4/A was granted. An application for the extension to the ethics committee was granted until 31st March 2013.

There were ethical challenges to my voluntary experience before undertaking the research interviews. For example, I was initially uncomfortable

'masquerading' as a volunteer with an ulterior motive. When I received authorisation that allowed me to announce the goals of my research, those anxieties dissipated.

It is important to note here that the potential study participants did not volunteer any personal information before the research started. I believe this was because they viewed me as a new volunteer and perhaps did not feel comfortable to share personal life stories. I also maintained an approach that ensured that there was no opportunity for personal information to be divulged with me. I achieved this by having another volunteer with me at all times so conversation was kept light.

Once I shifted from being a volunteer to research student, the women involved in street sex work were able to disclose personal information with the reassurance that it would be kept confidential. Concerns about participating in the activities at the Centre as an insider would later make it awkward for the shift to an outsider role, but the women's attitudes towards me did not seem to change.

It should also be acknowledged that in order to volunteer at a women-only Centre, being female was both an advantage and a necessity in this field. This has lent support to the position that in order to understand women's life situations and experiences, more studies should be conducted by women and for women (Ettore, 1989). Hollway et al. (2012: 28) mention that 'same-sex interviewing can minimise the defensiveness brought on by sex differences' however, it should also be noted that some interviewees presume that women interviewers would be more judgmental and therefore prefer not to disclose. This however did not appear to be the case in this research, based on my opinion of the interview atmosphere.

At the start of every shift during the opening hours of the Centre, 11am to 4pm, it was mandatory to collect an alarm. The alarm was tied with string to put over my neck and was to be handed back towards the end of the day. In an event of a physical attack or emotional outburst between two women who

access the Centre or toward the support staff, the alarm could be sounded and the staff on duty would be able to identify where the incident was occurring and attend to the situation.

During my voluntary time at the Centre, my alarm was never used nor did I hear an alarm bell go off. While conducting the interviews with my participants, the alarm gave me a sense of security in knowing that if any support was required, help was close by. The alarm gave me a sense of security because interviews were conducted in a single room away from public areas. Most of the women using the Centre's services had a background of anti-social behaviour or involved in problematic drug and alcohol use that made their behaviour erratic. From a feminist perspective, I was aware that having a visible alarm might be viewed as a lack of trust towards my participants so I made sure it was hidden underneath my blouse at all times.

As the interviews progressed, the women became more comfortable sharing their narrative accounts as street sex working women. The goal was for me to listen to the voices of how women engaged in street sex work construct their own understanding of and their health and wellbeing needs. It was important not to persist with particular issues that would likely raise emotional responses. Examples included discussing in-depth details about their family background, particularly their own children in foster care. A psychologist was available on site should any emotional support for the participants be required during or after the interviews. The interviews ranged from 15 to 45 minutes in length.

Bolt (2010: 165) explains how ethnographic research into 'vulnerable groups' is risky because it often involves interviewees being asked personal and potentially painful questions. The chances of these questions bringing emotional costs such as embarrassment, guilt or shame are potentially high in research into sex work because of the sensitive nature of the subject matter. For example, asking sex workers to discuss their personal situations is also asking them to visualise and analyse themselves as social 'phenomena' and

this risks precipitating some form of painful reaction or through self-awareness, to begin to struggle with issues of identity, which might have otherwise remained dormant (Bolt, 2010: 165).

Consequently, feminist researchers have criticised unequal power relations in the interview, whether based on gender, race, class and/or something else (Stanley & Wise, 1983; Maynard & Purvis, 1994). These researchers emphasise the way in which the subordination of women reproduced in the research relationship where women's accounts can be constrained by the power of the interviewer and analysis taken out of their hands, thus producing outcomes against their interests (Hollway & Jefferson, 2012: 28). I maintained a commitment to a feminist standpoint throughout the research design and process. This was shaped through an ethics of care framework that is in a 'feminist, caring, committed ethic' (Gabb, 2010) to the research participants. The next section explains where I reflect on my own position as a student researcher.

3.6.9 My Position as a Student Researcher and Nurse working within a Feminist Paradigm

In my professional role as a registered nurse, I have not cared for FSSWs in a hospital setting, but I do have experience as a feminist activist involved in a women's personal development program. This program aims to equip vulnerable women with the necessary skills required to improve their self-esteem and life conditions (Spry and Marchant, 2012). In addition, during the trajectory of my research, I have developed as a feminist who is interested in 'women's experiences of discrimination and repression' (Alvesson and Sköldberg, 2009: 239). This standpoint sits well with my nursing ethos.

The Nursing Midwifery Council (NMC) 'Code of Practice and Behaviour for Nurses and Midwives' (2015) does provide a guideline for the fundamentals of care towards people. These include treating individuals with kindness, respect, dignity and compassion. My approach to the women was informed by the principles of nursing in terms of a commitment to be non-judgmental

and to treat the women with dignity and respect. The hospital mandate where I work is that 'every patient is to receive quality care and be treated with compassion, kindness, dignity and respect'.

My experience with admitting 'patients' in the hospital ward setting is to get them to 'tell their story' meaning their surgical and medical history; this meant that I was also comfortable with asking the FSSWs questions about their history. I thus started with a commitment to uncover these women's experiences, enabling them to describe social realities based on their own experience (Acker et al., 1991).

I have critically reflected further on my research and believe nursing practice needs to incorporate a feminist understanding concerning women's multiple experiences of health and health services. This has caused me to rethink my practice as a professional nurse and to advocate further on behalf of the patient. Alvesson and colleagues states that:

'the capacity to swing between empathy and understanding on the one hand, and a critical questioning, reflection, conceptualisation and theoretical abstraction on the other, is the hallmark of good research' (2009: 245).

This reflects the approach I have developed since this study started.

In addition to Alvesson and colleagues (2009), trust and rapport was imperative to ensure quality research based on unbiased responses of the women who felt comfortable enough to share their experiences in the interview process. I felt that, given the sensitivity of the research topic, the Women's Centre was an appropriate venue to undertake the interviews as a 'safe house' because it was secure and supportive of women's social and health issues.

Even when I commenced the recruitment process of the women involved in street sex work, I was committed to understanding the world of the women I interviewed from their own lived experience as individuals and not my own assumptions about women in sex work. Although I had acquired some

background knowledge from the secondary data set, I remained objective in listening to the narrative accounts of the women. It was evident that the women came from an environment of daily hardships of survival as they had a need to attend the Centre for access to basic human needs such as food, shelter, safety, security and social interaction with others. I will now discuss my reflections about my own emotional labour in conducting the interviews with the women involved in street sex work.

3.6.10 My Own Emotional Labour

Fieldwork in this context was physically and emotionally draining. The accounts of sexual abuse recounted by the women meant it was necessary for me to debrief with the Centre, my university supervisors and family. I did not foresee the extent of the childhood abuse experienced by the women despite some general understanding of that from the literature review. The secondary data set did provide some background context to the lived experience of women involved in sex work but I did not expect to hear such graphic details of sexual abuse.

Burr (1996) illustrates that the effect of being involved in, and in a sense, sharing the private world of people in despair, can be a psychologically and emotionally wrenching experience. Perhaps, on reflection, whilst the 'researched' need to know how to protect themselves from 'us', we too, the 'researchers', need to know how to protect ourselves when undertaking sensitive research (Sampson, Bloor & Fincham, 2008). As the interviews progressed, I was more determined to tell the story of the participants through my thesis because of the life events that had happened in these women's lives and their subsequent health conditions.

Another methodological and ethical challenge was the process of leaving the field. It was important to leave the field, firstly as a volunteer and then to leave as a student researcher. This involved adjusting the level of involvement by participating less in the Centre's activities in order to establish the student researcher role. Shaver (2005: 304) states that this 'legitimizes

the withdrawal anxieties experienced by the researcher, who in spite of the attachments that develop on both sides, generally finds it a more difficult process than the participants' experience'.

In my experience, it was sad to say goodbye to both the women I had interviewed and the support staff at the Centre including other volunteers with whom I had become familiar. From a feminist view, this is because a connection had developed over time due to the mutual commitment we all had which was to see vulnerable women receive support and have a hope for their future.

On my last day, I thanked the team during the end of day team brief and this gave me an opportunity to let the staff know where to call if they had further questions or wish to see the results. Shaver (2005) suggests that the ritualised leave-taking provides additional protection for both the participant and researcher. It acknowledges the essential contribution made by the participant in a respectful and courteous manner. The next section will discuss what analysis strategy was used to explore participants views and experiences in relation to their health and wellbeing.

3.6.11 Thematic Analysis

The process of thematic analysis is to generate emergent themes and patterns in order to develop a narrative explanation that can account for and describe a phenomenon under study (Hammersley and Atkinson, 1995). This is achieved when initial themes identified from participants' accounts become categories for analysis (Fereday and Muir-Cochrane, 2006). The next paragraphs outline the steps involved in the thematic analysis process I used for my primary data sample using Braun and Clarke's 6 steps (2006).

1. Data Familiarity

This step required me to be fully and actively engaged in the data by transcribing the interactions, taking note of any useful ideas as a result

of the reading (and re-reading) of the transcripts. In addition, in this step I repeatedly listened to the recordings to immerse myself and set the context for the work ahead absorbing all of it. This step provided me with the necessary foundation for the rest of the research.

2. Generating initial codes

Once I was familiar with the data, I began to identify preliminary codes. These codes were the parts of the data that seemed to be meaningful and useful to emphasise. Manual coding worked well with the interview transcripts so there was no need to use computer data analysis programmes. Software packages are useful with a large text database in order to store and quickly locate the themes in the data however 'it is not required in order to conduct robust analysis' (Silver and Lewins, 2014: 11) Furthermore, preliminary codes gave the research an indication of the contextual setting during the interview process.

3. Searching for themes

My third step in this process was the start of the interpretive analysis. Relevant data was sorted according to overarching themes. My thought process was clear and logical linking relationships constantly between codes, subthemes, and themes.

4. Reviewing themes

To be comprehensive and thorough, an in-depth review of identified themes was achieved as I questioned myself on how to combine, separate, or dismiss some initial themes. On-going analysis is cardinal to further enhance the identified themes in this step and clear working definitions to capture the essence of each theme (Ryan and Bernard, 2000) in order to produce a unified story of the themes emerging from the interview data. It is these emerging themes that then become categories for analysis (Fereday and Muir-Cochrane, 2006). (Please

see appendix eight for a summary of the thematic analysis process conducted for interview 1).

5. Producing the report

Conceptual rigour in qualitative research involves in-depth planning and documenting of the analytical process so that it is transparent throughout data collection, analysis and interpretation of data (Horsfall, Byrne-Armstrong and Higgs, 2001). As a result, the final step was for me to interpret my findings and express how the themes were able to answer my research question. (Please see appendix nine for a summary of the core themes that emerged with eight major subject charts).

3.7 Summary of Methodology and Methods

This chapter has established the key aspects of the methods and methodology for understanding the health and wellbeing of FSSWs. The philosophical approach was interpretivist as it explored the social world of sex workers to unravel their reality through experiences, perspectives and life histories.

Orientation to the field in preparation for Phase 3 involved an iterative process in which Phase 1 and Phase 2 enabled me to go into the field to collect primary data. This meant that prior to my engagement with primary data in Phase 3, insights were gained by looking into historical and visual data on female sex workers. A feminist ethics of care approach (Gabb, 2010), to pay particular attention to the vulnerability of the group (Elam & Fenton, 2003) in Phase 3 and how best to act with integrity (Daly, 2007) underpinned the research process to eliminate rejection, stigma and discrimination in research practice.

In summary, this research study has incorporated visual, secondary and primary data in order to establish a detailed understanding of the research problem. A feminist qualitative methodology utilising a mixed methods

approach has guided the research process in order to provide a comprehensive picture about women's lives in the sex industry in relation to their health and wellbeing. The findings from the first two phases of this study are presented in the next chapter.

Chapter 4 – Phase 1 and Phase 2: Presentation of Visual and Secondary Data

4.0 Introduction

Chapter 4 presents the key themes that emerged from the analysis of data from Phase 1 of this study on the visual representation of women displayed in sex calling cards. The chapter also represents the key findings on the health perspectives of archived life history accounts involving three women in sex work from the late 1990s. These two phases of my study are to orientate me to the field. Adopting this approach enables me to view women in sex work with unconscious bias. Phase 3 described in chapter 5 will provide primary data consisting of findings from in-depth interviews conducted with female street sex workers (FSSWs). The goal of this phase of my study was to capture women's lived experience in street sex work.

A feminist centred approach underpinned by social constructivism will guide the presentation of data in these phases of my study as a means to understand the role and position of women in the sex industry. A feminist perspective has gender as a focus (Marshall, 2000: 12), puts women's own perspective's at the heart of research and gives priority to the voice and interpretation of women's issues in contemporary society (Campbell and O'Neill, 2013). Other key areas of focus include objectification, structural and economic inequality, power and oppression (Ackerly and True, 2010).

The first part of this chapter will present the findings from the visual analysis of sex calling cards. The cards show a construction of women displayed as sexual commodities influenced by a heterosexual dominant discourse that reduces women in sex work to little more than their sexual abilities. The influence of patriarchy on the specific nature of this finding draws attention to how society views and perceives women's bodies. This has implications for understanding gender role portrayals of female sex workers depicted in advertising for male consumption.

4.1 Visual Data: 'Sex Calling Cards'

From the visual analysis of sex calling cards, it is apparent that escort agencies select glamour models to use their bodies and push sexuality for the purposes of selling sex directed towards mainly male buyers. This is on behalf of women who are actually sex workers and their handlers commonly known as a pimp or madam. (Male sex workers also advertise for sexual services but for the purposes of this study, only female images are used). The fundamental understanding of female sexuality evident in these cards represents two key social constructions consistent with beauty and youthfulness. These key themes accentuate a construction of a healthy body image, which representations of women in advertising have tended to highlight.

According to a semiotic approach, themes developed revealed characteristic features in the cards: physical appearance, body language used (such as facial expressions, gaze, gestures and postures) followed by the explicit messages the cards convey. Beauty and youthfulness underpin these key features. The following paragraphs will illustrate the distinctive characteristics evident in the sex calling cards.

Firstly, the cards typically represent a flawless, attractive young woman, airbrushed to a popular image of perfection. The women on these cards have glossy hair, glowing skin and a well-toned body accompanied by cultural stereotype or race. A cultural stereotype that might fit into an idealised sexual fantasy for a potential male client included the following labels evident on the calling cards: "Hot Busty Italian Beauty" (see Image 1), "Gorgeous European Beauty" (see Image 3), "New Sultry Latin Beauty", "Young Indian Beauty" and "Beautiful Blonde". It is apparent that the stereotype and physical representation of a sex workers body reinforced the idea that there are essential characteristics of ethnicity that are considered specific to a woman's nationality that is desired by those who purchase sex.

Thus, these descriptions of the women’s physical features work in conjunction with a pre-conceived cultural or racial expectation in order to attract the client’s preference for the purchase of sex. Table 2 presents the semiotic analysis findings of the sex called cards. It shows that a cultural stereotype on a sex calling card (e.g. ‘Italian’ is signified) matched with the photographic image itself (the sign) in relation to a signifier (e.g. representation of Italian bodies as ‘hot and busty’). The physical characteristics of the signified images reinforce the stereotype. The sections with ‘no signifier’ in the table do not show an appropriate word that can describe the stereotype of the woman photographed. Some of the women are labelled as ‘model’ or ‘ex-model’ and featured as ‘new’.

Table 2: Semiotic Analysis of Women on Sex Calling Cards

Stereotype (Signified)	Representation of bodies (Signifiers)	Physical characteristics (Signifiers)	Model and Ex-model
Italian	Hot Busty	Olive skin tone Dark brown hair	No label given
Latino	Sultry Hot	Dark brown hair Tanned skin	Model New
European	Beauty Gorgeous Hot Sexy	Combination of Brown and blonde hair Tanned skin tone	Ex-model New Innocent
Scandinavian	Blonde	Blonde hair Tanned skin tone	No label given
Swedish	Young Blonde	Blonde Hair & Pale Skin	Ex-model

Black	Sexy Booty, Big Booty (bottom), Seductive	Black hair Black skin tone	Ex- model/Model New
Indian	Young	Dark brown hair Dark skin tone	No label given
Blonde	Gorgeous, Beautiful, Everyman's dream	Blonde hair	No label given
Brunette	Sexy	Tanned Skin tone	Model
School Girl	No signifier	Light skin tone	No label given
Professional Lady	Real Stunner	Blonde hair	No label given
Madame	Domination and Submissive	Blonde hair	No label given
Young Leggy Babe	No signifier	Blonde hair	No label given
Sexy Stars	No signifier	Combination of brown and blonde hair	New

Secondly, the calling cards reflect a normative perspective embedded in the public imagination of what constitutes female perfection fixed with notions of sexual availability. These are the same images and devices used to sell products using the appeal of women's bodies. Images such as these commonly found on advertising campaigns promoting make-up, hair products, car brochures, catalogues, television commercials and billboards. One such example is an advert for Wonder bra that depicts a young woman wearing only a black cleavage-enhancing bra; she has a "sexy body" which is presented as a key source of women's identity (Gill, 2008:42).

Thirdly, the 'othering' of female bodies conveyed in the cards of 'this is how sex workers look' demonstrates absolute female perfection creating a separation between 'us' and 'them' as an effort to distinguish the visual aspect

of female sex workers bodies for women who do not sell sex. The interpretation of how sex workers bodies are perceived within society promotes the 'othering' of female bodies. A social construction of this body ideal represents the image of a healthy sex worker. This finding has specifically contrasted the perceived failure of the sex workers body as observed in the literature review chapter with some primary images of female perfection raising the following dichotomies of good girl/ bad girl, healthy woman/diseased woman or the agent/victim relationship (Sanders et al. 2009: 6). This leads to an in-depth exploration of the finding that women involved in sex work represent a key feature of beauty.

4.1.1 Beauty

The women in the sex calling cards display the appearance of typically attractive features, perfect bodies and descriptions about their cultural characteristics that emphasise how such factors are linked with ideal notions of beauty. For example, the women seen in the 'Italian' images (image 1 and 2) have dark brown hair and olive skin that is typical of the physical characteristics of Mediterranean women. Their beauty revealed in these physical attributes correlates with the nationality these women are conveying on the card. Image 2 portrays another Italian woman with brunette hair and olive skin. She appears to be gazing away from the camera with a hand resting on her hip in a suggestive 'model' pose. A stance, which signifies the unspoken: 'I am beautiful, if you want me come and get me'.

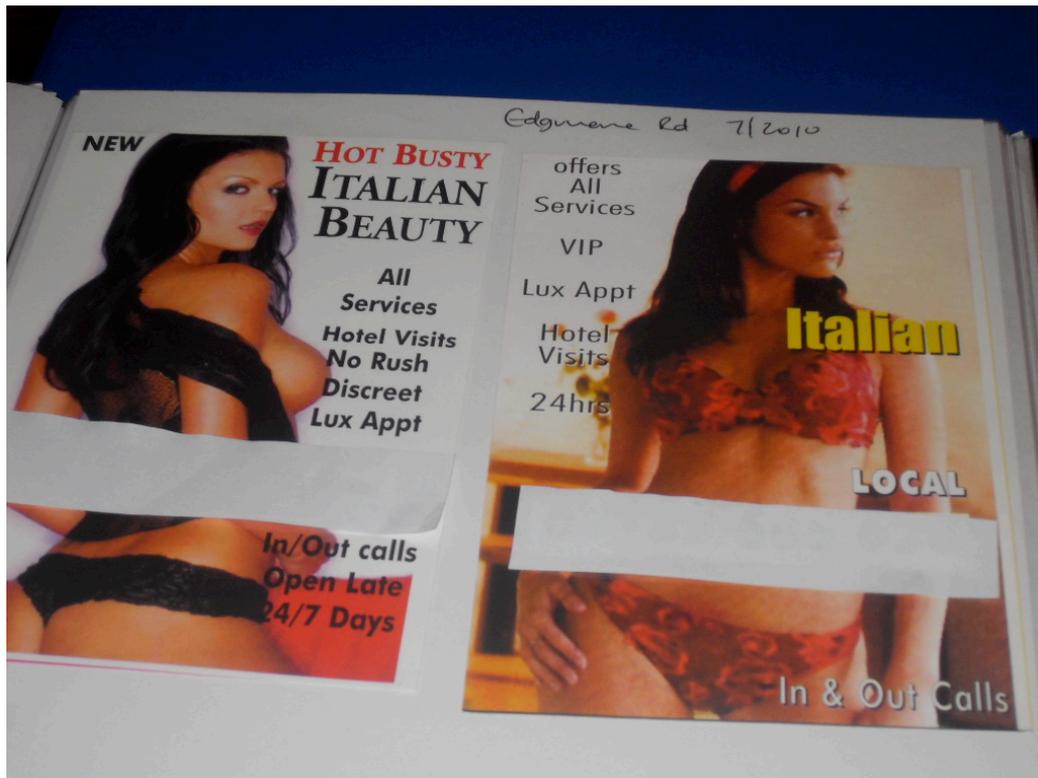


Figure 2: Image 1 and 2 of Italian women Sex Calling Card

The persona of beauty which is a dominate image represented by the women on these cards is also accentuated through the gestures presented to the public eye. The postures conveyed are symbolic of intentional flirtatious body language. For example, the woman in Image 1 has an arched back and she is turned away from the camera. Her mouth is open, but she is looking to the side and at the camera, signifying a common message across all the calling cards of 'I want you', combined with 'I enjoy this', coupled with a vision of a healthy, slim, beautiful and desirable woman. From a feminist perspective, this presentation of a woman has implications for devaluing women in society and effectively keeping her status lower to that of sex object.

On different sex calling cards there are also stereotypes of "Swedish" women as per Images 4 and 5. Blonde hair and a light skin tone represent the women selected. The outward appearance of the models portrayed in these photographic images appeals to a man's sexual desires (the customer/consumer) and fantasies about light skinned/haired women such as those from Scandinavian countries (e.g. Sweden). For this example, the

description of one of these women on the cards reads, “Young Swedish Ex-Model”. This description serves to emphasise the idea that the women advertising their sexual services are former models. Once again, this reinforces the impression that essentially women in sex work are thin and flawlessly beautiful. It also leaves further room for exploration of the assumption that women in sex work embody a physically fit body image of perfection. They are not the ‘vectors of disease’ discourse exemplified in the literature.

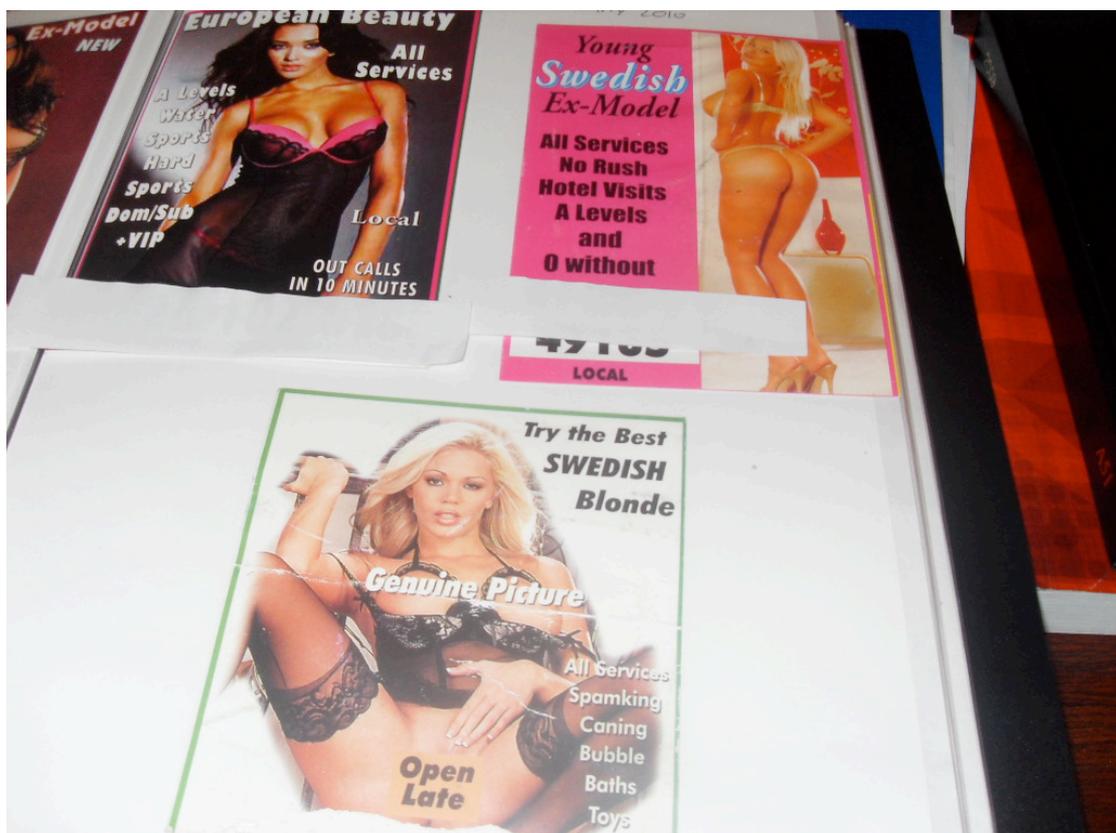


Figure 3: Images 3, 4 and 5 of European and Swedish Women

Similarly, Image 6 represents a “New Black Model”. This description signifies that this model is new in the sex industry to advertise her looks and body for sexual services. The “New Black Model” descriptor adds emphasis to her supposed freshness and perhaps innocence. Another observation on the use of the term ‘model’ in sex calling cards also conjures up particular images of female beauty with the woman being represented as, tall, sexy and glamorous, with no signs of ageing or being overweight. This is a stereotypical view of female models in society.

The term 'new' is also evident in Image 7 of "Sexy Booty". The woman in this image is modelling her 'booty', meaning her curves (hips and bottom), which represents a stereotype that black women have big, round bottoms. These conventional images of beauty on sex cards result in a formulaic and endless rhetoric of women's bodies on display simply for male demand and according to cultural/ethnic preference. This leads to an implication that sexual attitudes and beliefs influenced by gender stereotypes linked to the commodification of the female body.



Figure 4: Images 6 and 7 of Black Model Sex Calling Cards

Analysis of images 6 and 7 also demonstrate the intentionality of the women's gaze at the camera as one happy, the other coy, illustrating the idea of subtle enjoyment. These expressions constructed on the sex cards universally communicate a sexy, feminine code of attractiveness, which underscores the fact that 'the image of an attractive woman is the most effective advertising

gimmick' (Greer, 1970). Other cards depict something different such as youthfulness and service, which add to the appeal for some men.

4.1.2 Youthfulness

The women photographed in Images 8 and 9 convey signs of youthfulness and illustrate a sense of innocence, as they represent a young or seemingly young girl in a "schoolgirl" stereotype. Image 8 portrays a "schoolgirl" gazing in an undirected way or looking down, thereby signifying vulnerability and submission, which is different to the overt gaze of the earlier images of more adult women. The model in this image is wearing a school tie with a naked body and sitting on a skipping rope perched on a gym board. Here the young girl displays playfulness and sexuality whilst simultaneously tapping into a darker reality of the over-sexualisation of minors.

Image 9 illustrates a stereotype of another "schoolgirl". Here we see a photograph of a pretty, youthful-looking face gazing in an undirected way into the distance. Her breasts are partially concealed by a net top and she is wearing pink underwear, with her inner thigh slightly bent outward, to suggest availability. Both pictures (Images 8 and 9) offer the appearance of an active, fit, well-toned body characteristic of teenagers in their youth in contrast to the adult bodies, presented in the section on beauty.

However, from a feminist perspective this message of adolescent perfection tied in with girls bodies portrayed as sex objects in advertising can deeply affect the self-esteem and body image of young girls in their attempt to achieve flawless bodies (Dohnt and Tiggemann, 2006). 'The association of femininity and sexuality starts early' (Walter, 2010: 4). The likelihood that today's children are playing with the old fashioned notion of being seen as sex objects (Walter, 2010: 6) means that their other attributes, from their sporting prowess to their articulacy are devalued (Walter, 2010: 122).



Figure 5: Image 8 and 9 of School Girl Sex Calling Card

For instance, the glamour models have no signs of blemishes, stretch marks or tiredness. Their skin is glowing, symbolising both health and youthfulness. Virtually without exception, they also present toned bodies, perfectly symmetrical breasts and overtly feminine curves. Additionally their demeanour appears happy, thus articulating their role as a sex worker or 'proxy' girlfriend as being fun, non-committed and adventurous.

It is clear that the women in these sex calling cards are further perpetuating the idea of a fit, youthful and perfectly designed body for attracting the on-looking male. In addition to the emphasis on youthfulness, sexually explicit poses are also used, and an extreme case of this is found in Image 5, where a woman is exposing her vagina, which is then discreetly covered and blurred with the words 'open late', thus revealing 'soft pornography'. With her legs open, she further alerts the on-looking male to her availability for purchase, while also making it known that she is skilled in all the services mentioned on the sex calling card: 'spanking', 'caning', 'bubble baths' and 'toys'.

Image 10 portrays a woman dressed in black leather advertising 'Madam Domination and Submissive', which signifies the sexual service of sadomasochistic sex. The woman blindfolded in this image, holding a whip and leaning on a chair with her back away from the wall. This woman projects herself as being ready to be in control in order to play the game of dominating or being submissive in this kind of service. The services offered as mentioned include the sexual techniques of creating a 'fantasy', 'caning', 'strapping' and 'toys'.

However, the availability of these sexual acts may demonstrate something liberating about working in the sex industry but the underlining message is for the sexual convenience of the male buyer. This perspective also alludes to the fact that potential buyers of sex seek variety in their sex acts. From a feminist perspective, these negative hegemonic constructions of male privilege normalise sexual attitudes that treat sexual aggression or violence towards women as acceptable.



Figure 6: Image 10 of "Madam Domination and Submissive" and "Professional Lady"

Goffman's framework for the analysis of Gender Advertisements (1979) used as an approach to view the hidden meaning of the way women are positioned in photographic images. Table 2 illustrates the analysis of the photographic images of the sex calling cards presented in the findings section. Table 3 demonstrates the hidden agenda that the designers of the sex calling cards use as subversion strategies to reinforce the stereotypical image of female subordination.

The images grouped together represent: a "Schoolgirl", "Swedish", "Italian", "Black Model" and "Madame Domination and Submissive woman". Semiotic analysis of the sex calling cards reveals not only the representation of female bodies as sexually available within the context of ethnicity and gender stereotypes. It also shows how commercial advertising uses certain practices to depict women in specific positions and poses with the use of a particular gaze for the explicit purpose of male stimulation and desire. These social constructs ritualise female subordination. For example, the tendency for women presented in passive submissive positions and poses has implications that extend towards victimhood. This refers to the portrayal of women demonstrated in the calling cards to be dependent on men and conveyed as sex objects.

Another theme of Goffman's gender analysis (1979) is licensed withdrawal and this is the term used to describe certain types of gazes. For example, Table 3 encompasses the use of stereotypes to demonstrate how Goffman's analysis (1979) provides meaning on the way advertisements offer insight into subversion strategies. For instance, a gaze in an undirected way (almost into the distance) in a childlike manner implies the presence of a male acting as a protector.

Table 3: Sex Calling Cards Using Goffman's Work on Gender Advertisements (1979)

Stereotype	Goffman's Frame Analysis/ Agenda	Subversion Strategies
School Girl See Images 8 and 9	Licensed withdrawal	Gazing in undirected way
Swedish See Image 4 See Image 5	The ritualisation of subordination	Body turned away from the camera and looking back with both knees bent Positioned on the floor
Italian See Image 1 See Image 2	The ritualisation of subordination Licenced withdrawal	Body canting Gazing in undirected way
Black Model See Image 5 See Image 6	The ritualisation of subordination The ritualisation of subordination	Bashful knee-bends Smiling Oppression through difference and colour Pouts Exposing myths about 'black booty' (bottom)
Madame Domination and Submissive See Image 10	The ritualisation of subordination Licenced withdrawal	Body canting Bashful knee-bends Gazing in an undirected way

4.1.3 The Provision of Sexual Services

Semiotic analysis of the sex calling cards revealed knowledge about the sexual services women in the sex industry provide disguised in porn narratives such as “O Levels” for oral sex or “A Levels” for anal sex, “water sports”, meaning urinating on a client, or “hard sex”, which is to excrete faecal matter on the client (see Table 4). Understanding the meanings of these terms helps to uncover the sexual behaviour, services provided, and the types of sexual labour performed by women involved in sex work.

The terms used to describe the sexual services also normalise sex into these sexual acts ensuring that a woman disassociates her feelings from her body

in order to conform to the sexual practices stipulated in sex work. It is said that many 'prostitutes cope by dissociating from their bodies (Porter, 1999: 129). Porter (1999: 130) also stipulates that while some women in sex work enjoy their work, and some enjoy sex with their regulars, many have to endure physically repulsive or degrading acts with men for whom they feel no desire. In buying the 'sex act', men assume a patriarchal right of access to women's bodies (Porter, 1999:130). Women are subordinated, the man who contracts to use the services gains command over the use of her person and body for the duration of the prostitute contract' (Pateman, 1989: 130-131).

The following table identifies the meanings of the terminology used to identify the sexual services women in sex work deliver. This is relevant to understanding the context of women's sexual experiences in this 'work' however, not all the services provided are entirely for indoor sex workers. Outdoor sex workers such as street sex workers may also provide these services.

Table 4: Sexual Services Provided and Definitions of these Services

Services Provided/ Fantasies	Definition
Uniforms	Fantasy, dressing up to satisfy a particular fetish such as a nurse, dominatrix or maid, etc.
Water Sports	To urinate on the customer
Toys	The use of sexual aids such as vibrators and butt plugs
A Levels	Anal sex
O Levels and O Levels without	Oral sex Oral sex without the use of a condom
Hard Sports	Defecating on the client with faeces

Submissive	The service is to receive sex in a passive 'submissive' way
Spanking	Fantasy
Caning	To beat the client
Dominatrix	To dominate the client, sometimes with the use of mild to extreme torture
Kissing	Girlfriend experience

The sex cards advertise that sexual services are in operation 24 hours a day, 7 days a week, with hotel visits available (see Image 1). This suggests that being involved in sex work means women are either working a shift-work pattern or they are up at unreasonable hours all week long. Hotel visits also carry inherent dangers of women in vulnerable and isolated situations with men they do not know. This situation points to the notion of male dominance, which leads to the construction that for women who sell sex, their lives are characterised by a model of power. This model of power is one in which a woman's sexuality is controlled and defined within the boundaries of male privilege.

The next section portrays the perspectives of FSSWs from the primary data set in Phase 3 about their own feelings towards the sex calling cards. From a feminist perspective, this approach aims to provide important insights into FSSWs own views about the 'othering' of sex workers bodies observed in the calling cards.

The process involved presenting a visual display of the sex calling cards in a portfolio to each participant at the end of the interview in the primary data phase. Their responses revealed how listening to the perspectives of FSSWs portrayed very different interpretations of what the sex calling cards mean to them as a collective group versus the visual meaning of these cards constructed to the public eye.

It is important to emphasise that the women recruited for the primary data sample did not advertise their sexual services through calling cards. The calling cards instead represent a familiar aspect of the sex industry to the FSSWs interviewed in the primary phase of this study. The women demonstrated an understanding of how the public and wider society views them. Within this notion, it is necessary to consider the effect of the male directed gaze on the FSSWs even if they are not 'part' of the calling cards directly in terms of services and advertising. Men still look at these women on the street and buy sexual access to their bodies, reducing these women to merely just the sex acts that they provide with the same purpose in mind that the sex calling cards afford.

4.2 Perceptions of the Sex Calling Cards by FSSWs

In the previous section, the sex calling cards portrayed women involved in selling a wide variety of sexual services as being beautiful and youthful in appearance. This has provided a representation of the physical attributes of women involved in sex work and their visual display in society with the characteristic features of positive physical health illustrated by the way their bodies are constructed.

The narrative accounts of the FSSWs responses to the sex calling cards indicated that the majority of the participants had a negative reaction to the cards. The women viewed the cards as being part of the industry in which they work but as images that are far removed from their own experiences and appearance.

In the interviews, the women provided responses about the implications of the calling cards for women in the sex industry. The women tended to express views that indicated strong emotional responses of revulsion: 'disgusting' (Katie), 'sick' (Tally), and 'horrible' (Drew). In addition, some of the women also reported that the sex calling cards were demeaning to women and even underpinned some of the more dangerous and harmful experiences they experienced with male clients:

‘Socially unacceptable: to advertise it I think that is more dangerous...a lot of people have told me bad experiences what has happened to them through these, won’t go into them (Katie)’ ‘degrading to women’ (Poppy)

The statements made by the women imply that the women portrayed in sex calling cards emphasise a gendered stereotype of a sex object in a patriarchal society. The women are not looking at the picture of the glamour model but instead seeing the hidden meaning in the cards, which is to advertise for sexual services. Their social construction reveals a negation and rejection of the cards as failing to reflect their own reality and experiences in street sex work.

Other women in the primary data said:

Disgusting and these are cut from magazines (Julie, FSSW).

The women who do street sex work look nothing like the pictures on the cards and ... the men treat them according to what they see on the cards (Berry, FSSW).

Obviously, they don’t look like that – but because people have to be enticed, they have to look beautiful and glamorous (Nancy, FSSW).

Hence, Julie, Berry and Nancy have highlighted the point that the calling cards are a false representation of real street sex workers and the women demonstrate that there is a divergence between the fantasy image presented on the cards and the physical reality of how women engaged in street sex work actually appear. This resonates with a separation of ‘them’ and ‘us’ distinction representing an identification of differentness between these two categories of women.

Nancy further reiterates this theme of a woman portrayed to society as a desirable sex object by also acknowledging that women are created to look attractive in order to sell their bodies for sexual services because *‘people*

have to be enticed' (Nancy). Consequently, the sexual attractiveness of a woman, as expressed in the cards, can assist to formulate and strengthen the attitude and motivation of the male buyer of sex available on the streets, an attitude that is most likely to result in him treating her as a commodity. Porter (1999) states that 'objectification degrades, it lessens the status from person to object, moral equal to subordinate, diminishing or negating individual desires and interests. The person treated as a sex object is dehumanised'.

On the other hand, some of the participants mentioned during interviews that the women portrayed in the calling cards '*look good*'. For instance, some of the women reported that the cards '*look pretty I suppose*' (Drew) and another said '*I think they are pretty sexy*' (Steph). Mary mentioned, '*if you got it, flaunt it*' (Mary). In stating that the women looked pretty and attractive meant that these FSSWs were also uncritically accepting of the social construction of a form of gendered beauty stereotype in advertising and more broad socially constructed dominant norms relating to the definition of female beauty and sexual attractiveness.

In contrast, Kelly (aged 51) and Poppy (aged 28) provided a socially conscious response about the cards located in public spaces. Kelly was critical of the potential exposure to vulnerable children. She felt strongly that the sex cards were "all wrong" and stated:

Disgraceful, especially when men are seen masturbating themselves in the phone boxes and children go in and look at them or call the numbers displayed (Kelly, FSSW).

Poppy felt strongly about the cards too and used the words "I hate them". She thought they were "very degrading to women" and saw this "as an excuse for men to glare at them". She also believed that "the face is personal and should be covered". Poppy's view gives insight into her moral code about preserving a woman's identity from public display. She is of the opinion that essentially, women's faces should be omitted from the sex calling cards or at least covered up.

This analysis reveals that sex calling cards are about men's dominance over women. The cards encourage a sexualised image of women for commercial reasons that reinforce support male exploitation. For example, the FSSWs in this study may be locating themselves as distant from a 'spoiled' sex work identity of 'dirty work' (Ashforth and Kreiner, 1999) but in reviewing the cards, the women are critical about male responses and therefore also critical of the patriarchal construction of these cards, despite being in the same industry.

4.3 Summary of Findings from The Visual Data

The sex calling cards revealed that the role of the female body in portraying beauty and youthfulness is an essential component of advertising a healthy image for male buyers of sexual services. The cards display cultural stereotypes of ideal sexual fantasies too. It is possible to see how the origin, general appearance and body language of the female gender represent the sexual availability of a female sex worker.

Findings from the sex calling cards also reveal that fantasies of "schoolgirl" stereotypes reveal youthfulness, innocence and vulnerability as an attractive and desirable feature. These women are very much playing to the notions of male dominance over female vulnerability and weakness demonstrating the way in which feminine sexuality of the youth intersected with the values of the sex industry. Although, the social construction of women's bodies seen through the calling cards is about 'others'. The 'othering' of the female body through the images of female perfection feeds into the patriarchal constructs about the women. Accordingly, my visual data conveys the message that women are on sexual display in sex calling cards and objectified through the commercialisation of sex.

A common theme from the perspectives of FSSWs on the visual data, suggests that most of the women did not identify with the glamour models and considered the cards as "degrading", "disgraceful" and "disgusting". A couple of the women admired them but they did not see themselves as the women in the cards constructed so that men are "enticed" to buy their sexual services.

The women are then treated according to what is advertised, reducing the women to just their sexual availability with men having privileged 'on demand' access to them.

The second part of this chapter will now explore the lived reality of women involved in sex work through the secondary analysis of in-depth interviews, conducted in the late 1990s. This insight enhances an understanding about how life was lived as a sex worker in a particular time.

4.4 Secondary Data: 'Oral Life Histories of Sex Workers'

The secondary data consists of the examination of in-depth interviews undertaken in the late 1990s, which are stored in the British Library as a collection of *Oral life histories of Prostitution* by Wendy Rickard (1996, 1997). (As mentioned previously in Chapter 1, the preferred term is sex worker instead of prostitution due to the negative stigma attached to this word). The first part of this section begins with a chronological description of the biographies of three selected women involved in sex work, (Violet, Cherry and Rose), with a specific commitment to understanding how the women interpret their own experiences of health and wellbeing.

After the accounts of the women's background life histories, key themes developed from the experiences of these women's lived reality viewed through the key concepts developed from the findings of the sex calling cards in Phase 1. Analysis of the cards revealed the 'othering' of the female body, dominant heterosexual discourses and the influence of patriarchy. These key concepts highlight a feminist perspective that is concerned with the problematic relationships women in sex work have with clients and their role and position in society. The following accounts of the women from Phase 2 will provide insight into the background life stories of the following women in the sex industry.

Violet identified herself as a street sex worker who solicited her clients on the street (Harcourt and Donovan, 2004: 202). Cherry was a 'milkmaid' offering lactating sexual services to her clients and Rose was a high-class prostitute with a wealthy clientele from the Middle East. Rose differentiates from the other two types of sex work by the level of income she earns and the type of sex work carried out, which consists of services provided privately at her client's home or hotel room. The next part of this chapter will reveal the narrative accounts of the background context of the life histories of these three women in sex work, and an understanding of their social constructions on their own health and wellbeing.

Violet's Story

Violet was 37 years of age at the time of interview and had two sons. She described herself as belonging to the street because this is where she felt most at home. Violet revealed in the interview that her parents divorced when she was young. She grew up with them constantly threatening to put her in foster care. Between the age of five and six, Violet's brother and his friends sexually abused her. Violet recalled an experience of rejection and neglect from her father in her childhood. She felt that if she had the love of her father, her journey through life would have been different:

What hurt the most was my Dad pushing me away (Violet).

If my Dad came to me, loved me, I wouldn't be doing this, I probably would have become a nurse (Violet).

At school, Violet experienced bullying and started smoking at 11 years of age. She reported that she had no friends. Violet began frequenting pubs and clubs at around the ages of 12 to 13 years. At age 14 she started working as a street sex worker and mentioned in the interview that her entry into sex work gave her a "sense of power", "belonging" and "being in control" of her life. The way that Violet talks about her work thus reveals her rationale in choosing sex work. Violet married young (at age 17) and was divorced by the age of 23. Her husband at the time was on drugs, and in this relationship, she experienced intimate partner violence, including physical and emotional abuse.

Violet revealed knowledge about her own past medical and surgical history in the interview as follows:

- 1) She contracted gonorrhoea from an encounter with a client on the street, a constant risk in sex work if condoms are not used.
- 2) Violet was addicted to nicotine but not other drugs, which were not so widely available on the street at the time of interview (1996 to 1997). In

1996, just 0.6% of the UK population had used cocaine, but by 2005, this had risen to 2.4% (BBC, 2005).

- 3) Violet diagnosed with rheumatoid arthritis in both her knees and ankle joints stated the physical condition that affected her health related to street sex work. Her arthritis was particularly due to working in different types of weather. She indicated that standing on the street in the cold exacerbated this condition. She experienced increased swelling and gave the account of her knee swelling to “four times the size of my knee cap”.
- 4) At 28 years of age, Violet had to undergo a hysterectomy operation. The hysterectomy was due to the heavy bleeding she had over a two-year period. So severe were Violet’s menstrual issues that she would resort to pethidine injections (a strong opioid analgesic) every time she had a period. The heavy bleeding may have correlated with street sex work.

However, a health ritual that Violet maintained during her period was to “buy a natural sponge, put it in Dettol and stick it up my cervix then rinse it out after having sex”. Violet believed the risk of secondary infections minimised by this practise as she recalled in the interview that “go into your womb and ovaries from the use of tampons, cotton wool or toilet roll”. She described the risk in inserting tampons by stating:

I have seen a girl collapse by using tampons and they have had a reaction because it’s shoved up and up to the neck of her womb or they’ve lost the tampons (Violet).

This health advice came from the older girls who had been on the street and not from health clinics or a medical practitioner. Here constructions about the meaning and experience of preventing infectious diseases based on personal experiential knowledge of the other women in Violet’s social context exist.

Cherry's Story

While Cherry said she had a “happy childhood and was brought up in Zimbabwe with a loving extended family”. She expressed in the interview that at 16 years old, she experienced rape and fell pregnant but aborted the child. Later on, Cherry travelled to London for university but got herself into financial debt with credit cards. An escort agent signed her up and then began her career as a ‘working girl’. Cherry suggested that choosing sex work was the easiest way to make extra money. In her own words:

Going on the game was easy as opposed to working a 40-hour week in a fish factory for £100 a week (Cherry).

Cherry described herself as a “natural born leader” and a decision maker who chose to pursue sex work as opposed to working in a lower paid job. Of her work, she said:

I enjoy the idea of a man coming to me and then paying for a service where I do my best to satisfy my clients so they come back (Cherry).

Although Cherry made it sound as if being involved in sex work was easy and enjoyable, it had also come with a high cost to her health. While Cherry was a non-smoker and did not engage in substance misuse, her involvement health problems directly affected her involvement in sex work. She mentioned in the interview “my internal organs have been damaged from the impact of sex work and as a consequence, I suffer from the symptoms of throat pain from oral sex exacerbated by the latex found in condoms”.

Cherry expressed negative views about engaging in sexual services. She stated that the idea of having sexual intercourse with men who “smell”, have “halitosis” and “smelly feet” “could not be an enjoyable experience”. She mentioned that a “man comes to a working girl for his fantasy”. In her own family life, Cherry divorced her first husband and had three children. She experienced domestic violence within her marriage. In one incident, Cherry sustained a fractured nose and jaw, which in turn led to a miscarriage. Her current partner knew that she was a sex worker and she described him as having “the mental capacity to cope with my sex working”. Cherry stated that

her partner was aware that she saw “10 to 15 men a day” and was still able to love her, which she called “unconditional love”.

Rose’s Story

Rose was born in South Kensington and defined herself as a high-class prostitute mainly working from hotels in the Middle East. She was 37 years old at the time of interview and had two children. While growing up Rose’s parents divorced and – as in Violet’s story – there was a similar pattern of poor contact with her father. Rose’s relationship with her mother was, in her account, distorted by her mother’s jealousy, which caused her mother to be routinely competitive and envious of Rose. Her mother coveted Rose’s youth, strength and personality and this resulted in a relationship which Rose recollected as masked by maternal hate. Rose recalled her mother trying to sleep with every boyfriend she had. Her brothers were involved in cocaine dealing, and eventually become drug addicts. Rose believed that these experiences in childhood influenced her mental wellbeing in a negative manner; she suffered from depression and experienced a number of nervous breakdowns.

Rose, like Cherry, was raped at the age of 16 years. She felt that her early life experiences and the trauma in her adolescence made her feel ugly and insignificant, leading to her explanation for the low self-worth in later life. Rose indicated that the lack of nurturing or protection in childhood limited her full potential. She married young, at 18 years of age, to a man she described as a “junkie”. In the seventh month of pregnancy, she “kicked him out” and lived in a council flat. She later met a man she described as a “sugar daddy”, that is a man who met her financial needs in return for sex.

In the three narratives of Violet, Cherry and Rose the main themes identified were those of sexual abuse, neglect, loss and rejection in childhood, rebellion in adolescence and affection seeking from abusive relationships. This has had an impact on their physical, emotional and mental wellbeing in adult life. The next section will explore other consistent themes evident in this data

sample; namely the adverse effects of intimate partner violence, the management of identity, feelings of stigmatisation and routes into sex work.

4.4.1 Intimate Partner Violence

A theme consistent in all three participants' accounts was intimate partner violence (IPV). This theme of IPV had implications for the way that the women's accounts of physical, mental and emotional health and wellbeing were constructed and told. For example, Cherry experienced IPV with her ex-husband, who would "physically beat her up and consequently fractured her nose and jaw". Violet encountered psychological cruelty and violence from her ex-boyfriends and she mentioned about one partner, "he battered me black and blue on the right side when I was pregnant". She also suffered from severe migraines. Violet thought that the migraines were due to the IPV experienced from her partners after receiving "numerous blows to the head". Her life appeared to be one characterised by destructive relationships and her internalised feelings of a lack of self-worth expressed in this quote:

Nobody wanted me so I didn't want them (Violet).

This was consistent with how she described her emotional wellbeing as "not happy" and further indicated that she was inclined to please others but not herself. Violet said, "I do not enjoy sex and have never had an orgasm". She maintained a "no kissing policy" and the use of condoms for optimal health protection. She also further mentioned, "I never want to get close to a man". Violet felt it was difficult to connect in a healthy way with the opposite sex and be in a trusting relationship because the men in her life had always mistreated and abused her almost to the point of her near death. The following examples demonstrate the violence emphasised in Violet's accounts:

He kicked me in the eye, grabbed me by the throat. I did not love him (Violet).

He beat me in front of my children once in my eye and smashed up my eye socket (Violet).

Rose's beatings and the severe emotional abuse suffered in the context of her personal relationships eventually led to a diagnosis of post-natal depression and nervous breakdowns. She recalled how those people who she had intimate relationships with were less accepting of her involvement in sex work. During these arguments and discussions in which she was threatened, abused and called all kinds of insulting names, she stated:

The rows, bitterness and hypocritical ideals kept coming. He couldn't forget my past (Rose).

This account of the way in which Rose felt inadequate and different because of her identity as a sex worker, is consistent with the continual construction of female sex workers as 'other'. The lack of social acceptance Rose experienced from her own intimate partner relationship appears connected to the notion of 'whore stigma'. She perceives her role in sex work as a negative perception because of her partner's label as a 'bad' woman as opposed to a 'good' woman.

The next section will look at how these women developed coping mechanisms to manage their identities, both in terms of private and public personas.

4.4.2 The Management of Identity

In the secondary data set, three of the women maintained a family life and most had children who they looked after at home and supported financially. While these women were mothers, they each identified with a category of sex work. For example, Violet openly embraced her identity as a street sex worker and mentioned that her "home is on the street where I feel I belong" and where, ironically, she felt "safe". However, she was fully aware of the dangers of working as a street sex worker and the constant vulnerability presented on the streets. Violet recalled:

One must never be drunk or naïve on the streets because a punter will most certainly take advantage of you (Violet).

Rose identified herself as “a high class prostitute” engaged in indoor sex work; she also described herself as an “actress”. This was a common theme for the women. Cherry also saw herself as “an actress on a mattress”. Perhaps what this meant was that a separation takes place between the private and public aspects of identity. There are also conflicting identities between the roles of mother, partner and sex worker.

This strategy to establish a distance between their work and non-work lives was consistent with how Cherry described herself as being cheerful, bubbly and a “people person”. She got dressed up as an actress when sex working but when at home, she said she wore a “t-shirt and soft fluffy slippers”. Her identity as a sex worker did not continue at home. When Cherry appeared on a televised talk show programme as an expert in sex work, she disguised herself by wearing a wig. When she attended her university classes, she did not talk about her sex work because she feared being stigmatised by other students. However, in the in-depth interview, she contradicted this view by saying:

I am on the game and it's nothing to be ashamed of (Cherry).

Meanwhile Cherry created a ‘milkmaid’ persona with the following descriptive characteristic features: “38DD, 2-inch nipples, spray my milk three metres into the air”. With her clients, Cherry created the stereotypical image of a 1950s housewife wearing a housecoat, slippers and her hair in rollers. She distinguished both her work and herself as being distinct from street sex workers and especially as occupying a better social position than them; she described street sex workers as “alley cats” and said, “they are just trouble”. In direct contrast to this viewpoint, Violet distinguished herself strongly as a woman of the street and was proud of this identity.

4.4.3 Experiences and Feelings of Stigmatisation

The women in this oral history collection of sex work described situations in which they found themselves subjected to various forms of labelling, discrimination and exclusion when they were near someone who knew of their

profession as sex worker. Firstly, they experienced judgment from family members and partners who had been “disgusted in their choice to be involved in sex work”. A number of the incidents described by the women included the use of degrading or insulting language and the imposition of labels. In one case, Violet’s sister had called her names such as “slag, slut, and whore”. Her father disowned her when he heard she was a sex worker. She knows too that people look down on sex workers as the “lowest” in society, as she recalled:

We are still the lower, the low, and the lowest. We are just dirt (Violet).

Secondly, the lived reality of sex workers is that people react negatively to women who are involved in sex work because they construct their own perceptions of this group of women into stereotyped beliefs. This particular sentiment was emphasised further by Violet’s statement. In her own contextual understanding, she made a connection with the Victorian era much like that of Corbin’s analysis of ‘the prostitute as disease, symbolically associated with syphilis’ (1990: 213). Violet stated:

The word prostitute is a dirty word and it shouldn’t be. People associate prostitutes with filth, disease – and that’s from Victorian times when syphilis was rife (Violet).

Rose also demonstrated how the structural, stigmatising forces of sex work created a negative construct about her work as she feels a sense of shame over not possessing a “legal job” and socially approved occupation. Of her time spent in sex work, she noted:

I felt like a prisoner, a fraudster, working in an illegal business (Rose).

Consequently, the women in this phase of my study had collectively expressed that participation in sex work meant rejection from the general society and ‘othered’ by working in an illegal occupation. It is thus necessary to consider the pathways that are likely to lead women into sex work in order to gain greater insight into the social structures that perpetuate a woman’s choice or lack of choice in engaging in the sex industry.

4.4.4 Perceptions about Routes into Sex Work

Violet and Cherry both had strong opinions about women's involvement in sex work. Their perception about the choice to enter the sex industry stemmed from the realities of economic need, inadequate benefits and increasing debt. Violet gives an account of the economic reality that stems from the social issues a woman is likely to face that may lead her to sex work of which she is only too familiar with:

Single parent families on income support are living below the bread line (Violet).

There was a universal recognition that social security benefits do not adequately meet one's needs and therefore sex work, which potentially can provide comparatively more money, provided a successful strategy for survival. Thus from Violet's perspective, if a child from a single parent was in financial need, a valid way of buying clothes and having money was to engage in sex work.

Violet revealed another precondition or rationale for a woman's entry into sex work:

A woman has been divorced and has had children and their husband runs off with a younger bit of stuff because his wife's getting fat after having kids, where's she going to turn to? The street! (Violet).

This status loss from once being a married woman to then being 'demoted' to a single parent creates a catch-22 situation for women who may not have freely chosen to work in the sex industry. Practically they have decided that this is the best option available to them given their social and economic circumstances.

The women in this data sample also revealed their perspectives on the role that sex work played in society for men who purchase sexual services. Violet's response to a function of sex work is directed towards the institution of marriage where she explained that it is to "keep marriages together and to decrease the number of rapes". The other role mentioned by Cherry was to

“provide a service for men who are bored with the same standard”. The implications of these responses suggest uncontrollable male sexuality or that men paying to access the bodies of sex workers mean they **will not** leave their ‘good’ and ‘pure’ wives. This thought is in stark contrast to a feminist standpoint that would view these perspectives as suggesting male privilege over the availability of female sexuality.

Conversely, while the sex workers in this data set had strict views about how sex work was beneficial monetarily and otherwise to themselves, their families, and society, it was still noteworthy that these women did not recommend such work. Cherry’s advice to women who had the choice to enter into sex work was “don’t do it”. Her perspective on getting involved in sex work was that once you start it is very hard to break away from the “lure of the money”. In her opinion the only way out is to “marry a multimillionaire or to win the lottery”. Interestingly, despite her apparent predicament, she had distinct career aspirations to write books and help people as a sex therapist. Cherry also highlighted incentives for the government to consider such as “hostels so that sex workers have a safer environment in which to live”.

4.5 Summary of Findings from the Secondary Data Set

Examining the oral histories of sex workers from the late 1990s was useful to begin to understand the backgrounds and lives of women who were engaged in sex work in preparation for the field. The experiences of the women in phase 2 has provided a context against which contemporary women involved in sex work could be compared in terms of the factors underpinning the health and wellbeing of women in the sex industry. The health and wellbeing of the women in these interview records was influenced by a lifestyle choice in sex work that contributed to poor physical health followed by poor mental and social health related to family backgrounds of childhood trauma, parental neglect and divorce.

In addition, sexual abuse such as rape during adolescent life was evident in all three of these women's lives. In later life, these women had suffered from

intimate partner violence and psychological cruelty within their marriages and partnerships. From a feminist perspective, the analysis has revealed that experiences of oppression are consistent in these three women's lived experience in the sex industry. The women in these interviews felt that family members, friends and partners had judged them for their 'choice' to engage in sex work causing them to feel devalued and rejected. In short, these women experienced mental, physical and emotional abuse by male heterosexual dominance.

The women in this data set expressed a view that they were driven into the sex industry through economic need which presented as the best option to them given the context of their socioeconomic status against a backdrop of their background life histories of abuse and neglect. Essentially, the women felt that this option found them. The women were also aware of the challenges many women face that underpinned their entry into the sex industry. This awareness provided an understanding of the social processes in family life that potentially position women in this work in order to make a living.

Moving on to the findings developed from the field in phase 3, specific attention will be focused on how 10 FSSWs working in central London presented their own perceptions about health and wellbeing in relation to their lived experience. The insights gained from the visual and secondary data, an understanding about women in sex calling cards and the socioeconomic context of women's involvement in sex work, entwined with knowledge on the health issues experienced by women in the sex industry has served to enhance the analysis of the in-depth interviews made with contemporary FSSWs.

Chapter 5 – Phase 3: Presentation of Primary Data

5.0 Introduction

The primary fieldwork phase of this study identified the perspectives of female street sex workers (FSSWs) through their socially constructed experiences of health and wellbeing. Specifically, phase 3 explored and examined the deeper meanings through which contemporary women involved in street sex work perceived their own health needs through the social context in which these women live in. This findings chapter will outline the key themes to emerge from data analysis based on in-depth interviews with 10 female street sex workers (FSSWs). The women's own voices remain consistent with the interpretations of their lived reality expressed in indented quotes within narrative accounts.

The FSSWs are located in a women-only drop-in centre already used by the women. The centre provides support services that meet the complex range of social issues those women in sex work face mentioned in chapter 3, section 3.6.2. The Women's Centre is a key aspect of the day-to-day living for these women as it represents one of the few resources for support that make a positive contribution to their health and wellbeing.

This chapter also seeks to understand specific aspects of the social roles and experiences of FSSWs from a feminist viewpoint. A feminist perspective points towards a commitment to the context-specific ways in which gender hierarchies play themselves out and the conditions under which resistance emerges (Eschele and Manguashca, 2007: 286). At the level of epistemology, a feminist view will also seek to expose socially constructed meanings about how FSSWs are interpreting their own health and wellbeing based on their historical and social perspective.

Table 5 gives an overview of the demographic characteristics of the recruited participants. The women ranged in age from 28 to 51 years and commenced their involvement in street sex work between the ages of 16 and 35 years.

Thus, the majority of the participants have been engaged in the sex industry for over 10 years. Most of the women had between two and four children but only two of the women were currently in a relationship. In relation to accommodation, two of the women interviewed were homeless while most of the other women lived in hostel accommodation.

Table 5: Demographic Characteristics of the 10 Participants (Phase 3)

Interviewee's Name Anonymous	Status and No. Of Children	Age	Age at Entry	Accommodation Type	Ethnic Origin
Tally	Single, no children	28	18	Hostel	White-British
Katie	Mother, 4 children: Children live with her ex-partner Single	32	20	Hostel	White-British
Berry	Mother, 2 children: adoption	34	16	Lives with Mother	White-British
Mary	Mother, 4 children: 3 grown up, 1 in foster care Partner	46	18	Hostel	Caribbean-British
Drew	Mother, 3 children: Adoption and foster care Single	38	17	Homeless	White-British
Poppy	Mother, 3 children: children live with her parents Partner	28	16	Council Accommodation	White-British

Interviewee's Name Anonymous	Status and No. Of Children	Age	Age at Entry	Accommodation Type	Ethnic Origin
Julie	Mother, 2 children: 1 in foster care, 1 in adoption Single	38	19	Homeless	Caribbean-British
Steph	Single, no children	42	31	Hostel	White-Irish
Nancy	Single, no children	42	19	Hostel	Caribbean-Scottish
Kelly	Mother, 2 adult children Single	51	35	Hostel	White-British

The following paragraphs will examine the FSSWs own account of their traumatic life events as they perceive and interpret them. The implications of these traumatic events consisting of sexual abuse and abandonment issues highlighted key themes that have implications for how the women view their health and wellbeing.

5.1 Health implications in relation to “trauma on top of trauma”

This section of the primary data sample will explore how the women in this phase of the study reported experiencing sexual abuse in their childhood and abandonment issues relating to neglect, loss and rejection. The key theme of “trauma on top of trauma” identified and named by one of the participants (Tally) gives a strong emphasis to the multiple harrowing, abusive and violent events disclosed by the participants in this study. Nancy (aged 42), Katie (aged 32), Drew (aged 38) and Berry (aged 34) had shared experiences of sexual abuse and the consequent implications for their health and wellbeing.

5.1.1 Sexual Abuse in Childhood

Nancy expresses her sexual and physical abuse in childhood as follows:

I was adopted when I was young, before that I was in foster care and that was when I was five. My adopted father used to, like, physically abuse me. He raped me on numerous occasions (Nancy).

Nancy's account of her early childhood years in foster care, then to be sexually abused by her caregiver on "*numerous occasions*" demonstrated that her vulnerability was taken advantage of. Here there was a failure on the part of health protection agencies to safeguard Nancy from child abuse when she already presented as a potentially vulnerable child under the adoption process.

The implications of childhood abuse to her current life is linked to her inability to form positive relationships; she expressed herself by stating, "I don't really like people too much". When probed in the interview whether this related to trust or other factors, she felt trusting people was a key issue and mentioned, "*trust, yah*".

Following on with the theme of childhood sexual abuse, Katie another participant shared her experience:

Growing up I was sexually abused...from a young age (Katie)

She also described the neglect in her childhood.

I never had love and support from family and could never talk to my mum about what happened (Katie).

Katie's experience of sexual abuse linked with childhood neglect potentially increased her risk of traumatised behaviours. From Katie's recollection of her school years, she was "*sent out of class*". She recalled the label as "*attention seeking*" in the classroom and consequently Katie stated, "*I left school not being able to read and spell and that is frustrating*".

Katie's account demonstrates that the trauma and sexual abuse negated by others (teachers and authority adults in her life) located her experiences of sexual violence solely within apparent disorders of her personality. Her behaviour was trivialised as "*attention seeking*" thereby constructing her as a child that did not deserve care and understanding.

Katie expressed how in her adult life she "*isolates herself a lot*". She believed this was mainly due to feelings of "*insecurity*" which in her own words were "*from the abuse*". This form of defence or self-defeating behaviour demonstrated her fear of being hurt again. Her individual response to this trauma meant that she subsequently became addicted to drugs, which she said she used to "*block out things*". Katie recognised that she needed support for mental and emotional health but given the violent and traumatic nature of her experiences, her call for help seemed muted. This indicated a marginalised position in which real support is unlikely to have been forthcoming.

I need more confidence boosting; I think I still need a bit of support.

Drew is another participant who also disclosed her sexual abuse as a child, "*I was abused when I was a kid*". When she told her mother about the abuse, her mother said, "*stop lying*". This expresses a view that Drew gave a misleading account about the sexual abuse and subsequently shows a lack of maternal support for her traumatic childhood event. Drew mentioned how she told the school and the school clinically screened her to confirm the sexual abuse. Her Mother was informed but continued to live with the partner who abused her own daughter. She made the following comments about her school life:

I went to a special school. I went to boarding school coz I had behavioural problems.

Essentially, for Drew, Nancy and Katie, their shared experiences of sexual abuse resulting in "*trauma on top of trauma*" while growing up seem to have been ignored by those who should have acted. Another participant, Berry described her experience of sexual abuse in the account below:

I got raped when I was 16 and I done my hardest to be a virgin coz I always thought I would settle down with someone but I got raped by my Dad's next door neighbour.

Berry was another victim of sexual abuse. Her desire as a teenager was to conform to traditional gendered normative expectations of a *“virgin and settle down with someone”*. However, male sexual violence affected her ability to conform to patriarchal value standards placed on women. Consequently, Berry felt positioned as an entity outside of those standards following the sexual abuse. She further recalled how she has never seen *“sex as a love or pleasure thing”* but rather *“an object or thing to use to get money”*. The result of this response to her idea of intimacy is possibly due to the traumatic sexual experience she encountered as a teenager.

Nonetheless, the women have been labelled as having health problems located in their individual personalities rather than as victims of sexual violence and neglect in childhood. While the constructions of health put forward by Nancy, Katie and Drew demonstrated an awareness of what constitutes positive health and wellbeing, they were also aware of these labels and their use in constructing or diagnosing their health problems. When the women provided information about their mental health illnesses against the backdrop of their history of sexual abuse, the impact of *“trauma on top of trauma”* had influenced and shaped how the women perceived their current health status. The issues of abandonment that stem from neglect, loss and rejection from significant people in the women's lives continue to be discussed in the next section.

5.1.2 Health Implications of Abandonment

The social construction of abandonment; neglect, loss and rejection, feature strongly in the accounts given by Julie (aged 38), Mary (aged 46) and Drew (aged 38). These feelings were consistent with the key theme related to the background experiences of *“trauma on top of trauma”*. The lived experience highlighted a link between substance misuse as a way of coping with trauma

in childhood and adolescence and their current health and wellbeing. The statement that follows outlines Julie's introduction into drugs:

My Dad killing himself, being depressed. I got introduced to it...I was about 19 or 20 when I got onto crack.

The loss of her father and the subsequent depression she experienced appear linked to the genesis of her substance misuse. Julie shared her perception of her health and wellbeing in a drooling tone and half asleep; she said:

I don't know that I can get up in the morning; you know that I don't feel I can get up in the morning (Julie).

My understanding of Julie's expression of health and wellbeing is to have the strength to get up in the morning and, attend to day-to-day activities. It appeared in Julie's quote that she found it difficult to achieve these goals at the time of interview. She mentioned that she had visited her doctor for the following reasons:

To renew my prescription for methadone and to get my other prescriptions for depression and schizophrenia.

This form of medicalisation may reduce rather than increase the control Julie has over her health by the mental health labels and substance misuse to continue on-going treatment. This makes Julie dependent on the medical system because of her poor mental and physical health. During the interview, Julie appeared tired and her appearance dishevelled. She also mentioned at the start of the interview, *"I've got two children". I'm pregnant with my third*". Her other two children had been adopted and she was homeless *"not living anywhere"* at the time of the interview. Julie's vulnerability was extreme. She was not only homeless but also pregnant which exacerbated her vulnerability on the street and her continued need to engage in street sex work for survival.

Seven of the women interviewed had experienced separation from their children. The pain of loss manifested itself in the sadness of the women's accounts. Some recalled the events leading up to their children taken away

by the local authorities. Mary described a sense of guilt and regret about her own parenting:

I have abused my own children mentally because I was never really there for them – and I have lost one child to social services.

Mary recalled in the interview that social services got involved because of her label as *“being a prolific offender and drug abuser”*. As a result of their intervention, she felt *“suicidal”* at the loss of one of her children and stated:

I could not believe I lost my daughter. I wanted to kill myself. I wanted to die (Mary).

From this narrative account, it was apparent that Mary felt robbed of her role as a mother who could not nurture and care for her own offspring. She appeared to feel helpless but also guilty about her engagement in substance misuse. Drew described the experience of loss and separation from her children as pushing her back into substance abuse as a way of coping:

My kids are in foster care and two have been adopted. One has been fostered. After my last kid was two, they took him into care. I went bang on the drugs – back on heroin.

The women experienced such a deep loss that substance misuse became their coping mechanism, which reinforced the necessity to fund this habit by undertaking sex work on the streets. Tally (aged 28) represented this theme as *“a catch-22”*, as an expression of entrapment. From the health implications of traumatic life events such as sexual abuse and abandonment issues to the women diagnosed with poor mental health, it appeared that their underlying concerns were unresolved. They continued to experience life from a position of vulnerability.

5.2 Being in a Position of Vulnerability – “It’s a catch-22”

A theme that emerged from the women’s narrative accounts of early trauma involved the women running away from home and being vulnerable to the

point where they became involved in street sex work to pay for their substance misuse. In Tally's interview, she said:

There were a lot of issues from where I came from as well so sort of running between the two and when I came back (to London), I was pushed into it again (sex work) and that's when it started, my drug use. My alcohol use...I was addicted to quite a lot of drugs and it's sort of a catch 22 I think. You need the drugs to work but you need to work to get the drugs.

Tally said not having the right employment contacts to get a job when she arrived in London was a major concern:

I didn't know anything about the UK, about benefits, about help; when I found myself in a frightening position, I did not know there was anyone I could go to (Tally).

Of Tally's vulnerability it is apparent that not only did she feel forced into street sex work because of circumstances such as homelessness but the economic imperative to fund her drug habit combined with her childhood sexual abuse were contributing factors to entering into the sex industry. From a feminist perspective, her position in society as a young woman with a low level of educational attainment could not have afforded her a different kind of lifestyle. It would soon be evident that she would fall into those intent on exploiting her vulnerability. She described of her awareness in relation to the potential for control by pimps (usually male associates who control sex workers and arrange clients for them, taking a percentage of their earnings in return) and her vulnerability.

The pimps can see you are vulnerable and they take advantage of this whenever they can (Tally).

Tally said her childhood had contributed to the following mental health conditions:

I get quite bad anxiety. I've got PTSD (post-traumatic stress disorder) as well.

In the interview, Tally responded about the development of her PTSD by stating:

Just after the trauma, quite a lot from my life from when I was little really umm I was using previously, I was using to sort of subdue it.

This is a pattern among the FSSWs interviewed. Their common entry point into street sex work stemmed from a place of vulnerability. This vulnerability made them susceptible to coercion thus creating a cycle of street sex work and substance misuse. All of the respondents had a high dependency on illegal drugs and reported taking an addictive substance every day. These drugs primarily included crack (a smokable form of cocaine), cocaine, heroin, methadone (substitute drug for opiates such as heroin) and alcohol. The women linked the use of 'drugs' to their subsequent continuation in street sex work in relation to money.

You use drugs; you make money that's it really (Julie).

You go out there every day to feed your habit (Kelly).

Sex is for money, drugs and drink (Berry).

When I smoke drugs and the money runs out, I find that I am on the street selling myself for sex (Katie).

These accounts from the different women at the Women's Centre illustrate their dependency to substance misuse and the need to fund their drug use through working as street sex workers.

Poppy, who was 28 years at the time of the interview, met her partner and the father of her three children at the age of 16. In retrospect, she considered herself naïve and she gave an account of her partner controlling her and introducing her to drugs. She said:

He would lock me in the house; control whom I saw, when I went out and things like that. He held a knife to my throat.

Poppy experienced intimate partner violence in the form of physical and emotional abuse. She described how this volatile relationship had an impact

on her children, who were adopted by Poppy's parents. Poppy described the domestic violence she faced as the "*domino effect*" as she stated:

It's affected me. It's affected my kids, my Mum and Dad.

Although Poppy left her controlling and violent partner while continuing to engage in street sex work, she found herself often returning to him. She would return to him when in that "*vulnerable state*", which she mentions in the following quote along with her coping mechanism:

I just smoke so much drugs to try and block it all out and stuff and then – when I am in that vulnerable state – that's when he comes back round again and I just seem to fall for everything he says (Poppy).

For the majority of the women in this group, whether their perception of themselves was that of a victim of coercion, or the survivor of traumatic and challenging life circumstances, there was clarity in their recall of the reasons for their initial involvement with street sex work. What had also emerged from the interviews is that the FSSWs justified funding their dependence and drug habits with street sex work as an approach to mask or internalise suffering and unresolved trauma. The next section seeks to understand how FSSWs construct their understanding of health and wellbeing.

5.3 Understanding Health and Wellbeing from a FSSWs perspective

The WHO definition of health (1948) encompasses a broad definition of physical, mental and social health and wellbeing. When the research participants asked what health meant to them, social constructions varied. They ranged from healthy ideals or positive definitions of health to awareness about the negative influences on health and wellbeing. For some of the women, the internalised issues related to feminine ideals of being thin or fit based on an idealised form of the female body through dieting or going to the gym.

In order to be healthy, being skinny and slim is feeling healthy (Tally).

This emphasis on presenting oneself as physically perfect has an impact on women throughout society. In Tally's quote mentioned above, her healthy

ideal came at a price. She gave an account of her current health status by speaking about her eating disorder:

I've had a severe eating disorder since I was about eight so that's affected me a lot (Tally).

She was very thin and gaunt in appearance and revealed that the *"effects of [anorexia] are becoming more apparent with my bones and teeth"*. This is a sign that her physical health was compromised affecting her ability to maintain good nutrition and intake of food. She realised that her own personal risk-taking behaviour was having a negative effect on her own health and wellbeing. She shared the impact of her eating disorder in the following quote:

When I binge or don't eat or I self-harm. Anything I do that hurts me is probably not good for my health like drugs or alcohol or self-harm or whatever it is that is not healthy (Tally).

Nancy gave her own perspective of health and wellbeing:

Feeling good about yourself. You know all the good things not just going to the doctors but also basically washing yourself and all that sort of stuff.

This view of health is in line with the WHO (1946) definition of health, which has embedded within it the notion that how she feels about herself including her ability to function normally is consistent with maintaining mental, physical and social health and wellbeing. She also suggested that to improve the health of women involved in street sex work, condom vans should be more readily accessible.

There is nowhere to get condoms from in the middle of the night. There used to be a van out here that used to dish out condoms up until late at night.

Katie believed that *"healthy eating, healthy lifestyle and going to the gym"* denoted good health. However, of her own lifestyle and health Katie reported:

Having sex with people that you don't know affects your health (Katie).

Katie begins with a healthy ideal and the behavioural choice to engage in eating well and being involved in physical activity in order to enhance her

health. At the same time, she referred to the implications of having multiple sex partners and their role in health outcomes. Concern about the risk of infection in women who are involved in sex work is not new. There was no mention of HIV amongst the participants, but other sexually transmitted diseases such as gonorrhoea and Hepatitis C were.

Drew, who spoke about the impact of her substance misuse on her health and mentioned another view of an influence on health outcomes:

Smoking and drinking and all that, affects your health very much.

Despite knowing the health risks associated with health, the women take drugs “*to block things out*” (Katie) or “*to sort of subdue*” (Tally) the traumas these women faced in the past, and continue to face. Therefore, the consuming nature of living with an addiction takes control over the women’s desires to achieve positive health outcomes. Mary described her physical health in the following account:

I need to lose my belly a bit and I want to be able to walk 200 yards without sounding like I have just run for a bus. I am also short of breath and tight chested and that’s because I abused my body.

I need to stop my drinking and my liver’s got a few problems.

Mary was aware that her lifestyle of alcohol abuse had taken its toll on her health and in particular her liver. She experienced physical ailments such as aches and pains, which she feared were a consequence of alcohol misuse. She was worried about a diagnosis of liver cancer, which runs in her family and claimed her dad’s life. Mary also had difficulties stemming from her physical appearance and especially her teeth:

I am very embarrassed about my looks, my features, my teeth, and my gums. I talk like this all the time (holds her mouth). If I am eating, food drops out of my mouth because I got no teeth to hold them in (Mary).

The other nine women interviewed also did not have a full set of teeth. Their teeth were often broken, very badly stained and only had very few teeth

remaining with which to chew food. The women attributed the cause of their dental issue to two factors:

- 1) Injuries: Physical violence to the face.
- 2) Substance misuse: Smoking crack cocaine mixed with sugar, which causes dental caries.

Kelly reported that her husband who was in jail “knocked” all her teeth out and would use her body to put out cigarette butts. This violence has had a major effect on her self-worth and body image. Kelly stated of her current health status in the following account:

My health has gone down the drain mate. I can't be bothered with myself anymore. I don't sleep. I have nightmares. Every time I look at my body, I just want to be sick when I look at the scars all over my body and what a punter done to me. It makes me depressed.

Kelly felt she did not have the energy to look after herself and felt alienated from her own body. The condition of her body had affected her mental health, as she felt depressed by her past traumatic experience. This helpless state perpetuated in her lack of self-worth was a common feeling reported by other participants.

From a feminist perspective, this means that the women's bodies have become objects that reinforce self-loathing and mental health distress. Their bodies present the hallmarks of physical abuse committed by men, which the women continually revisit. As a result, these women receive neither emotional nor physical healing.

In the next sub-section, the women – Julie, Tally, Kelly, Mary, Berry, Drew and Katie - use their health experiences to examine their emotional health and wellbeing.

5.3.1 Emotional Health and Wellbeing

The narrative accounts of some of the women interviewed reveal characteristic features of poor emotional health and wellbeing. Constructions of poor emotional health included low self-worth, helplessness and self-hatred.

I don't sleep. I don't eat. I have horrible nightmares. I make myself violently sick all the time. I am sad all of the time. It is not nice (Kelly).

In addition to Kelly's disordered eating, which has affected her physical appearance and her emotional state; she lacked sleep and was frequently sad. Mary also suffered from sleep disturbance and poor emotional health. Feelings of self-hatred consumed her emotions as she stated, "*I hate myself*". This critical inner voice is a destructive enemy to many that battle with self-hatred. Anthony (1991: 60) acknowledges suicide is the extreme expression of the feeling "I don't like myself".

Julie's concern about her health revealed a degree of helplessness and fatalism in thinking about what it meant to be healthy and consequentially to possess control over her own health and body:

When your time comes, it comes. I can't waste my life stressing about 'oh if I don't do that'. I don't really think about that otherwise I will become bogged down with that and it will be another stress or anxiety over my head and it is too much (Julie).

Berry (as mentioned previously) experienced rape at the age of 16 and was homeless at the time of the interview. She was also addicted to alcohol and crack cocaine. She reported having such low self-worth that "*health does not mean anything*" to her and she "*does not really care anymore*". In essence, Berry and Julie were unable both mentally and physically to access the capacities and resources that would enable them to have good health and wellbeing and there was a resultant sense of helplessness. The additional baggage of low self-worth compounded this sense of helplessness.

Mary described how she sold her body for drugs in a “crack house” and felt degraded. She recalled the following account:

Sometimes you can be there, waiting for that pipe while the man plays with you, and sometimes you don't end up getting it [the pipe]. This makes you feel really dirty and cheap.

These feelings of low self-worth were the ramifications of desperation to feed a drug addiction. In the process, women like Mary felt de-valued and worthless in sex work. Similarly, when Drew was asked, “What is the hardest thing about street sex work?” She responded:

Knowing I have to open my legs to sell my body to feed my drug habit. I have lain on my back and let a man have sex with me – I just feel very low about myself, my confidence and my low self-esteem (Drew).

Drew and Mary experienced low job satisfaction in sex work. Both were emotionally affected by the lack of choice they had in sustaining their drug addictions to achieve a brief state of euphoria free from the pain of their traumatised life histories. Nancy expressed her own situation to this predicament in the following way:

Having a drug problem is the hardest thing and if I did not have to smoke crack, I would not be a prostitute.

Arguably, for the women in this study the choice to ‘work’ as a street sex worker had chosen them but rather their life circumstances had persuaded them that they lacked other viable options. The life they lived came with a high price and that was the humiliation and shame experienced in sex work. In the words of Katie and Drew, it was “*horrible*”, “*dangerous*” and like “*letting everybody abuse you*”. Katie further noted that the routinely small amount of compensation received by most street sex workers for intimate acts added to the degradation:

What they require you to do for a little bit of money is humiliating.

Katie's conclusion articulated well the nature of lifestyle trapped in a cycle that many street sex workers seem unable to break:

When the money runs out, you are on the street selling for sex – it is horrible.

The next section reports on mental health illnesses and struggles reported by the women in the primary data.

5.3.2 Mental Health and Wellbeing

In this study, the level of mental disorders among the FSSWs interviewed was high. In Tally's case, she had five mental health diagnoses by healthcare professionals, which in her mind related to "*trauma on top of trauma*". She correlated the childhood abuse she experienced to the following mental health disorders: post-traumatic stress disorder (PTSD), depression, anxiety, suicidal thoughts that progressed to suicide attempts and a fear of bumping into people.

Drew had mental health problems inclusive of depression and acts of self-harm; she also mentioned taking Citalopram as an antidepressant. She described the act of cutting herself (self-harming) as "*relieving the pain in my heart – so if I cut myself, it releases the pain*". She cited a lack of emotional support in her life: "*I never had proper counselling*". Perhaps if the appropriate services to address the sexual abuse she experienced in her earlier life had been available; her current situation may have looked different.

For instance in Drew's own words, she linked her behavioural issues to "*being abused, my background and upbringing*" and mentioned in the interview about her mental health status:

I got mental health, depression, and self-harm issues.

Aside from this account of her own health illnesses, she expressed a perception of what a healthy ideal meant to her:

It is very important that you are healthy and strong and you haven't got any diseases or illnesses (Drew).

Her knowledge about what health constitutes related to how one should feel about herself including the 'medical' model of health approach that health is

the absence of disease. However, Drew's state of wellbeing was not consistent with this view of health given her mental health status.

Nancy described her mental health in the following way:

I suffer from personality disorder, apparently; I suffer from psychosis so if I don't take my medication, I get stupid and my behaviour is erratic. I explode over nothing, and get abusive towards people.

From this account, it appeared that both her behaviour and personality were labelled as disordered and these were what warranted treatment, rather than a health care response to her traumatic life experiences. For instance, her own understanding of her clinical diagnoses demonstrated evidence that healthcare professionals had labelled her with mental health and behavioural problems relating to her personality, literally 'a disorder of her personality'.

Like Tally, Drew and Nancy's descriptions of their mental health issues, Berry's diagnosis included depression, bipolar and personality disorder, which she expressed as affecting her health and wellbeing. She expressed her experience of these mental health conditions in the following way:

I don't know, it just comes and depends on where I am, what place I am in and whom I am around depends on which personality I am.

She described this as being "*detrimental*" in that she is "*one character out on the street and another character with her family*".

Poppy also spoke about having a bipolar disorder in her interview. She expressed this experience in this way:

I was having a lot of highs and lows and the doctor said it's very mild bipolar disorder.

She linked this mental health condition to the amount of drugs she was taking. These medicalised constructions of her mental health encourage medical solutions while ignoring the social context of her day-to-day living. Poppy also attributed the psychological difficulties she experienced to her "*kids being taken into her Mum's custody, [and] the drugs and all the violence*". Poppy

noted that these environmental triggers precipitated a downward turn in her emotional wellbeing, which evolved into the following point:

Waking up in the morning, smoking so that I could comatose myself and go back to sleep... and then it is another day.

Poppy felt that there was no purpose to her life anymore. The highs and lows had also made her feel unsure about her identity and she gave an account of this position by stating:

I am still not quite sure of who I am (Poppy).

These moods had also affected Poppy's ability to consider employment outside of street sex work. When making a start to do this she would have mood swings and failed to continue to pursue that goal. This she said "*is what bipolar affected people feel like.*"

It is also worth noting that all of the women interviewed were on methadone prescriptions to prevent withdrawal symptoms for heroin addiction. This entailed visiting a drug/health service every two weeks where other prescriptions for mental health disorders were available. The pharmacist ensured that the methadone – the "*green liquid*", as Katie described – was measured accurately and given to the women to self-administer on a daily basis.

The women noted that methadone when not taken meant they were faced with another set of withdrawal symptoms, which they termed "*going into a cluck*". This means experiencing symptoms such as: "*hot and cold sweats, diarrhoea, a failure to hold your back passage, you feel sick, and your joints kill you*" (Katie). The women all noted that these symptoms had the potential to affect daily living.

You need the methadone to manage yourself because without that, you can't do anything (Kelly).

All the participants in this data set shared their struggles of addictions to a drug habit. One of them described her addiction to crack cocaine as being

“so hard to come off it because it gets in your bones” (Katie). Drug dependency had a major impact on the physical and mental health of the women in sex work. May and Hunter (2006) reveal that depression and anxiety may often be associated with problematic drug use, particularly crack cocaine. A specific example of this was visible with Mary stating that drug use affected her mentally. She said:

With crack, it is mental and it is so hard to train your brain not to want something because your brain is what makes you talk through everything.

Methadone maintenance therapy in lieu of ‘hard drugs’ was described by Katie as being on *“a ball and chain”* experience. This referred to her having to stay in close geographical proximity to the area in which her methadone prescription was available. Nancy echoed Katie’s methadone experience:

Waking up at 10 am, getting up at two and going to get my methadone then coming back home to watch television and wait for a call for business or smoke crack.

Nancy noted that while the methadone is effective to some degree, it was far from a cure-all for all drug addictions: *“Methadone stops you from smoking heroin – not crack”*.

Another side effect from substance misuse that affected the mental wellbeing of some of these women interviewed was ‘hearing voices’. Whether the result of undiagnosed schizophrenia or a dissociative disorder not otherwise specified (DDNOS), the women afflicted by such auditory-type hallucinations noted that hearing voices had an impact on their wellbeing. Steph reported:

The voices make me do things like sex work and they come on stronger when I am on drugs.

Alcohol and other substance misuse have exacerbated the mental, physical and emotional health of the women in this study. The next section explores the link between the women’s experience of stigma and discrimination linked to social exclusion in street sex work.

5.4 Experiences of Health-Related Stigma and Discrimination

In the stories told by the 10 women in this study, there was a sense of segregation from the public world, a sense that they inhabited a different, secret world. This had an impact on their social health and wellbeing where their responses indicated that they had no sense of involvement with the community and only felt stigmatised.

A feminist viewpoint acknowledges the social differences that women feel in society such as feelings of 'otherness'. A feeling of 'otherness' is consistent throughout the data sample especially when the women shared their experiences of the agencies and services that should support their health and wellbeing. Instead, the women felt a sense of injustice when health service agencies and police interaction became stigmatising forces. For instance, Tally and Drew made clear their experience that the medical profession reacts negatively towards FSSWs. Drew and Tally's negative stigmatising responses was as follows:

When they found out I was a working girl, they would treat me really different like really nasty (Drew).

As soon as they find out you are a junkie, they come and treat you differently. Their views would be that we are choosing to do what we do (Tally).

The two accounts of similar responses to the treatment these women experienced from health service personnel indicate that there was a negative attitude towards FSSWs. Katie referred to the treatment received by health services with a sense that there was a lack of care and compassion. She reported the following:

Health services are just giving you the script and letting you go.

The view of these women by health professionals is disregard and apathy for their health and wellbeing. Kelly also felt her GP did not care about her personal wellbeing and that the responses from health services are often judgmental ones:

They just say it's your problem. You should have been stronger not to do it.

Mary echoed what Katie, Kelly, Tally and Drew noted. She stated the following opinion of health service personnel:

They look down on you like something on the bottom of their shoe.

When Berry visited her local GP, she felt the medical profession was not paying attention to her needs. She said:

He knows what I am going through and can read on my records what I am like but I don't think he is listening to a word I am telling him.

Her perception about the GP practice she attended illustrated that Berry had unmet health needs and given her past medical history she felt that she was not being listened too. It appears that Berry was reliant on the service to meet her health and wellbeing needs but may have become reluctant to seek help if there was a lack of concern for her current life situation.

To avoid such health-related stigma Nancy did not reveal to her GP what her profession was: *"they don't know that I am a sex worker"*. Neither did she speak about her profession to her family as she stated *"but it is not really talked about"* thus Nancy's entire lifestyle kept a secret. The key consequences of failing to reveal her lifestyle to her GP might be that her GP is unable to address fully her health concerns. This choice makes Nancy and the other women acutely aware of the fact that women who engage in street sex work are stigmatised and socially excluded from society.

The stigmatisation FSSWs face at the hands of healthcare systems and agencies was the same among the women's closest circle of family and friends. To avoid the backlash from those closest to her Poppy did not like to class herself as a 'sex worker'. Rather she liked to describe herself as *"a working girl"*. For Poppy, this sounded more neutral. Poppy said that when she told her Mum that she was a *"working girl"* her Mum cried and it broke her heart. Meanwhile, Mary reported that in her long-term relationship:

If my partner knew I had done sex for drugs, he would not want to know me at all.

Kelly's own children were dismayed to learn of her involvement in street sex work. She recalled how her sons were "*shocked*" and "*took it hard*". Kelly reports that they are "*okay with it now*". Many of the women felt unable to mention their choice of work at all to their family and friends, for fear of discrimination. Berry stated:

I do not want to be pinpointed as a worker and do not want to be classified as one (Berry).

The sense of 'otherness' continued to be perpetuated by the women's experiences of health service discrimination and in their interactions with the police. From a feminist perspective, the women may feel that they belong to a stigmatised group where a sense of male dominance derived from law enforcement officers and health services show very little concern for the health and welfare of street sex workers. Kelly acknowledged that the police did not care or take an interest in the dangers faced by women on the street and expressed her view as follows:

When the police come, they just look at us like we are just garbage or pieces of crap to them (Kelly).

Many of the women interviewed expressed similar thoughts about the judgemental nature of the police. This sentiment as noted in a quote from Kelly:

The police don't care. If anything should happen to us, they don't find our parents or report it on the news or anything. They leave us to die or if they find us, they send us to prison.

The women in this study felt that rather than responding to their needs or protecting them, the police simply judged them. For women like Kelly, she felt that the situation on the street was going to lead to worsening situations:

The girls are getting younger and younger and the police should be getting the punters off the streets – because the streets are not safe because someone is always going to be out there to kill them or beat them up.

Kelly continued and described the streets as “*horrible*”. She referred to “*the punter that killed all the prostitutes in Camden, chopping us up in black bags*”. She referred to those women who fell victim to this brutality, as a part of herself in solidarity with them when she uses the term ‘us’. Her sense of identity was closely associated with the profession of street sex work and linked to a ‘sisterhood’ theme amongst women of the same profession.

As is evident from the narratives, the women’s social health and wellbeing influenced by the experience of discrimination may have been a pattern that began in childhood and had followed them throughout their lives. With the continuation of abusive adult relationships and the loss of their own children, the women appeared to have internalised a sense of ‘otherness’ a difference from early on. This has fed negatively into their sense of self thus affecting their social health and wellbeing.

There is one place where the women spoke positively about the influence of social support. The Women’s Centre where the interviews took place offered support to vulnerable women caught up in the cycle of substance misuse and street sex work. The women felt valued and cared for as opposed to the experience of discrimination. Comments by Katie, Kelly and Tally describe the positive feelings about the Centre.

If it wasn’t for the ‘Centre’, I don’t know where I would be because this service helps me a lot. It keeps me focused (Katie).

It’s a shame there’s not a few more good places like this (Kelly).

I had to spend six months looking for a counsellor (a psychologist works at the Women’s Centre). It’s just a shame that things aren’t accessible (Tally).

It is apparent that the Centre contributed to the health and wellbeing of the lives of the women involved in street sex work by addressing their social, emotional and mental health needs. The women's physical needs were met too as the Centre provided food, clothing and toiletries to the women who accessed it. Chapter 3 of this thesis provides further details of the role of the Women's Centre.

5.5 Summary of Findings from the Primary Data Set

In exploring the in-depth interviews made with FSSWs in this study, a feminist paradigm informed the focus on women's lives in the setting of a Women's Centre, achieved through a commitment to understanding the issues and concerns of women from their perspective while being attentive to the broader social context of their lived experience in street sex work. It is possible to see the main themes emerging from the women's own accounts about their traumatic childhood experiences of sexual abuse, neglect, loss, rejection and then subsequently running away thereby increasing their vulnerability.

The drugs and street sex work cycle featured heavily in structuring the day-to-day lives of the women represented through this data set. The FSSWs appear to not only be involved in street sex work as a means to survive but increasingly were driven to fund their expensive drug addictions to such substances as crack cocaine and heroin. As a result of their drug use, most of the women's children in the primary data sample are in local authority care, while some have been legally adopted.

From this point, the next step into involvement in street sex work appeared retrospectively as almost inevitable. For these women their sense of agency appeared negated by the events and experiences in their childhoods. This negatively influenced their sense of self-worth and their ability to make choices, which led them into a pathway to street sex work.

In summary, the women's narrative accounts illustrated how the realities of substance misuse, alcohol and drugs determined and constructed their lives

in street sex work. Health services were not providing the care and support needed for this group of women. The women felt like they were 'treated differently'. This reinforced an identity construction of an 'othered' position in which their health needs both mental and physical were seen as resulting from individual failings in their personality or behaviour rather than male physical violence.

These research findings present the voice of the FSSWs own experiences of their health needs. The findings in the study offer a better understanding of the lived experience of FSSWs with detailed evidence regarding key public health issues that have significant consequences for women's health and wellbeing.

Chapter 6 – Discussion and Conclusion

6.0 Introduction

The overall purpose of this study was to explore the perceptions and needs of female street sex workers (FSSWs) in relation to their own health and wellbeing. In the preceding chapter, the key themes in the findings included childhood trauma consisting of sexual abuse, neglect, loss, abandonment issues and in adult life, intimate partner violence. The women experienced judgmental attitudes from health service personnel, family members and friends adding to the likelihood of social exclusion.

Hence, applying a social constructivism paradigm to the analysis of the research findings helped me to understand the perspectives of women in sex work that perpetuate these structural inequalities. This understanding was shaped through the collected life stories in the FSSWs own personal accounts and my interpretations about their social reality in the context of the Women's Centre where the women were recruited for Phase 3 of this study.

Smith (2005) introduces the notion that people might not understand how structures and culture shape their preferences and perceived options for action, however they are still the experts on their own lives. Therefore, locating the study in social constructivism and a feminist perspective grounded the work 'in the set of theoretical traditions that privilege women's issues, voices and lived experiences' (Hesse-Biber, 2014: 3). This feminist paradigm provided the political and ethical standards for informing the conduct of the research process, which had implications for exploring the reflexive nature of the research encounter with women in street sex work. The key themes highlighted in the findings chapter are discussed below and will be later seen through the lens of Bourdieu's theoretical framework.

6.1 Impact of Trauma

A common relationship identified in the women's accounts provided evidence about the occurrence of childhood trauma and poor mental health. Their childhood trauma consisted of one or in some instances more than one of the following: sexual abuse, abandonment issues such as neglect, parental rejection and family breakdown. According to the Diagnostic and Statistical Manual of Mental Disorders IV and V (2000), childhood trauma refers to exposure consisting of actual or threatened death, serious injury, or sexual violence. In adult life, the women frequently experienced intimate partner violence and the loss of their children to social services.

The women often reported that they had low self-esteem and body confidence. This related in many cases to their physical appearance, specifically dental damage and visible damage and scarring to their bodies caused by physical assault. The women also again articulated and understood the connections between the long-term consequences of physical violence and emotional health. Their lack of body confidence represented an area that required further emotional attention and support.

Trauma and its consequences from physical and sexual violence, including the emotional abuse experienced, could be seen as constructing the women's poor mental health across the life course from behavioural issues in childhood to depression in adulthood. The women clearly identified how all of the above circumstances have contributed to their poor mental health issues and life chances.

6.1.1 Social Exclusion

The evidence of 'whore stigma' was embodied in the findings of this study, which demonstrated that the women participants experienced a lack of social acceptance from their environment that included family members, their interactions with health service personnel and law enforcement officers. The implications of these findings are that the women felt disempowered and

marginalised because they were not able to participate in normal relationships available to the majority of people in society (Levitas et al. 2007). Sanders et al. (2009: 23) suggested that stigma and its effects on sex workers demonstrated that the negative images and attitudes attached to the sex industry are increasingly the most damaging aspects of sex work.

Other studies also suggest that women in sex work experience a great deal of negative and discriminatory social stigma (Bradley, 2007). This is detrimental to the overall health and wellbeing of women in sex work and intimately linked to inequality and exclusion (Scambler, 2007: 1087). The women in this study also experienced housing difficulties and some were staying in hostel accommodation described as hectic and chaotic, contributing to the isolation they experienced. This was partly due to the behaviour of the other occupants living in the temporary accommodation. Evidence provided by the Cabinet Office (2006) in their action plan on social exclusion suggests that exclusion from society has a long-term negative effect on health. It affects both the quality of life of individuals and the equity and cohesion of society as a whole (Levitas et al. 2007).

6.1.2 Judgmental Attitudes of Health Services

Another important finding from the primary data set was the negative perception of the performance of health services and agencies in addressing FSSWs' health needs. The FSSWs experienced differential treatment and not regarded or treated with care but instead they said they felt like outsiders, reinforcing to FSSWs the idea that they appear to have an unwanted membership in a marginalised group. This had an influence on the way the women felt about their interactions with health service personnel.

However, it is also evident from the findings that there appeared to be a lack of support from services across the life course. This included the education system where participants spoke of not being able to read and write. Some of the women were sent out of the classroom for being disruptive in school, whereas greater efforts by teachers to understanding their emotional health

needs would have been beneficial. The women mentioned that instead, they were labelled with mental health issues.

In the absence of services that responded to their health needs both physical and emotional, health risk behaviours such as excessive alcohol consumption and substance misuse (mainly crack cocaine, heroin and methadone) represented the main way the women navigated and managed their distress. Addiction to alcohol and crack cocaine was also significant in contributing to their poor health issues across the life course.

6.1.3 Defining Health and Wellbeing

The social construction of health that emerged from the primary data findings showed that women defined their own health in ways that encompassed both the absence of disease, for example not being ill, tired, or short of breath, as well as more functionally such as the ability to perform social roles (Cowley, 2008: 214). For the women in this study, these social roles encompassed a limited scope of functional activities such as being able to wake up in the morning and attend to routine every day activities.

Some women did define health as a having or maintaining a positive set of lifestyle behaviours, with examples given such as going to the gym and keeping fit, however this definition was applied in the context of health that was possessed by 'other people' and did not relate to the participants' own lifestyle. For the participants in this study, they identified good health as unattainable due to their current physical and emotional health status.

The women were aware of the risks of unprotected sex and the consequences of multiple sex partners. Some were thankful to have never acquired a sexually transmitted disease. However, those who did not always use protection mentioned acquiring a sexually transmitted disease. There was also a strong message to increase the availability of condom vans in the community, which links with the women's perception of understanding the consequences of unprotected sex.

The next section provides the main theoretical lens to interpret and critically discuss the lived experience of FSSWs in relation to their own perceptions and health needs. At the core of Bourdieu's theoretical perspective are three key concepts useful to this study: habitus, capital and the field. These concepts seek to make deliberations about the relationship between objective social structures, such as institutions, discourses, fields and ideologies, and everyday practices (Webb, Schirato and Danaher, 2002: 1). Bourdieu's key concepts are also pertinent to social constructivism and a feminist paradigm by way of exploring the social processes and women's social interaction at play within their own social context.

6.2 Using Bourdieu's Theoretical Framework to Understand the Lived Experience of FSSWs

Bourdieu's theoretical approach – which is the interlocking nature of his three main 'thinking tools' (Bourdieu & Wacquant, 1989: 50): habitus, field and capital, explores the key findings in this study and their relation to the lived experience of women involved in street sex work. In addition, the strength of a feminist approach, which reinforces a sensitive research ethic, provides a critical perspective on social life that draws attention to the ways in which 'social, political, and economic norms, practices, and structures create injustices that are experienced differently or uniquely by certain groups of women' (Ackerly and True, 2010: 1). This has implications for understanding the dynamics of power, knowledge, relationships and the social context of the women in this study.

Likewise, Bourdieu's key concept of habitus refers to a system of dispositions that guide people's choices, cultural practices, health behaviour, lifestyle, attitudes and ways of being (Bourdieu, 1984). This concept is useful when encapsulating how the women's childhood traumas carry forward into their present circumstances. For the women interviewed who are involved in street sex work, the evidence suggests that in relation to their risk-taking health behaviour, their habitus is influenced by sexual abuse in childhood that results

in substance misuse in adulthood as a means to desensitise and reduce the pain of their trauma.

The seemingly limited choices facing them are highly dependent on the position the women occupy within the field of this study. This can be summarised as an individual's practice from relationships between one's dispositions (*habitus*) and one's position in a field (*capital*), within the current state of play of that social arena (the field) (Grenfell, 2012: 50). This in turn leads to the second element within Bourdieu's theoretical framework, which is the concept of the field.

A field can be defined as a 'social space', in which 'agents do not act in a vacuum, but rather in concrete social situations governed by a set of objective social relations' (Bourdieu, 1993: 6). Understanding the field that FSSWs occupy is relevant because it sets out to recognise the structuring roles of social constructs in relation to the forces that restrict women's access and the influence of the concept of agency. A woman's access can be referred to as the 'capacity to obtain greater economic resources such as opportunities, services and assets required to upgrade her economic position', while agency refers to the 'capacity to make decisions and act on opportunities that lead to economic advancement' in life (USAID, 2012: 3).

Invariably the women's *habitus* structured alongside the same social space or field in which they are located, that is, within multiple positions of vulnerability, substance misuse addictions and temporary accommodation. The women's social class belong to the position of street sex workers, which the literature refers to as the lowest of the low (Costello, 2003). In Bourdieu's theory, the amount and composition of capital determines the power position in this field or social space (1986: 241).

The third key concept in Bourdieu's theory suggests that people from different social positions differ from one another with regard to their possession of four forms of capital; those being economic capital, cultural capital, social capital and symbolic capital. In summation, Bourdieu's key concepts provide a

framework that acts as a guide, a sociological understanding of the social structural constructs that are at play in exploring the lived experience of street sex workers. Bourdieu's key concepts operate in such an order to illuminate the socio-economic inequalities mentioned in the introduction that restricted opportunity and further perpetuated the marginalisation of women in street sex work.

6.2.1 'Her' Social Position in the Sex Industry

Linking back to the social position (mentioned in the previous paragraph above), feminist perspectives that attempt to position women in sex work are grounded in two feminist debates. Specifically these include the perspective that the 'prostitute's body' is seen as a form of sexual exploitation (Barry, 1995; Farley, 2004), that being that women working as sex workers are exploited by those who manage and organise the sex industry (mostly men). Sex work and the wider sex industry underpin and reinforce sex work as a patriarchal institution that affects all women and gender relations (Scoular, 2004). This is noticeable in the concept of 'whore stigma' (Pheterson, 1989; Corbin, 1990) where this label is 'implicit in social and structural mechanisms, through the law, gendered policy, and the organisation of work' (Sanders, O'Neill & Pitcher, 2009: 23).

A feminist perspective (see literature review chapter) illustrated that 'sex work is seen as a form of sexual labour and considered to be work' (Sanders, O'Neill & Pitcher, 2009: 9). This adds to the notion that 'these women working in the sex industry deserve the same rights and liberties as other workers, including freedom from fear, exploitation and violence in the course of their work' (O'Neill, 2001: 16). The feminist view also refers to a non-judgmental attitude towards a woman's free will and her ability to make decisions about her own circumstances. It is how she chooses to use her body (Sanders et al., 2009), meaning that in an ideal or in near ideal circumstances these women have agency and choice.

To elaborate further on the argument on the view of 'sex as work', a research publication conducted by Lucas (2005) on 'elite sex workers' offers a different kind of impression of women in sex work to women in street sex work. Lucas conducted 30 open-ended interviews with American female sex workers who worked as escorts. The findings suggested that sex workers choose their work for the same reasons that other people choose their profession. Many sex workers justify their work as being no worse and possibly better, than other work in which women engage in. The benefits mentioned in the Lucas (2005) study demonstrated that sex work is a cash business with a high demand and that the women can tailor their working hours to their financial needs, working more when they have debts, and working less when they desire time off. The primary incentive that leads women to engage in sex work for 'elite sex workers' is that it is a rational choice and economically empowering.

Economic capital refers to material assets that are 'immediately and directly convertible into money and may be institutionalised in the form of property rights' (Bourdieu, 1986: 242). Economic capital includes all kinds of material resources used to acquire or maintain better health (Mirowsky & Ross, 2003). For the women in street sex work in this study, their economic capital is limited, which acts as causation for them to become vulnerable to 'survival sex' in street sex work. This type of engagement refers to a last resort where individuals engage in sex work to provide shelter, food, or fund severe addictions in a 'work-score-use' cycle (McNaughton & Sanders, 2007; Sanders, 2007). Low level of economic capital is identified as having a negative effect on health due to the lack of material and psychosocial resources available (Pinxten & Lievens, 2014: 1098).

While this distinction is clear, there are still other field operations to consider about women's choice of sex work, which are not economic capital. Bourdieu (1999: 4) states that using material poverty as the sole measure of all suffering keeps us from seeing and understanding a whole side of the suffering that is characteristic of the social order. This does not imply that material circumstances are specific to the poor health and wellbeing

experienced by FSSWs. It provides the breathing space to acknowledge social structures and processes that help shape the life courses and biographies of the women interviewed in this study through an understanding of their habitus.

In the collated evidence collected in the secondary data set, the women demonstrated agency in the decisions taken to increase their personal finances through sex work; these women were also able to see their decisions as being about 'work' and that their decisions were a choice to support their living arrangements. As a result of this determination, the women's entire lives and identities were not defined by their decision to engage in sex work.

Sex work for the women on the street as presented in the primary data set was not about 'work' or control and choice in the workplace, it was about 'survival sex'. Sex in this context is a commodity they sell in order to survive another day. This perspective is in marked contrast to the position of the women's experiences highlighted in the study conducted by Lucas (2005). The women involved in street sex work cannot be merely viewed as 'workers' who have a choice of occupation but rather they appear to be to a large extent powerless.

These vulnerable women are trapped in a self-perpetuating cycle of substance misuse and the constant drive and need to fund their drug habits. Thus their health is a part of their wider habitus, both in the way in which their health is experienced (with poor health outcomes resulting as a consequence of street sex work), and also the way in which health services are perceived, whereby these services don't deliver what is needed for this particularly vulnerable group.

The next section will discuss the habitus of the burden of living with a mental illness. This is one of the particular key health issues facing women in street sex work, which arguably mitigates the possibility of making fully informed or truly free choices, in the light of their complex mental health needs.

6.2.2 The Habitus of Living with a Mental Illness

Bourdieu extrapolates and recognises that 'where an individual is at in any one moment in life is the result of numerous events in the past that have shaped the present' (Grenfell, 2012: 51). Evidence from this study suggests that the multiple mental health problems reported by the FSSWs that have arisen from their past experienced events of childhood trauma are linked to their habitus, and therefore influence the manner in which the women are currently acting, feeling, thinking and being. For instance, as noted above, women interviewed at the Women's Centre reported a diagnosis of clinical depression and described symptoms such as fatigue, disturbed sleep, feelings of helplessness, and depressed moods.

Another mental illness mentioned by the women in the primary data sample is PTSD (Post Traumatic Stress Disorder), which is defined as a severe psychological disturbance which usually results from a singular or a series of similar traumatic events (Callghan & Waldock, 2006: 238). The symptoms mentioned by the women included; traumatic flashbacks, increased levels of anxiety, suicidal thoughts and tendencies and depression. Personality disorders and bipolar disorder were also mental health conditions reported by the women and related to participants feeling emotionally unstable. More specifically, their inability to control their anger in turn led to the participants having unpredictable behaviour patterns.

Childhood traumas, particularly those that are interpersonal, intentional, and chronic are associated with greater rates of PTSD (Post Traumatic Stress Disorder) (Wisdom, 1999) depression (Wisdom et al. 2007) and anxiety (Copeland et al. 2007) antisocial behaviors (Luntz and Wisdom, 1994) and greater risk for alcohol and substance use disorders (Dube et al, 2006). Research has found that the more adverse life events people experience prior to the age of 18, the greater the impact on health and wellbeing over the lifespan, including poor mental health, severe physical health problems, sexual and reproductive health issues, engaging in health-risk activities and premature death (Anda *et al.*, 2010).

Overall, the women in the primary data sample constantly had to navigate drug and alcohol misuse, poor mental health and multiple positions of vulnerability. These issues positioned them to seek out sex work to survive on the streets, the combined toll of which influenced and shaped their personal habitus.

Understanding the research participants' personalised habitus, according to Bourdieu, is a key construct in the manner in which this state captures how the women carry within them their personal history. How they bring that history into their present circumstances, and how they then choose to make choices and to follow through with actions in certain ways, as opposed to other potential choices and outcomes (Grenfell, 2012: 51) provides an understanding of their habitus. The habitus mind-set of the women participants in the data sets engenders a sociological gaze through which to view FSSWs' risk-taking behaviours in relation to the impact of trauma.

6.2.3 The Habitus of Substance Misuse

Without exception for the women interviewed from the Women's Centre, substance misuse and addictions created tensions between wishing to leave sex work and the need to maintain their drug dependency. This tension has demonstrated that a specific health consequence of this connection, if not managed with care, has the potential to increase the individual's already high vulnerability to violence and abuse. At the same time, the research participants frequently overlooked their own personal physical, mental and social health and wellbeing to engage in the risks of the lived experience of street sex work. Adamson (2014) in his publication *Behold the Man*, states that a drug addiction becomes a destructive disease-trapping process in which the human soul (in this case the habitus) is trapped inside a being that is obscured by a lust that perpetuates self-destruction (Adamson, 2014: 10).

The short-term physical risks to health due to an addiction to a substance as destructive as crack cocaine include the over-stimulation of the Central Nervous System (CNS), increased levels of agitation, the possibility of

hallucinations, hypertension (high blood pressure) and tachycardia (an increased heart rate). Long-term use leads to dysrhythmia (an irregular heart rate) and an eventuality of potential cardiac arrest (British National Formulary, 2014). These potential symptoms influence the FSSW's habitus state. In the context of the conducted study, the women frequently spoke of symptoms that included insomnia and other common withdrawal symptoms of drug use such as; cold sweats, diarrhoea or flu-like symptoms. The most potentially fatal reported consequence of drug misuse described within the course of the study related to a drug overdose, with one participant recounting her personal experience of having injected herself with heroin and ending up in hospital in an unconscious state.

Callaghan and Waldock (2006: 214) stipulate that continued dependency on substances and their perpetuated misuse exacerbate all other relevant psychiatric illnesses; specifically anxiety states, panic disorders, mood disorders and psychotic disorders including chronic alcohol use linked with cognitive impairment in mental status such as dementia (Callaghan & Waldock, 2014). For many of the women involved in the primary data set, high alcohol consumption was a key feature in their day-to-day living, which exacerbated other aspects of their mental health.

Another health consequence for the women in the primary data set who were drug dependent related to their reality of the social services' involvement in safeguarding children from their parent's harmful use of substances. Seven out of the 10 women interviewed reported having their children removed from their care by social services and fostered or adopted. The role played by social services in safeguarding the children was a sensitive and deeply impacting area for these women. This study has identified the implications that call for future consideration to removing children from their biological mothers in populations such as FSSW women.

The trauma of the loss of their children for the women in the primary data sample produced a level of emotional pain that caused a great longing to be reunited with them. The women's separation from their children led to

experiences of guilt, suicidal attempts and deep sadness. These feelings further influenced the health and wellbeing of the FSSWs, which exacerbated and perpetuated the cycle of drug misuse in order to numb the pain of loss. Campbell (2000) extrapolates that drug use can be constructed as a form of violence that women commit against their own being and those human beings that are most intimate to them.

Farley (2005) argues that sex work is continually detrimental to both the women who engage in sex work and to women's position within society as a whole. Evidence in this study suggests that this is a reality for street sex workers who are drug users. With the primary data sample, it was evident that living with a drug dependency and the subsequent impact of having their children taken away by social services negatively affected a woman's health and wellbeing by shifting the identity away from women experiencing motherhood to the juxtaposition of being associated with street sex work and a substance misuse offender. This now leads to the exploratory understanding of how the women in this study resort to a pathway of street sex work, which will be referred to as the capital-related term 'survival sex'.

6.2.4 The Capital of 'Survival Sex'

An exploration of the personal narrative accounts given by the women in the primary and secondary data sample revealed the inter-relationships of social structure, background context and habitus in the understanding of the health and wellbeing of FSSWs through the lens of Bourdieu's theoretical framework. Additionally the women in both data samples spoke of relationships between dependency on the inadequate provision of Social Security benefits and the need to engage in sex work as a means to survival. All the women were drug dependent and street sex work was a means of earning money to fund their drug habit. Most women had no educational advantages to support the option to look for an alternative job outside of the field.

There appeared to be a complete absence of choice about their engagement in street sex work. McLeod (1982) argues that a woman's entry into sex work

is characterised by an act of resisted avoidance of the experience and cycle of relative poverty or the threat of said poverty. For the women in the primary data sample, poverty and low-income status were a reality and contributed negatively to their suffering, preventing these women from engaging in social activities and an adequate standard of living.

In the secondary data set, the women interviewed had developed and retained a sense of resilience and agency about their involvement in sex work. Agency refers to 'the ability for individuals to deploy a range of causal powers' (Frohlich et al. (2001: 781) and the women in this data sample demonstrated that they regarded their decision to engage in street sex work as providing a service, which built their perceived capital in relation to their economic advancement.

In a study conducted by Perkins and Bennet (1985), other sex workers have cited that sex work provided financial rewards, freedom and autonomy and the satisfaction of providing a needed service. This indicator of capital in relation to entry in sex work largely being for economic incentives and providing a sexual service linked to social capital. The relationship between social capital and health explored through the lens of a sex workers group membership and social networks for mutual benefit provided an understanding of their social position in wider society.

6.2.5 The Social Capital of FSSWs

In Bourdieu's research, social capital refers to the accumulated sum of actual or potential resources, which relates to the provision of a durable community with either increased or decreased institutionally based relationships of mutual acquaintance and recognition (Bourdieu, 1986: 248). For the FSSWs, their social capital built through the friendships they have on the street and the Women's Centre provides a sense of security and an essence of sisterhood based on a network of mutual support and protection. The Women's Centre also provides resources in the form of access to necessities such as nutrition

and toiletries as well as assistance with medical appointments and temporary housing possibilities.

With reference to the women's personal lives, their ability to feel safe was hindered by the women reporting in both data samples (secondary and primary data), the occurrence of Intimate Partner Violence (IPV), also referred to as Domestic Violence. Black (2011) explicates the notion that victims of IPV suffer significant negative health consequences due to the physical, sexual, emotional, and psychological abuse they have experienced. The most overt consequences of IPV are the physical injuries sustained by the attacked person. This is the nature of violence against women where the most common perpetrators are male intimate partners as described by the women in this study. Astbury (2010) clarifies that for women who are the unfortunate victims of intimate partner violence, a sense of inferiority and shame results in a decreased sense of self-respect that ensues after the violence.

In relation to the legal support offered to the women in regards to reporting violent attacks, the women tended towards verbal negativity about the provided police services. Mainly they felt at an obvious disadvantage in regards to the manner in which their personal experiences lead them to feel unprotected by the police and instead they have a sense of distrust towards them. By focusing on this experience, it is evident in the work of Bourdieu that, in particular, 'symbolic violence' can shed light on the dominance of the legal structures and processes in place through which negative experiences are reproduced for women involved in street sex work.

Powell and Snag (2015: 921) explain that 'symbolic violence is not physical but may instead take the form of individuals being denied access to resources and treated as inferior or being limited in terms of realistic aspiration'. For example, negative experiences of interactions with police or health service professionals (see the findings chapter) contributed to the women feeling worthless and gaining no sense of personal safeguarding or amelioration of suffering in interactions with services such as health or the police. The

women's experiences of having pleas for help ignored have also been previously reported (Thukral, Esq and Ditmore 2003),

The concept of 'felt stigma' is one way in which the impact of these experiences on the women is apparent. Felt stigma denotes an internalisation of shame and blame as well as a fear of being discriminated against (Scambler & Paoli, 2008), which is also consistent with the women feeling marginalised and excluded from fair treatment and the lack of care by police personnel. This form of symbolic violence is likely to be attributable to the current legislation and structural barriers that maintain these women in an isolated state. The criminal justice system, with its emphasis on prohibition and restrictive policies, has impacts on sex work, which are common worldwide and are in contrast with a lack of focus on the health and potential health risks for women involved in sex work.

From these findings, it would appear that sex work for these women is a closely guarded secret and some women in the study even expressed shame and fear that their family would find out about the exact nature of their 'work'. It is clear that the women possessed little social integration into a world outside of their membership group as street sex workers and they have poor relationships with networks of support that are available to social integrated members of a society such as family members, which compounded and perpetuated their marginalisation in wider society. The role played by family members in making judgments about the women's involvement in sex work potentially contributed to the extreme social isolation they felt.

Stigma is therefore a persistent aspect of FSSWs' social capital and has been a characteristic feature throughout the documented history of sex work reports (Sanders, O'Neill & Pitcher, 2009). William, Wong, Holroyd and Bingham (2010: 50) suggest that stigma can have a demoralising effect on a sex worker's health. This is achieved both through the obvious manifestations of physical or verbal abuse by other persons or by persistently making sex workers feel as if they needed to cover up their identities and remove themselves from popular forms of social networking.

Thus in illuminating the concept of stigma through this study, the implications are required to be considered to guide and aid the direction of support services towards the de-stigmatising processes and practices that seek to respect and give recognition to women's empowerment. The next section addresses the role of existing health services in meeting the needs of FSSWs.

6.3 Health Service Discrimination and Stigma

It appears that the attitudes of key health professionals towards FSSWs seeking access to health services have a negative impact on the women. This is evident in the narrative account given by the FSSWs in which they state they were extremely sensitive to the looks of judgment and the manner in which health personnel approached them. The women expressed that they felt the treatment they received in comparison to other patients was insufficient and that the health service personnel who attended to them did not care about their health needs by demonstrating a dismissive approach toward them whilst accessing health care.

The notion of 'otherness', particularly in the judgments conveyed to the women by health professionals treating them differently, is reflective of stigmatisation. With specific reference to the literature review chapter, Goffman (1963) defines stigma as an attribute that resonantly discredits an individual or concept. The recognition of this attribute leads the stigmatised person to a reduced whole from a seemingly normal person to one that is pertained to be tainted or discounted. Link and Phelan (2001: 363) define stigma as the 'co-occurrence of its specific components – labelling, stereotyping, separation, status, loss and discrimination'. The women in this study had experienced these components and Scheff (1966) claimed that 'labelling' is the single most important cause of mental illness, in that a person becomes what the labelled placed on them.

In considering the 'othering' process in an attempt to dissolve the overarching dichotomies seen here, best practice can be achieved when health service

personnel are well informed about the importance of understanding in-depth the women's experiences in street sex work; the importance of understanding their health needs and the traumatic life histories that continue to torment these women's existence. This thesis adds to the diverse evidence (Masenior & Beyer, 2007; Scambler & Paoli, 2008) that policies resulting in stigmatisation are antithetical to improving sex worker health and wellbeing. They are also particularly detrimental to public health incentives and care programmes based on the principles of social solidarity and human rights.

Failure to recognise the role of health service discrimination and stigma in contributing to the marginalisation and oppression of women in street sex work adds to the status of these women as deviant and problematic. This particular mind set harks back to earlier societal norms that viewed women in sex work as profane, diseased, and excluded as per the standards of the nineteenth century exemplified by Bell (1994: 2). Assimilating street sex work with deviant behaviour has consequences for furthering the prejudicial ideological view of the street sex worker as an 'other'. This reproduces the dualisms of modern expressions of women in sex work as victims and subjects, alongside a primary image of female perfection contrasted with the street sex worker that is, the contrasts of 'whore' with 'Madonna', 'good girl' and 'bad girl', and a healthy normal woman and a diseased body (Bell, 1994: 2).

Implicit in Bourdieu's view of the world is that differentiation and distinction result in a kind of violence perpetuated on persons who do not belong to dominant social groups. This symbolic violence is manifested in the health service discrimination and 'whore stigma' experienced by the FSSWs who subsequently become victims of its violence. However the problem with only considering this approach in understanding the lived experience of FSSWs is that there is an assumption that this violence occurs as a result of a specific individual's trait deviance rather than an outcome of socio-cultural sub-conscious processing (McCordic 2012: 70). It is therefore necessary to continue with Bourdieu's framework in understanding the cultural capital of the

women's visual representation in society through the analysis of sex calling cards.

6.4 The Cultural Capital of Women's Identities in 'Sex Calling Cards'

Implicit in Bourdieu's (1993: 7) definition of cultural capital is the idea that 'it comprises a form of knowledge, an internalised code which equips the social agent with empathy towards, appreciation for or competence in deciphering cultural relations and cultural artefacts'. Thus, historical constructions of the 'prostitute' in literature, media and political discourses have been fascinated with the concept of 'the whore stigma', which has dominated the cultural imagination 'categorising women in the sex industry as immoral, dirty and criminal' (Sanders, O'Neill & Pitcher, 2009: 23).

This ideology of 'whore stigma' is different to the modern depictions of women posing as sex workers illustrated by glamour models on sex calling cards. These women perceived as having desirable bodies displayed and consumed as visual sexual commodities in public spaces. However, this is a view that demonstrates the manifestation of a patriarchal society that downgrades women such that they objectified as objects of male sexual desire (Pateman, 1989).

Therefore, a patriarchal viewpoint is central to the cultural construction of the visual representation of women in sex work. The sex cards depict a unique cultural code with which to lure men for the purchase of sex through the selling point of the female body. The encoded message within the photographic image related to the key themes of flawless beauty and youthfulness. Textual data also revealed insight into the services women in sex work provide.

The importance of this data from a feminist perspective has provided a vital space in which to articulate the harm women have experienced and continue to experience under eroticised power relations in their expression of males buying sexual services, which ultimately reduces women to mere sexual

objects. The placement of these images in public domains also serves to reinforce the current sexualised culture where the objectification of women in advertising is normalised. Shrage (1994: 134) states that this reifies an image of the sex worker as a supposed sexual subordinate. This sustains the myths and norms of the sex industry that views men as potent and women as submissive rather than transforming these images. This finding has implications for sustaining the ideological position of the objectification and commodification of women in sex work.

The irony of the situation remains in the fact that the images of the women in the cards are of glamour models displaying their female sexuality to advertise for sexual services, images that are far removed and differ vastly from the 'suffering bodies' of women involved in street sex work seen in this study. Due to their work, the FSSWs have sustained scars on their bodies and some women have no teeth because of the violent episodes they have experienced in their lives. The women are malnourished and suffer from insomnia, so in this case their physical appearance is far from as alluring as compared to the women displayed in the sex calling cards so their symbolic capital is low.

Bourdieu (1993: 7) refers to symbolic capital as 'the collective resources available to an individual on the basis of honour, prestige and recognition'. However, Doezema (2000: 11) notes that 'claiming the injured prostitute as the ontological and epistemological basis of feminist truth forecloses the possibility of political confrontation with sex workers who claim a different experience'. During the interview process with FSSWs, the women spoke of their own perceptions and opinions towards the sex calling cards.

The responses revealed that the physical appearance of FSSWs and the 'popular images' in the media of women involved in sex work, are in sharp contrast to the realities of the poor physical, emotional and mental health experienced by the women in the primary and secondary data sample. Scambler (1997) ascertains that the popular images and stereotypes of the sex worker are concentrated largely if by no means exclusively on the street sex worker. For instance, popular movies such as *Secret Diary of a Call Girl*

(2007) with Billie Piper as “Belle de Jour” – a high-class London call girl, based on the diaries of contemporary writer Brooke Magnanti (1928), *Leaving Las Vegas* with Elizabeth Shue (1995) and *Taxi Driver* with Jodie Foster (1976) represent young, beautiful street sex workers.

Analysis of the sex calling cards helped to demonstrate that the perceived capital of FSSWs (attractive, alluring women, in control of their work/lives/choices) is incredibly polarised from their actual lived reality and actual capital. The majority of the FSSWs interviewed described the media representation of women in the sex calling cards as humiliating to other women. In this instance, the contradiction lies in the fact that while they are street sex workers, they do not see themselves as the women who are glamour models choosing to advertise their bodies for the sale of sexual services. It is evident that a sense of ‘otherness’ is expressed by the negative reaction given by the FSSWs to the sex calling cards. This emphasises the point that FSSWs have not chosen to be involved in the sex industry but the sex industry has chosen them, partly due to their problematic drug and alcohol misuse and their traumatic childhood backgrounds.

Barry (1995) puts forward the argument that sex work is sexual exploitation; she states that ‘when the human being is reduced to a body, objectified to sexually service another, whether or not there is consent, violation of the human being has taken place’ (1995: 12). The sex calling cards offer a graphic example of male domination exercised through the medium of sexuality (Scouler, 2004: 343). Alternatively, as Kesler (2002: 19) indicates, it is ‘the absolute embodiment of patriarchal male privilege’. In order to alleviate this gender inequality it is important to consider the social structures that disempower women’s agency as discussed in the next section through Bourdieu’s concept of field.

6.5 Understanding a FSSWs Field

A field refers to a specific social arena in social life (Bourdieu, 1984). Specifically it relates to the various social and institutional arenas in which

people express and reproduce their dispositions and where they compete for the distribution of different kinds of capital (Gaventa, 2003: 6). When being assessed in relation to street sex workers, the specific power dynamics at play identified in the analysis of the primary data include the Women's Centre, the law, social media, social support groups, housing associations, social services and health services. These are the regulatory bodies and services for women in street sex work. The following paragraph illustrates the outworking of these dispositions through the lens of government policy.

Government policy advocates for an increased crackdown on street sex work and stricter enforcement of the kerb-crawling laws that were first introduced in the 1980s. This social policy contributes to increased vulnerability for street sex workers as opposed to increased protection and rehabilitation (Late, 2006). A growing body of evidence shows that these policies enhance the powers of third parties (those such as clients, managers, pimps, traders, and traffickers) while undermining sex workers' social and occupational status, as well as their health and wellbeing (Davis, 1993; Butcher, 1994; Elias, Furlough, Elias & Brewer, 1998). Additionally Davis (1993: 3) reports that 'penalizing prostitutes costs the state huge sums of money for little more than a 'revolving door' situation, whereby offenders are merely recycled through the system and are out on the streets within hours'.

While it is evident that health service discrimination discussed previously in this chapter highlighted existing health policies such as the *Tackling Health Inequalities Review 2002* referenced in the literature review, made recommendations aimed at addressing health inequalities. Both this report and the *Sexual Health and HIV Strategy 2002* give little emphasis to the wider health needs of sex workers, particularly street women. The failure by Government health policy to provide the interventions required to meet the specific health needs of women in street sex work gives direction for re-assessment to cause more effective policies and strategies to support and improve health practice.

In addition to considering the field in relation to the dynamics on the 'street', narrative accounts of the women interviewed in the primary data set stressed their vulnerability and fear when street sex working as they felt exposed to danger or open to attack. For one research participant, a violent attack left her emotionally and physically scarred for life. She repeatedly relives the trauma of the event, causing her to suffer from PTSD, depression and to live in fear for her life. These personal experiences provide a direction for police services to support women involved in street sex work in order to alleviate the physical, emotional and mental pain of the effects of client violence.

Research on client violence against sex workers in Glasgow, Edinburgh and Leeds (Church, Henderson & Barnard, 2001) illustrated that the risk of violence related to the working environment with 81% of 115 street workers experiencing violence from clients, compared to 48% of 125 indoor sex workers. This picture is similarly found in a study conducted in Birmingham in 1993 (Kinnell, 1993) where all forms of violence linked with women in the sex industry were associated with street sex work.

In relation to the FSSWs in this research study, their continual exposure to work-related trauma in adult life, such as violence from clients, coupled with being homeless at times (two participants in the study were homeless) places the women in a defenceless situation on the street, which in turn compromises their health and wellbeing. Most of the women interviewed live in temporary accommodation or are homeless. Paradis (2000: 854) mentions that in a study involving homeless women, researchers must recognise that 'homeless women are very vulnerable to harm as individuals, and as a community because of the extreme victimisation, stigmatisation and marginalisation they endure'. It is, thus, not difficult to see the social construction of these women's background stories arising from hardship and social isolation.

The WHO (2005) states that violence and lack of control over one's life while engaging in sex work raises immediate concerns for safety and survival. Marmot and Marmot (2004) as well as Marmot and Wilkinson (2003) report

that prolonged exposure to violence is seen to contribute to chronic stress arousal, leading to increased risk of physical conditions such as premature heart disease, mental health issues such as depression, an anxiety disorder, or an addiction. Black (2011) mentions that there are both physical stressors (such as trauma, physical abuse) and psychological stressors (for example fear, threats, and humiliation) related to violence and these conditions can continue well after the abuse itself has stopped. This strongly suggests that specific emotional and mental health services, such as safe housing and support services that offer counselling, legal and resilience support, are required to meet the needs of victims of client violence.

The Women's Centre where the FSSWs were recruited and interviewed represented a significant role in promoting a bridge between the women getting help with access to some health related support away from their social and economic hardships. One example of support the Centre provides is to promote social inclusion: during the week, the women who access the Centre come to interact and participate with other members in this field that include the staff and other service users of the Centre, making it a key part of enhancing their health and wellbeing. (A detailed description of the services provided by the Centre was documented in the methodology and methods chapter).

Hammersley and Atkinson (1995: 140) explain that 'although the perspectives elicited in interviews do not provide direct access to some cognitive and attitudinal base from which a person's behaviour in natural settings is derived, they may still be capable of illuminating that behaviour'. With this perspective in mind, the women's accounts of their lived reality in street sex work as situated through the lens of the Women's Centre's boundaries, are grounded in the principles of a trauma-informed approach (TIA).

According to the Head of Services at the Women's Centre, there are no rules for women accessing the services but rather this model of approach is used. TIAs can be defined as 'a system development model that is grounded in and directed by a complete understanding of how trauma exposure affects service

user's neurological, biological, psychological and social development' (Paterson, 2014).

The key principles embedded in this model that permeate the service delivery of the Centre are adapted from the United States Federal Substance Abuse and Mental Health Services Administration (SAMHSA, 2014). These principles include: 1) Safety, 2) Trustworthiness and Transparency, 3) Peer Support, 4) Collaboration and mutuality, 5) Empowerment, voice and choice and 6) Cultural, Historical and Gender Issues.

The Women's Centre does provide a supportive space for vulnerable women to feel safe through peer support and through the environment the nuns and support workers create. The nuns do come from a Catholic denomination but hold professional qualifications too that include backgrounds in teaching and nursing. In terms of the history related to the founding order and the Catholic element, the Christian Gospel value of 'the Samaritan woman met by Jesus at the well' mentioned in the book of John in the Bible is the ethos behind the Charity's identity. The mission of the Centre is for women to be empowered to achieve their full potential free from discrimination, abuse and neglect. There is an understanding that most people in contact with the services provided have experienced trauma in their lifespan.

The majority of the women recounted a history of sexual abuse as children and then having experienced intimate partner violence in adulthood and now struggling with drug and alcohol abuse issues. The storyline is the theme of 'abuse or victimhood'. The events described by the participants were consistent with this theme.

I am aware that this storyline may have been shared enough times as the Women's Centre provides support to vulnerable women with problematic drug and alcohol abuse and mental health issues. They would have each been assessed in order to receive the support services of the Centre. This means that 'the shape of their stories shifts and take on slightly different meanings and importance as they are told to other people, as those people react, and

as discourses are negotiated' (Béres, 2014:18). These 'truths' are 'normalising' in the sense that they construct norms around which persons are incited to shape or constitute their lives (White and Epston, 1990: 19-20).

6.6 Implications for Effective Support and Health Practice

This study has highlighted a key finding that relates to the failing level of health service provision for FSSWs, which has implications for the potential of this research to improve health care practice. Further work is required in health service provision to develop incentives for effective early responses and approaches to addressing the health problems to vulnerable women in street sex work.

The attitudes that health professionals are conveying to the women attending health services perpetuates the habitus of FSSWs, which is likely to mean that women in street sex work are reluctant to disclose information about their sex working lives. This has the potential to engender a lack of trust towards health professionals. It is imperative that value judgments remain outside the field of clinical practice. There is therefore a need to support and educate healthcare professionals on the importance of maintaining a non-judgmental approach to the clinical support given to women in street sex work and to provide an empathetic approach to these women.

In addition, if general practitioners (GPs) are not aware of the sex worker's habitus in the field, this can impair the nature of the medical advice given to the sex worker. Romans, Potter, Martin and Herbison (2008) report that if GPs are unaware of their patients' work, they will not be able to assess occupational hazards accurately, and this in turn will impede the comprehensive health evaluation needed. Day, Ward and Harris (1988) state that there is a widespread lack of trust by women in sex work of other professions.

However, given the interrelated problems facing street sex workers, one agency alone cannot address the multiplicity of problems. Health agencies

have to take on a multifaceted long-standing approach to street sex workers in relation to the health needs and issues identified in this thesis. This includes integrated services that tackle multiple health problems and social care needs. For instance services that can address social capital, such as housing needs, would be valuable. There are charitable projects (Shelter, 2004) that offer a variety of services. These include support and advice in relation to homelessness and housing. In some instances such as the Women's Centre, there have been some successes in providing a service of mediation between the local authority housing department and support agencies.

Clarke and Squires (2005) explain, 'service providers must therefore be prepared to overcome service discrimination and seek to establish trust by providing surroundings in which confidentiality, non judgmental attitudes, and sympathetic listening predominates'. The evidence that social support is beneficial to health and that social isolation leads to high incidence of disease is now considerable (Stansfield, 1999).

Pearce (2007) notes the need for a dual approach, which focuses on individual risk factors and social problems. Additionally at a service provision level, it is important that adequate training and resources are available to raise awareness of the reasons why this is difficult to reach a group and develop health services from a relationship-based approach (Jago & Pearce, 2008). Pearce (2007) maintains that practitioners develop trusting relationships with women in sex work.

6.6.1 Mental Health and Implications for Effective Practice

Evidentiary findings presented within this study suggest that improvements in treatment, prevention and health promotion strategies are necessary to inform effective policy responses to mental health illness, primarily in order to reduce the vulnerabilities for the development of mental health conditions, which for these women stem in many instances from the childhood trauma of sexual abuse. While early intervention in childhood would have been beneficial when

these women were exposed to sexual risk, the findings have demonstrated that the lack of control the women had over their own time, and the constraints imposed by living a chaotic lifestyle, meant that accessing health services, including mental health services, was problematic.

Therefore, specific psychological interventions targeted to meet the emotional and mental health needs mentioned in the findings, such as PTSD, depression, anxiety and suicidal attempts, require services tailored to meet these specific needs in order to facilitate inclusiveness into society. The ramifications of unresolved health issues and poor management have only further perpetuated the marginalisation of this group of women.

Much of the research on successful PTSD intervention recommends removing clients from the potential exposure to further trauma (Foe & Rothbaum, 1998) and establishing a safe environment before commencing therapy (Benedek, Ursona & Hollway, 2005). For the women in the study, establishing a safe environment and minimising on-going exposure to trauma would ultimately entail leaving the sex industry (Roxburgh, Degenhardt & Copeland, 2006). This approach has been criticised in the literature as it promotes a 'rescue and rehabilitation' ideology, which potentially reinforces women's guilt and shame in sex work (Nath, 2000). It is important to ensure that interventions do not promote the marginalisation of these women further.

While the provision of quality health services is important, social structures such as poor housing, health service discrimination and low-income status have significant effects on health as well. The decisions of governments and public institutions in areas outside the health portfolio may also potentially require input into the overall strategy to improve the mental health outcomes of women in street sex work. For a more positive outcome to be obtained, this can be achieved through mental health services working in partnership and collaborating with government bodies to secure the safety of these vulnerable street sex workers, while at the same time building ways to create positive pathways for achieving social capital outside of working on the street.

Drop-in centres such as the Women's Centre provide assistance with services such as accessing government benefits, GP appointments, and accessibility to housing and mental health services, for instance, counselling. More of these centres need funding to operate; they provide a nurturing, consistent, holistic environment, which should remain a priority for Non-Governmental Organisations (NGOs) and government agencies to fund as they serve as the first point of contact with vulnerable individuals. Without such stability and support, treatment options such as drug treatment programs and psychological interventions are unlikely to be effective (Roxburgh et al., 2006). Similarly drug rehabilitation programs, (including substances: heroin, methadone and crack cocaine) are an essential means by which the individual can withdraw from the drug culture (Rekart, 2005).

In addition to these incentives, this study recognised that the women participating in this study suffered from low self-worth and a lack of confidence. The cause of this state was due to the key finding that women in street sex work felt powerless to change their situation. The women revealed that a perception of lack of choice and hopelessness to pursue other options available in life hindered them from making positive steps towards active change. Unlike the health service implications for effective practice mentioned previously in relation to intimate partner violence and improving mental health services an empowerment program to meet these specific emotional needs is necessary. The next section will specifically give a direction for the promotion of empowerment for facilitating FSSWs' movement out of marginalisation.

6.6.2 Empowerment of Women

The World Health Organization (WHO, 2005) stresses that many sex workers experience low self-esteem, emotional stress and depression associated with living with violence and fear of arrest. Consequently, some women resort to alcohol and drugs as a way of coping with their situation. This highlights a need for personal development programs that enhance the confidence and self-esteem of FSSWs and that also recognise their rights in society, so that

instead of them feeling that they belong to a world of similarly outcast people who belong to the street, they can feel equipped to change their circumstances.

Spry and Marchant (2014: 32) recognise that a woman's self esteem, emotional intelligence, purpose and mobilisation into the work force are developed by personal development programmes; programs that focus on equipping a woman with the necessary knowledge to realise her worth, strength and purpose (Spry and Marchant, 2014: 32). This study has implications for considering the concept of empowerment in order to develop the confidence and skills needed for FSSWs to move forward in life through education and training. Empowerment is the means and opportunity for self-assertion (UNAIDS, 2002).

Beteta (2006) explains that empowerment is the process of helping individuals to identify as active agents on behalf of themselves and others. Porter (2013) reports that empowerment for women provide greater meanings and possibilities. The WHO (2010) identifies the importance of furthering the empowerment of women and acknowledges that this contributes to the betterment of their health. With the same priority, the UN (2005) developed Millennium Development Goals (MDGs) and in particular MDG 3, to promote gender equality to empower women.

Empowerment through partnerships with social support networks may offer holistic and sustained approaches to enhancing the health and wellbeing of women in street sex work. Such approaches must start from an understanding of the impact of health service discrimination on marginalised groups and the use of effective methods to work towards equality to strengthen the situation of these women in street sex work.

The United Nations Development Programme (UNDP, 2010) recognises that there must be some recognition that humanity develops in every sector of society when the benefits are all-inclusive and stability applied to practice areas. Empowerment would therefore make a significant contribution to

policy and practice as it relates to promoting the health and wellbeing of women in street sex work, that which serves to promote effective health practice and relates to considering a way forward to address the violence experienced by women in street sex work.

6.6.3 Safeguarding Vulnerable Adults from Physical Violence

The UN Women's Empowerment Principles (2010) recognise health, safety and freedom from violence as one of the key areas of focus. This study highlighted that intimate partner violence is a recurring theme amongst the FSSWs. Therefore establishing the importance of health policy on safeguarding vulnerable adults (DOH, 2011), particularly for FSSWs, is necessary in order to maintain their safety and prevent the risk of further physical abuse, violence or harm.

In considering the issue of violence, promoting the safety of women in the sex industry has implications for support services to ensure safeguarding of women against harm resulting from violence. The role of the police and other agencies in acknowledging the seriousness of violent crimes against sex workers is imperative. Concerning street sex workers, Woods (1999) explicates that the illegal nature of the profession means that prostitutes often find themselves in dark street areas and in defenceless situations.

This study emphasises the need for suitable housing to promote a safe environment for FSSWs to regain a sense of wellbeing and stability in their home life. The findings revealed that the hostels that these women inhabited could be life-threatening places, where the women were fearful of the violence and illicit drug use that was rampantly evident there. Adequate housing schemes are required to maintain the personal safety of these women who, as this study has revealed, are vulnerable to violence.

6.7 Limitations of this Study

One of the limitations of this research study was the constitution of the sample with the primary data. The primary sample was limited to a focus on only the

women that access the Women's Centre. Therefore, the results might not be generally applicable to other street sex worker populations. Scambler (2007) confirms sex workers can be framed in a wide variety of typologies, which means the tension exists in the idea that not all women in sex work see themselves as mere victims.

Spice (2007: 323) mentions that research into commercial sex work is hampered by several methodological challenges; one of them being that the study populations are small and are unrepresentative of wider sex worker populations due to problems in gaining access to sex workers and establishing their trust. McLeod (1982) has emphasised that the undercover and individualistic nature of sex work makes it extremely difficult to establish the size of the population of the women involved. However, the women interviewed are, it is considered, typical of sex workers who access the Women's Centre, since all those using the Centre at the time of the study were interviewed, not just a sample of them. Further research with different groups of FSSWs may however reveal different findings.

This study puts forward six recommendations for change.

6.8 Recommendations

The following recommendations are based on some of the key findings of this study.

1. Mental health care services should be expanded and tailored to address unresolved psychological issues that stem from abandonment experiences such as neglect, loss, rejection and sexual abuse in childhood. Specific targeted interventions that include integrated mental health and drug treatment services should be effectively developed in order to address the unresolved mental health disorders these women are experiencing. This is due to the multiple mental health issues these women are diagnosed with and the complications exacerbating their health and wellbeing. It is congruent to state that

any service intended to improve the health of FSSWs must consider the reasons for their behaviour, tolerance of their abusive existence and the factors and burdens contributing to their poor mental health. The services provided to the women would need to identify individual circumstances and improve on these through 'professional support' (Rossler et al., 2010: 9).

2. Health service personnel need to become less judgmental in engaging with FSSWs, as the study found that sex workers perceive that they experience discrimination from them. Health services should provide specific training to instruct health service personnel on how to support and communicate with FSSWs to alleviate marginalisation and social exclusion.
3. Policies that mitigate social exclusion and discourage social stigma should be developed and implemented by health services, instead of being located in the criminal justice system. There should be more partnership across agencies working to respond to the women's broad health and social care needs to address social exclusion and intimate partner violence. Mobile support services could 'piggy-back' on other health providers' interests such as dental health and mental health services.
4. The Women's Centre described in this study provided a safe place for the women to feel cared for and to a degree nurtured. It also importantly assisted them to navigate access services such as advocacy, support and counselling, including the provision of food and clothing. This meant that some of their basic health and wellbeing needs were met. The potential of the Centre's model of service provision to address some needs of this highly vulnerable population of women warrants further policy and resource consideration.
5. Mobile facilities such as condom vans would provide useful information and delivery of condoms. The van should ideally be positioned to meet

the women on the street. This would be a proactive measure in assisting sex workers with the availability of condoms, which would not only serve as a health promotion strategy but also could help prevent the spread of sexually transmitted diseases.

6. London Borough Councils should do more to prevent the public display of sex calling cards in order to alleviate the objectification of female bodies in public telephones in central London.

6.9 Conclusion

Previous research on women in the sex industry has focused on health studies that revealed aspects of the physical, mental and social health of sex workers. However, personal accounts of FSSWs' experiences and perceptions of what they believe to be their own health and wellbeing needs were missing from the literature and so public policy in relation to this vulnerable group is not as well informed as is desirable.

My qualitative study enhanced an understanding of FSSWs as a member of a population with multiple vulnerabilities that have occurred and been reinforced across their life course, often by the institutions of both education and health. Both systems have failed to recognise the effects of vulnerability and trauma from early childhood to later adult intimate partner violence. Public policy and action has singularly failed to attend to the health and wellbeing of these women.

The FSSWs perceptions of their personal health-related experiences demonstrated a strong relationship between childhood sexual trauma and mental health and wellbeing. In adult life, all the women interviewed reported labels according to psychiatric categories and viewed as to be included in a 'problem category' rather than having recognition and empathy for the cycle of abuse they have all experienced.

The significance of the primary data provided evidence that FSSWs recruited at a Women's Centre in London were not only vulnerable but also

marginalised from the wider society. Socioeconomic conditions such as lack of available job opportunities and low levels of education had an influence on their social health and wellbeing. This lack of symbolic capital added to their disadvantaged position in society and was a determinant of their marginalised state. Structural and social inequalities consisting of felt stigma and discrimination from family members including health care professionals and the police perpetuated their social exclusion further, thus making them highly vulnerable. Some participants reported attempting suicide in relation to their separation from their children by social services.

The research emphasised the value of visual data in exploring the healthy body ideal promoted by sex calling cards for women involved in sex work. While these women are not street sex workers, the women in the primary data had suffered from permanent scarring and broken teeth. Their physical appearance was a continual reminder of the physical and emotional harm caused to them and perpetuated their feelings of low self worth and lack of confidence.

The oral life histories indicated a marked contrast between female sex workers in the late 1990's and those in the second decade of the 21st century. Alcohol and substance misuse was not a key theme with the women's accounts in the secondary data as it was in the primary data set, which implies that the context for street sex work has changed for the worse. All the participants in the primary data sample were addicted to substance misuse such as alcohol and/or crack cocaine. The women in the secondary oral history data set demonstrated agency in the decisions taken to increase their personal finances as opposed to engaging in street sex work for 'survival'.

The health needs highlighted in this study indicate the need for more effective support services and agencies that eliminate health service discrimination and have a specialised focus on mental health support. Thus, health services that consider a non-judgmental approach will be able to create an environment where FSSWs will feel comfortable when accessing the services with confidence that discrimination and personal judgement will not be a barrier to

their health needs. The findings of this study will benefit health professionals, mental health services, social support networks and society by ensuring that a greater understanding of the background life histories to women's lives in the sex industry are acknowledged in context to their lived reality.

Specifically, the recommendations listed in this chapter are of paramount importance to making practical changes for improving the day-to-day realities of the women recruited from the Women's Centre and women like them, who sell sex on the street for survival. These centres attached to a health service run by specially trained staff that do not treat women in street sex work in a stigmatising way but can refer them on to sympathetic and relevant service providers.

A key feature of the UN's Millennium Development Goals (MDGs) promulgated in 2005 was empowerment of women and was considered as a necessary process to alleviate low self-esteem and vulnerability to violence. This incentive requires not only that programmes focus on creating the opportunity for improving women's self-confidence and resilience but also to ensure that interventions provide sustainable emotional support to achieve a positive sense of health and wellbeing. This study is therefore timely and in line with MDG 3, which has implications for 'promoting gender equality and empowerment of women' (WHO, 2005).

This study has also contributed to the value of employing secondary data through providing a background context within which to begin to understand sex workers' life histories, while the primary data gives voice to the critical and multiple standpoints of women working in street sex work by representing their perceptions, experiences and meanings in relation to their health and wellbeing.

My research has contributed to the body of knowledge on the lived experiences of women who are involved in street sex work. It also makes a significant contribution to the science of public health research and the sociology of women in sex work. The use of Bourdieu's theoretical framework

and feminist research practice provides a unique theoretical contribution to advancing our understanding of women's health and wellbeing.

The centralised hope of this study is that it reinforces the view that the health and wellbeing of FSSWs should no longer be a secondary consideration in public policy. It needs to be at the heart of any actions for improving policy and practice related to bettering the lives of women engaged in street sex work.

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Appendices

Appendix One: Letter to the Project Manager of the Women's Centre



Dear Project Manager

What is the lived experience of female street sex workers in relation to their own health and wellbeing?

I am a postgraduate student based at the University of Hertfordshire and a Registered Nurse/ Sister working at a hospital in London. I am looking into the health needs of women who work in the sex industry. Very few studies have asked women for their views on their health needs and wellbeing, particularly those working in this industry.

I wish to have a 90-minute talk with a small group of women involved in street sex work. This will be informal and there are no right or wrong answers – I am interested in hearing/writing about what the women's views are. A £10 gift voucher from Sainsbury's will be given to each participant as a token of my appreciation for her time.

Participation is voluntary, and the person interviewed would, of course, be free to withdraw at any point. All information would be anonymised and treated as confidential.

I look forward to hearing from you.

Kind regards,

Nalishebo Elliott

Appendix Two: A Poster Inviting Potential Participants



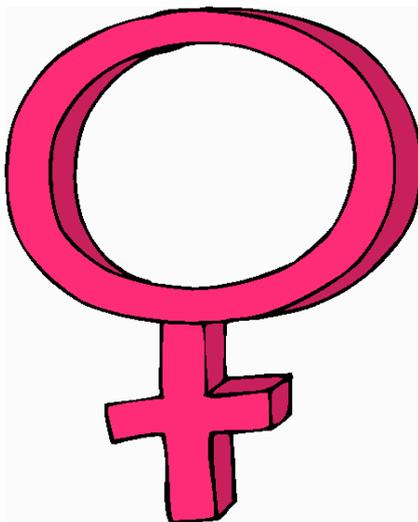
Do You Have Views on Health Care For Women?

I am trying to find out what women who have been involved in sex work think and feel about their health needs: I would like to hear what you think.

- If you would like to help, please let reception know and Nali will be in touch with you.
- The discussions will be at the women's centre and at a time to suit you.

A £10 gift voucher from Sainsbury's will be given to you at the end of the discussion as a thank you.

Thank you for your help!



Appendix Three: General Information Sheet



INVITATION TO PARTICIPATE

Hello,

I am a postgraduate student based at the University of Hertfordshire. I am looking into the health needs of women who work in the sex industry and I am interested in talking to you about your experiences and views on health. Very few studies have asked women for their views on their health needs and wellbeing, particularly those working in this industry.

- I wish to invite you to take part in a 40-minute talk about your views on health and wellbeing. This will be informal and there are no right or wrong answers.

With your permission, the discussion will be recorded so I can listen again afterwards.

- Anything you say will be treated with respect and your name will not be used in any publication.
- On receiving your acceptance, I will contact you by telephone one day before the discussion to confirm your participation and to answer any further questions.
- A Sainsbury's voucher worth £10 will be given as a thank-you for taking part in this study.

Thank you for taking time to read this sheet and you can obtain further information about this study from:

Nalishebo Elliott

University of Hertfordshire

Email: n.gaskell3@herts.ac.uk

Your signature below shows that you have read and understood the above information.

Signature

Date

Appendix Four: Consent Form

University of
Hertfordshire



CONSENT FORM

This form is designed to check that you understand the purpose of the study, that you are aware of your rights as a participant and to confirm that you are willing to take part.

Please tick as appropriate

Yes No

1. I understand that I am free to refuse to take part if I wish.

2. I understand that I may withdraw from the study at any time without having to provide a reason.

3. I understand that all information arising from the study will be used without naming me and quotations from the interview might be used in the final research report and publications.

4. I agree to take part in the study.

Signature:

Date:

Name in block letters please:

Please provide a contact number/email:

Appendix Five: Interview Schedule



Interview Topic Guide

Women's experience of health and wellbeing

We do not hear much about the voice of women and what they think about their health and wellbeing needs. Therefore, I would like to find out a bit about your background and experiences concerning what health means to you. There are not any right or wrong answers to the questions I will ask you, so I am not testing you. We will just talk about various things and if you have any questions, I will make sure we have time to talk about them at the end.

- You can say as much or as little as you would like too.

- We will talk for about 40 minutes, but it depends on how much you have to say.

- I want to tape record what we say so that I don't have to write it down – is that OK?

- When I have listened to what you have said on the tape, I will give you a false name, so even the people that I volunteer with will not know your real name. I will also change the names and details of anyone else you talk about, so you can tell me anything you want.

If you want me to stop the tape, or feel uncomfortable talking about something, just say 'I want to stop now' and we will not continue.

1. Your story

Please could you tell me a bit about your life?

Prompts:

- What is a typical day like for you?
- What do you enjoy doing?

2. Work.

- **Now I'd like to talk a bit more about your work**
- **Tell me what you do?**

Prompts:

- If you are working, where do you usually work?
- How old were you when you first started working?
- Do you find this work rewarding? What is it that you enjoy/find rewarding?
- What is the hardest thing?
- Where would you like to work if you had a choice?
- If you had different opportunities, would you stay in this work?
- Are there times in your work that make you feel worried or scared?
- What safety precautions do you take?

3. Health

Health means different things to different people. How do you think your health is?

What things do you think affects your health?

Prompts for factors that affect health:

-Housing/Living conditions

-Stress in daily life

-Your lifestyle – things like exercise, smoking and drinking

- What do you do that might help your health? Is that important to you?
- What does being healthy mean to you? Where do you get your information?

Prompts: GP, health practitioners, magazines, newspapers, TV

- What things do you do that you think are bad for your health?
- Is there anything that you would like to change about the way your health is? How do you think you can achieve or do that?
- What makes it difficult to achieve that?
- How concerned are you about your health?

- What are your experiences with health services?

Prompts:

- GP Surgery
- NHS
- Doctors
- Nurses
- Community support workers

4. Relationships/family

Tell me a little about your family?

Prompts:

- Mum, Dad, siblings etc.?
- Were you a close family?
- Do you have children?
- Do your children live with you now?

5. Images

If you could choose an image to describe yourself, what would it be?

What do you think about these photographs?

Prompts:

How do they make you feel?

What about the words used?

What do they mean to you?

How do they make you feel?

6. Concluding questions

How was it like to talk about your experiences?

Were you comfortable during this interview?

Are there any questions you may have for me?

Thank you for your time and willingness to talk with me today.

Appendix Six: Words to Describe the Women in the Sex Calling Cards

FSSWs Personal Views on Sex Calling cards	Perspectives
Katie	'Disgusting' 'Dangerous'
Berry	'Disgusting' 'They don't look like that' 'They treat them the way they see them in the pictures'
Drew	'Horrible' 'They look pretty I suppose' 'We do it for drugs so it is different' 'We should get more sympathy coz we don't get no choice' 'They are not English as well'
Poppy	'I hate them' 'Degrading to women' 'Another excuse for men to glare at them'
Julie	'They are selling a prep basically'
Steph	'I think they are pretty'

Sexual Service Terminology	Tally's (FSSW, phase 3) Response
Water Sports	'Weeing on the customer'
Hard Sports	'Pooing'

Appendix Seven: Framework Analysis of Secondary Data for Phase 2

British Library Secondary Data: 'Oral History Collection on Prostitution', In-depth interviews (Rickard, 1997)

Table 1

Themes (Concepts)	Violet	Cherry	Rose
Typology	Street sex worker	Working girl Milk Maid	High class prostitute
Family Background	<ul style="list-style-type: none"> Family breakdown Abandonment from Father Sexual abuse from siblings 	<ul style="list-style-type: none"> Happy childhood Domestic violence Divorced 	<ul style="list-style-type: none"> Unhappy childhood
Reason for entry	<ul style="list-style-type: none"> Lack of financial support Poverty 	<ul style="list-style-type: none"> Debt 	<ul style="list-style-type: none"> Financial gain
Perceptions and behaviour	<ul style="list-style-type: none"> 'Life is what you make it. I'm a fighter. You get beat down, you get up'. 	<ul style="list-style-type: none"> Enjoys the temptation of being naughty Choice 	<ul style="list-style-type: none"> 'Thought everyone hated me' Prostitution is not her choice
Health diagnosis	<ul style="list-style-type: none"> Smoker Gonorrhoea Hysterectomy age 28 due to heavy bleeding Arthritis 'I suffer bad migraines but I don't take 		<ul style="list-style-type: none"> Post natal depression Nervous breakdown Abortion
Health beliefs	<ul style="list-style-type: none"> Natural sponge soaked in Dettol when having a period Condom use No kissing Reluctant to visit the clinic 'Escape is the street, home comforter' 	<ul style="list-style-type: none"> Anti-smoking Non-drinker 'Pain in throat from blow jobs – all that rubber' No kissing No anal sex 	<ul style="list-style-type: none"> Condom use No kissing
Mental Wellbeing	<ul style="list-style-type: none"> Domestic Violence 'I don't think I've had a happy time maybe if I won the lottery' 'Strong enough mentally to take the shit on the street' 	<ul style="list-style-type: none"> Addicted to the game 	<ul style="list-style-type: none"> Domestic violence Sadness Emotional breakdown Poor self worth Stress
Stigma	<ul style="list-style-type: none"> Husband called 	<ul style="list-style-type: none"> No shame 	<ul style="list-style-type: none"> Husband called

Disgusted	<p>her a Slut, slag, whore</p> <ul style="list-style-type: none"> • Sister called her a slag, slut, whore • Dad was disgusted in me when he heard I was a prostitute 		her a 'dirty prostitute'
Entry into Sex Work	<p>'You never come off the streets because if you need money, you know where to go' 'I am way past the stage of trying something new. It's easy money. What's the point of going to college?'</p>	<p>'Don't. I'm warning you that the lure of the money is so all consuming but very hard to break away once you learn how easy it is to earn big amounts of money'.</p>	<ul style="list-style-type: none"> •
Identity as Mother	Mother	'I'm a Mother'	<ul style="list-style-type: none"> • I'm a Good mother
Choice	<p>'Escape was the street. Retreat. Home. My comforter. My territory, Nobody can take that away from me. It's where I belong' (p.1)</p>	<p>'Here today because it is my choosing' 'Not an easy thing to do to take your clothes off in front of a stranger'.</p>	
Work (Agency)	<p>'I'm doing a service. I don't enjoy sex</p>	<p>'Yes, I am on the game and nothing to be ashamed of. I provide a service and I get paid for the service I provide'.</p>	<ul style="list-style-type: none"> • Hostess • Receptionist • Madame • Travelled to the Middle East and lived in Hotels

Appendix Eight: Thematic Analysis of Interview 1 Provided as a Summary of the Analysis Conducted

Interview 1

Pre-set code	Themes	Codes	Categories
Life Events	<p>'I just moved back to London from rehab' (line 1)</p> <p>Trauma in childhood (line 16)</p> <p>Moving to London - 'Fear of bumping into people and being taken back to that sort of way of life' (line 31)</p> <p>'Couple of suicide attempts' (line 95)</p>	<p>Rehab</p> <p>Trauma</p> <p>Anxiety</p> <p>Fear</p> <p>Suicide attempts</p>	<p>Trauma in Childhood</p> <p>Mental Health</p>
Health	<p>Anxiety – 'I get quite bad anxiety' (line 10)</p> <p>'Yes, it's complex PTSD so I think its trauma on top of trauma' (line 179)</p> <p>'I got depression ...it's quite heightened at the moment everything with mental health' (line 26 and 27)</p> <p>'Flash back or a nightmare' (line 22)</p> <p>'I've had a severe eating disorder ... and the effects of that are becoming more apparent like with my bones and my teeth</p>	<p>Anxiety</p> <p>PTSD</p> <p>Trauma</p> <p>Depression</p> <p>Mental health</p> <p>Anorexia</p>	<p>Mental Disorders</p> <p>Physiological</p> <p>Physical Health</p>
Coping strategies	'I was using drugs to sort of subdue it' (line 17 and 18)	Drug use	Addiction
Sex industry	<p>'It's a long story but I didn't really have a choice and I started off working in Soho and managed to escape' (line 41)</p> <p>'Pushed into it and started my</p>	<p>Choice</p> <p>Drug use and alcohol use</p>	<p>Lack of choice</p> <p>Addiction</p>

	<p>drug use and alcohol use and towards the end it was my choice to be in the sex industry' (line 45-46)</p> <p>'You need the drugs to work but you need to work to get the drugs (line 48-49)'</p> <p>'Pimps, they can see that you are vulnerable or that you don't know anyone and they hone in on that' (line 155-156)</p>	<p>Entry into sex work</p> <p>Choice v's need</p> <p>Vulnerable</p>	<p>Push and Pull factors</p> <p>Isolation</p>
Safety precautions	<p>'Nothing at first' (line 57)</p> <p>'Perfume under the pillow' (line 58-59)</p> <p>'Keys'</p> <p>'As women you try and just look out for each other. But you got to stick together' (line 61)</p>	<p>Danger precautions</p> <p>Sisterhood</p>	<p>Harm Reduction</p> <p>Social Relationships</p>
Health services	<p>'When they found out I was a working girl, they would treat me really different like really nasty' (line 97-98).</p> <p>'They don't understand. Their views would be that we are choosing to do what we are doing. A lot of us don't have a choice' (line 102 – 105)</p> <p>'Medical profession or police treating you like shit, you are less likely to talk to them' (line 156)</p>	<p>Judging</p> <p>Lack of understanding</p> <p>Victimisation</p>	<p>Health Service Discrimination</p> <p>Stigmatization</p> <p>Non Disclosure</p>
Health perceptions	<p>'Being slim is healthy but I don't think that's how we should think but at the moment I sort of feel healthy if I am skinny (line 79-78)</p> <p>'I think when I do things like binge, or don't eat or self harm, anything I do that hurts me is probably not good for my health like drugs or alcohol (line 82-84)</p>	<p>Eating habits</p> <p>Weight conscious</p> <p>Binge eating</p> <p>Self harm</p>	<p>Perception</p> <p>Identity</p>

Routes into sex work	'I was running away from something. When I came, I didn't know anyone'. I didn't have a job' (line 161 – 163). I didn't understand anything. (Line 166) Lengthy process to get a national insurance number (line 166)	Escape from trauma Jobless Vulnerable Naïve Lack of support	Vulnerable Running Away Homelessness
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Appendix Nine: Core Themes Emerging from the Open Coding of the Primary Data

Childhood trauma

- Family dysfunction – parental abandonment
- Childhood sexual abuse – happens from 0-16 years.
- Rape
- Physical abuse
- Manipulative caregivers

Drugs (Opioid dependence)

- Heroin
- Crack-cocaine
- Methadone script
- Alcohol
- Street drugs

Physical Health

- Liver disease
- Gum disease

Sexually transmitted diseases

- Hepatitis C
- Gonorrhoea

Mental and Emotional Health

- Depression
- Helplessness
- Bipolar
- Personality disorder
- Schizophrenia
- Post traumatic stress disorder
- Fear
- Anxiety
- Isolation
- Shame
- Irritability
- Insomnia

- Flashbacks
- Nightmare
- Self harming
- Suicidal thoughts

Distorted Ideation – how they see themselves

- Drug user
- Alcoholic
- Working girl
- Street sex worker
- See themselves as sex objects
- Eroticized ideation
- Vulnerable to exploitative relationships
- Low self esteem
- Low self worth
- Guilty Mother

Social issues

- Social exclusion
- Addiction behaviour
- Emotional abuse
- Domestic violence
- Imprisonment
- Children taken away by social services to foster care homes or adopted out
- Homelessness
- Hostel accommodation

Wellbeing

- Sense of shame
- Self-harm through cutting
- Feeling permanently dirty
- Lack of ability to sustain intimate relationships
- Relationships are erotic
- Using sex as a currency, or as a way of controlling others
- Sex work as addictive where women find it difficult to break out of it even when they have an opportunity to stop

- They feel stigmatised