

LIVING THE LIFE:  
PROSTITUTES AND THEIR HEALTH

IN HET LEVEN:  
PROSTITUTES EN HUN GEZONDHEID



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PROMOTOR: PROF. DR. CH. D. KAPLAN  
OVERIGE LEDEN: PROF. DR. J. HUISMAN  
PROF. DR. P.J. VAN DE MAAS  
PROF. DR. W. KORNBLUM

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## PREFACE

"Living the Life" refers to the experience of the women who are involved in female heterosexual prostitution. In this context "the Life" refers to the social world of prostitution. This reference has been utilized by both prostitutes (e.g., Godelier, 1978) and social scientists (e.g. Boggs, 1979; Enablers, 1978; Winick and Kinsie, 1971). The 120 female prostitutes upon whom this dissertation is based, also described their involvement in prostitution as being "in the Life". According to the New Dictionary of American Slang (Chapman, 1986) the term is used to describe the life of those who are "occupied or engaged in some specialized or usually socially despised way of living, such as the homosexual subculture or prostitution". The term "the Life" can also refer to a broader area, e.g. the world of drug use (Agar, 1973), or both the world of drugs and prostitution (Prus and Irini, 1980). Wepman and his colleagues (1976) point out that "the Life" more or less covers the entire "culture of poverty", but warn that this does not mean that all urban, lower-class blacks participate in "the Life". They state that the community of "the Life" is, in large measure, defined by illicit activities as petty crimes, drug use, prostitution and gambling and by unique behavioral and culture patterns related to these illicit activities. The behavior of those participating is centered around "the game--a pattern of exploitative interaction". The key counterparts of the prostitutes in their "game" are their pimps,

their customers and the police. Depending on how successful the prostitutes are in their game of selling sex for money and/or drugs, they gain status within the world of prostitution. Call girls are seen as more successful "players" than "streetwalkers".

In this dissertation prostitution is considered a paid sexual encounter between a male client and a female prostitute. The exchange between both partners is without social obligation and the sexual services provided by the women are paid for in money/and or drugs.<sup>1</sup> Gifts are not included, since they are not part of the "business" interaction. Until the 1960s the definition of prostitution was limited to the exchange of sex for money only. Due to an increasing attention to drug use among women during the sixties and the related increase of female drug users involved in prostitution activities, the definition was expanded to exchange for money and/or drugs (Goldstein, 1979). Prostitution is a phenomenon which occurs in most parts of the world, and has existed throughout history. Its presence has been hotly debated and simultaneously tolerated. Most studies focussing on prostitution have examined it from a psychological, psychiatric, medical, economic, criminological or sociological point of view.<sup>2</sup> According to prostitutes, the majority of the works published on female "sexworkers"<sup>3</sup> reveal more about the author's perspective regarding prostitution than they do about the subjects studied. "Sexworkers" responded to this by publishing their own works, e.g.

Delacoste and Alexander (1987), French (1988), Hampton (1989).

The questions that have captured the attention of most social scientists studying commercial vice are "Why do some women become prostitutes and other women in a similar situation do not?", "What are their personalities like?", and "What different kinds of prostitution can be distinguished, if any?" In "Living the Life", a study of prostitutes in their natural setting, the methodological procedures upon which this dissertation is based will be discussed (Chapter One), followed by a description of the research population (Chapter Two). In Chapter Three different occupational types, or if one prefers, a stratification system (Rosenbaum, 1981) will be distinguished among the study-participants, based on the length of time the women have been engaged in prostitution and their drug use or non-use. Prostitutes, like other women, have to deal with health issues related to their reproductive function. Issues related to their reproductive function, e.g., menses, contraceptives and birth control, are presented in Chapter Four. Finally, infections like hepatitis B, syphilis and HIV among the prostitutes are discussed (Chapter Five). Also in this chapter, risk and protective factors for HIV infection are identified among the respondents, e.g. drug use practices and condom use, and a model to predict HIV infection among the prostitutes is developed.

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Dealing with prostitutes, drug users and the street scene certainly affects one's personal life. I made friends and felt guilty to "leave the Life". Vernon Boggs and Kirk Elifson made me sit down, read drafts and gave me support in many other ways. There are too many things to thank them for, and that is why I dedicate this dissertation to them.

## INTRODUCTION

This dissertation is based upon research among 120 female prostitutes in "Northeast", an urban area just outside a major city along the east coast of the United States. Northeast is one of the most densely populated areas in the United States (U.S. Bureau of Census, 1980). The area is characterized by a high rate of poverty. Business and political officials reported as early as in 1967 that the area had the nation's highest percentage of substandard housing, the highest crime rate per 100,000 inhabitants, the highest rate of venereal diseases and of infant mortality. Also reported was the high number of drug users and related problems (Hayden, 1967).

The black population in this area is disadvantaged in many respects. At the end of the 1960s this led to race riots supported by civil rights groups. Following these riots many whites moved from the city to the suburbs and businesses abandoned the central business districts. As a consequence, urban development, which was primarily controlled by whites, was interrupted and most neighborhoods were transformed into non-white urban ghettos.

Northeast faced economic decline since 1970. The majority of the population still lives in neighborhoods with many burned, deteriorating and boarded-up houses. It is in these areas, comparable to "inner-city ghetto's", where one finds drug

copping zones (buying zone) and prostitution "strolls" (street zone). Northeast has four main prostitution strolls, two in areas with a largely black population and two in predominantly Hispanic neighborhoods. On these strolls most of the prostitutes working are black and Hispanic. The "strolls" are located near transfer stations for truck drivers and near important traffic routes. Northeast also has a few bordellos, with mainly Hispanic prostitutes, and escort services in which white women predominate.

In pursuing research on prostitution, issues related to the prostitutes' health, primarily their drug use, their reproductive functioning and AIDS related issues have become increasingly important. This led to the following research questions:

- o Can a stratification system or occupational types be distinguished within the world of female prostitution? If so, which strata/types exist?
- o What can be said about the prostitutes' reproductive functioning within the different categories of female prostitutes?
- o Is there an overlap between the world of prostitution and the world of drug use? If so, what are the consequences of this overlap?
- o Are female prostitutes a high risk group for acquiring and/or transmitting sexual transmitted diseases (STD),

including HIV? If so, what are the characteristics of the infected prostitutes, and which risk and protective factors can be distinguished?

In this chapter a brief methodological overview of the study is presented as well as an overview of the literature dealing with female prostitution, prostitutes and their reproductive function, prostitution and drug use and literature regarding STD, including HIV infection, among prostitutes.

### Methodological Overview

As mentioned earlier, the respondents were all female prostitutes, older than 18 years of age, who worked in Northeast. A proportion of the women are "residential prostitutes" (Sterk and Leonard, 1988), that is, they live in the same neighborhood as where they ply their trade. More than two-thirds of the study participants (N=101) worked as street prostitutes; the remaining 19 women worked either for an escort service, in a house of prostitution or in another form of prostitution, e.g. "party girls". The majority of the study participants are black (N=96).

The study was conducted between July 1986 and January 1988. Female prostitutes were recruited at a variety of sites such as, "strolls", brothels, escort services, drug treatment programs, hotels and parks. Complementing direct recruitment by the

researcher was the use of chain referral sampling: respondents were also identified by "informants". This method of "snowball sampling" was developed more than twenty years ago by Goodman (1961), and was later applied by Biernacki and Waldorf (1981) for studying ex-opiate addicts and by Kaplan and his colleagues (1987) for studying prostitutes and drug users. This sampling procedure allows the researcher to verify the eligibility of potential respondents and provides insight into their social networks. All study participants participated on a voluntary basis. After informed consent had been obtained, a sample of 10 ml blood specimen was drawn by venipuncture, and was tested for seromarker for hepatitis B (HBsAg, anti-HBs, anti HBe) and Treponema pallidum/syphilis (RPR, MHA-TP, FTA-ABS) and HIV antibody (Elisa, confirmed by Western blot).

Quantitative data were collected by using an interviewer-administered questionnaire (see appendix B).<sup>4</sup> This data collection instrument was structured to probe the following areas: general demographic data, medical history, drug use history, sexual history and sexual activities. In addition, a rather limited and superficial medical examination was conducted among the respondents to determine visible signs of possible infection, such as rashes and lesions on the skin, soreness or patches in the mouth and swollen lymph nodes in the neck or under the arm. The information from this examination was reported on a separate sheet (see appendix C). The quantitative

data are analyzed using analysis of variance, also uni-variate and multi-variate logistic regression analysis is employed.

Qualitative data were gathered using ethnographic research methods, refined by sociologists at the University of Chicago since the 1930s.<sup>5</sup> The different stages of the ethnographic research are discussed: finding research sites, gaining entrance and trust, and identifying (key) respondents. Additional attention is given to obstacles the researcher has to face in doing research dealing with the prostitutes' reproductive function and prostitution during the AIDS era. Open-ended interviews as well as other research activities took place in the usual setting of the respondents and the focus was on their current and past lifestyle, especially their drug use practices, their sexual activities, the different contexts in which these activities took place, and the women's future perspective. These data were reported directly after each "fieldtrip". A distinction was made between theoretical, observational and methodological fieldnotes. The data were also coded, and the codes continually evolved during the period of data gathering. In this dissertation an integrated analysis of qualitative and quantitative data is conducted. Qualitative data are used to corroborate statistical findings and vice versa.

## Literature overview

### SOCIAL SCIENCE AND FEMALE PROSTITUTION

Most published sociological studies on prostitution have focussed on reasons why women might enter the occupation and on the various types of prostitution. When categorizing various kinds of prostitution, a distinction is often made depending on the site of recruitment of customers. One distinguishes prostitution in brothels, behind windows, in sexclubs, hotels and bars, for escort services and street prostitution. Other categorizations are based upon a hierarchical model. Both in- and outsiders make a marked distinction between the judgement of two well-known categories of prostitution: call girls and streetwalkers. Call girls are placed at the top of the hierarchy. They are seen as the "ladies" among the sexworkers. At the bottom are the women working the streets, the "ho's".<sup>6</sup> A street prostitute is frequently under the watchful surveillance and distrustful eyes of her pimp, is constantly harassed by potential customers who want to be serviced as cheaply as possible, and is subjected to frequent arrests by the police who respond to the complaints of neighborhood residents about commercial vice activity in their vicinity. The call girl on the other hand is spared these problems since she is less likely to be publicly visible, unlikely to work for a pimp, her clients are willing to spend considerable money, and she is less frequently arrested by the police since she is seldom accused of undermining the public order. Although it seems like we are

dealing with two different classes or styles all of these women are in "the Life".

Another focus presented in the literature are explanations why women might enter the world of prostitution. Over time four explanations are offered: (1) during the nineteen-thirties those taking a psychological approach dominated and they concentrated on the personalities of the women. Prostitutes were seen as different from non-prostitutes, because of marginal mental ability and abnormal sexual proclivities. Ellis (1937) states that prostitutes act against the public order. They do not act in accordance with societies expectations, namely to be receptive and monogamous. The Gluecks (1934) studied five hundred females in Massachusetts and concluded that prostitutes, in contrast with other females, are not able to control their sexual impulses. Kemp (1936) studied 530 street prostitutes in Copenhagen (Denmark) and focused on the hereditary dimension. According to him the women's entrance in the world of prostitution can be explained by the fact that their mothers were already "abnormal". The strength of the psychological approach lies in the fact that attention is paid to the background characteristics of the women involved. The weakness, however, is that the psychological tests used were not well developed, and no research among control groups was done. (2) others saw social class as an important explanatory variable for women entering the world of commercial vice. In this so-

called structuralist approach, social stratification and money were key issues.<sup>7</sup> Prostitutes are seen as innovative persons who turn to illegitimate means like commercial vice in order to earn money when legitimate means are insufficient or blocked (Merton, 1957). Davis (1937) called this "social utilitarianism". He suggested that prostitution created a possibility for affectional and non-threatening outlets for the desires of men. He saw prostitution as functional in a family-oriented society and as a way to prevent divorce. Those supporting this structuralist approach view the organization of society and its influence on individuals as critical, but the ideas, views and values of the individuals involved are ignored.

(3) the psychoanalytic approach, which dominated in the 1960s and 1970s, is rooted in Freud's theory about "infantile sexuality". Those scientists supporting this approach<sup>8</sup>, state that the prostitutes' adult sexual behavior is related to their early stages of sexual development. Prostitutes frequently report that as small children they were raised in situations in which traditional family love was lacking. These psychoanalytic studies are based upon a small number of participants, varying from two to twenty, who were very often patients of the researchers. Limited studies such as these do not lend themselves to generalization.

(4) more recently social scientists started emphasizing the impact of social relationships, social processes and subcultures

on the process of decision making. In this interdisciplinary approach multiple factors are seen as underlying the women's entrance into "the Life".<sup>9</sup> James (1976), Rosenbaum (1981) and Miller (1986) all report multiple motives of which financial concerns are the most important, followed by early negative sexual experiences (incest) and peer pressure. The financial reasons very often tie in with drug addiction which becomes very clear in Rosenbaum's study among 100 heroin-using women of whom more than half were involved in prostitution activities.

#### PROSTITUTION AND HEALTH

It is common knowledge that every individual needs to be in good physical and psychological health in order to survive. Feelings, thoughts and activities influence an individual's general health condition. The fact that prostitutes work in an unstable social, economic and emotional environment has consequences for their general health status. Literature dealing with several aspects of the women's health condition, mainly related to their reproductive function, will be discussed.

Like other women, prostitutes must deal with menses, and related problems as dysmenorrhea (painful menstruation) and possible symptoms like rapid changes in mood, physical agitation, fatigue and poor motor coordination, called the premenstrual syndrome (PMS) (Friedman, 1982). The women also

experience problems with contraception. Most contraceptive techniques have negative side effects (Belsey et al., 1986). Oral contraceptives can cause side effects like circulatory diseases, headaches, elevated cholesterol levels, nausea and behavioral changes or psychological effects such as depression and anxiety (Lipson et al., 1986). The intrauterine device (IUD) can cause pain, bleeding and pelvic infections (Gottardie et al., 1986). Diaphragms such as the cervical cap are less effective in preventing pregnancies and their insertion and removal causes discomfort (Powell et al., 1986). Prophylactics have no negative physical side effects but often have psychological negative effects, e.g. male partner can not obtain an erection or the partners feel that condom use inhibits their sexual pleasure.

Prostitutes frequently engage in sexual encounters with partners who pay for their services, and neither partner has the intention to cause pregnancy, but the woman are always held responsible for the prevention of pregnancy. Effective contraception is predominantly a concern for the women. With a few exceptions (Darrow, 1984), it is only since the AIDS era that scientists paid attention to contraceptive use among prostitutes. Research is needed concerning the use of contraception and the obstacles to such use.

Prostitutes engage in sexual encounters with multiple sexual partners, many of whom engage in other heterosexual relationships. Their motivations for using the services of prostitutes vary from lack of a relationship with a woman to desire to have impersonal sex with a unknown female partner.<sup>10</sup> Because of the fact that the prostitutes have sex with multiple men who might have other sexual partners, one infected prostitute could theoretically infect many people. It is due to this and the fear in society for STD that historically prostitutes have been seen as a reservoir for infection and responsible for the spread of STD (Winick and Kinsie, 1971; Rosen, 1982; Hobson, 1987; Brandt, 1985;1988). The most common STD are syphilis, gonorrhea, chlamydia and herpes simplex (HSV2). More recently an increase in genital ulcers has been reported (Stamm et al., 1988). Individuals infected with a STD are stigmatized, and according to Freidson (1970), they are treated differently than persons with other infectious diseases. Generally speaking people who are sick are not blamed for their illness, while persons with an STD are held responsible for their condition mainly because of the stigma associated with the mode of transmission (Bell, 1971). Persons with HIV infection are stigmatized in a similar way (Sontag, 1988). Prostitutes with a STD are negatively labelled twice, first as individuals with a STD and second as "whores". The role of prostitutes in the transmission of STD has mainly been used as a way to (socially) control the phenomenon of commercial vice.<sup>11</sup>

Throughout much of history, prostitutes have been forced to submit to periodical medical examinations for STD and, if found to be infected, were placed under quarantine until they were pronounced cured (Burnham, 1971; Darrow, 1983). Other methods of combating the spread of STD vary from prohibition to decriminalization of prostitution (Bell, 1971; Smith, 1977).

Prostitutes themselves emphasize that they are more aware of the consequences of their sexual activities than are other women and that they are relatively "cleaner". Stein (1974) points out that prostitutes know how to inspect a man for visible signs of STD, how to "freshen up" a client, and how to douche. Since prostitution is illegal in most of the United States, with the exception of a few counties in Nevada, one has to be very careful in drawing conclusions based upon known infection rates among sexworkers. The information available about infection rates among prostitutes is biased towards those who have been apprehended by the police or are treated by STD clinics.

In addition to the prostitutes' health condition their psychological health status can not be ignored. Prostitutes themselves point out that their lifestyle is stressful. On the one hand they thrive on stress, but on the other hand they pay a considerable price. Tubesing (1981) puts it this way: "You need enough tension to make the music, but not so much that it

snaps". Research among female prostitutes has not addressed the consequences of stress and psychological harm on the women's health condition.

Related to all this, is the rate of violence experienced by prostitutes (Rosen, 1982; Miller, 1986). Prostitutes are viewed as models of female unchastity (Silbert and Pine, 1985). Since men pay for the sexual services provided by women, sexual abuse and rape are not defined as such or as violence against the prostitutes. This is seen as part of the women's job. Although prostitution is seen as a "victimless crime" (Schur 1967; Johnson et al., 1985), the women involved report frequently report having to deal with violence and see themselves as victims.

#### PROSTITUTION AND DRUG USE

Until the 1960s women were mainly regarded as users of legally prescribed drugs like tranquilizers, while men were seen as the primary users of illicit drugs, such as heroin and cocaine. During the sixties female drug use increased as did the attention paid to ways in which these women supported their consumption of these substances (Ellinwood et al., 1966; Maglin, 1974). Women are primarily known to support their drug addiction by resorting to shoplifting, fraud, larceny, drug dealing and/or involvement in the world of prostitution. As Boggs (1987) indicates, there seems to be a clear overlap

between the world of prostitution and the world of drug use. Studies among female drug using prostitutes often distinguish two groups. There are those women who entered the world of commercial vice "drug free" and later began using drugs as a form of self-medication in order to cope with the occupational pressures. Secondly, there are those who started using drugs because they were available, and those women who were drug addicts prior to the moment they resorted to prostitution in order to support their drug habit.<sup>12</sup> There is a group of prostitutes who remained "drug free" even after having spent years in "the Life".

James (1976) argues that drug use among prostitutes makes it easier for the women to work, it increases their ability to withstand emotional stress, and helps them to relax after work. One serious consequence of their drug use is that they, like many other drug users, eventually become addicted. Observations suggesting the existence of "controlled drug use" are a myth. Drug using prostitutes are considered by non-drug users in "the Life" to be less professional, less hygienic, more unkempt, and more willing to take risks of infection by customers or arrest by the police. These are activities non-addicted prostitutes feel should be avoided if a woman considers herself to be a professional.

Studies in which attention is paid to drug use among prostitutes mainly focus in on the use of pills, alcohol, marijuana and heroin (Ellinwood et al., 1966; Goldstein, 1979; Rosenbaum, 1981; Cuskey and Watkey, 1982; Inciardi, 1982; Miller, 1986). Only recently have scholars studied cocaine-/crack use among prostitutes (Friedman et al., 1988; Sterk, 1988), and the possible association between crack use and increases in STD (Goldsmith, 1988; Rolfs and Cates, 1989).

Drugs are most frequently used with other like-minded drug users. The principal ways of using drugs are smoking, snorting and injecting. Within the United States drug use constitutes a deviant subculture, and sociological/ anthropological studies regard drug use as a subcultural activity (Agar, 1973): that is, a distinctive group with a singular set of values, norms and rules, that exists within the larger, conventional society. From the perspective of its members, the subculture is meaningful and is not an escape from reality (Prebble and Casey, 1969). Prostitutes participate in the subculture of drug use as well as in the subculture of commercial vice.

Drugs are primarily used in a socio-recreational context (Siegel, 1977). A relevant aspect of the subculture of intravenous drug use (of heroin, cocaine or a combination of the two called a "speedball") is the "sharing of works". This includes the sharing of syringes ("spikes"), necessary to inject

drugs, "cookers", in which the drugs are heated and dissolved prior to injection, and cotton, used to strain the drug solution as it is taken into the syringe. Smith and Gay (1972) originally documented the importance of needle-sharing among IV drug users, and more recently needle sharing among intravenous drug users has been discussed due to increasing HIV seroprevalence rates among them. The sharing of hypodermic sets has been identified as a risk factor for HIV transmission (Battjes and Pickens, 1988).

The sharing of "works" is an important symbolic and practical part of the intravenous drug use subculture (Des Jarlais et al., 1986). Needle sharing takes place as part of the initiation in the subculture, and is a sign of a positive emotional link between drug users ("shooting partners"). The phenomenon of sharing hypodermic sets also occurs because needles are scarce and possession of syringes is illegal. More recently alternate forms of "sharing works" among intravenous drug users were reported, e.g. "front loading" (Grund et al., 1989) and "sharing a load" (Des Jarlais, personal communication).<sup>13</sup>

The injection of drugs mainly takes place in so-called "shooting galleries".<sup>14</sup> An increasing distinction is being made between "shooting galleries" in which heroin users predominate and those locations where mainly cocaine users gather (Friedman

et al., 1989). Cocaine users inject more frequently than heroin users and tend to share needles more frequently the longer they are "binging".

The smoking of crack/cocaine takes place in so-called "base"- or "crack houses" (Jekels et al., 1986; Friedman et al., 1988). The use of cocaine/crack greatly heightens feelings of affection for surrounding individuals (Adler, 1985). Sexual activities among its users increases because of the aphrodisiac effect and the willingness of (female) cocaine addicts to exchange sex for drugs. Hopkins (personal communication, 1986) conceptualizes this as "instant prostitution".

#### AIDS, PROSTITUTION AND DRUG USE

Since the early 1980s it has become increasingly clear that the impact of the AIDS epidemic on public health cannot be ignored. The magnitude of the crisis we are dealing with is hard to estimate, since reliable data on the prevalence and incidence of HIV infection are lacking. Estimates are difficult to make since those individuals identified as persons with AIDS are only a small proportion of those infected, and many of those infected individuals do not show any symptoms of the disease. Table 1 shows the HIV surveillance data provided by the Centers for Disease Control.

**Table I.1: AIDS Cases Reported by the CDC through August 1989**

EXPOSURE CATEGORY	PERCENTAGE	NUMBER
Homo/bisexual males	61 %	61,614
Intravenous drug users	20 %	20,619
Sexual partners of individuals at risk	5 %	4,595
Persons who received a blood transfusion	2 %	2,472
Hemophiliacs or persons with coagulation disorder	1 %	968
TOTAL	89 %	90,268

The remaining cases are undetermined or due to multiple risk factors. Among children under 13 years of age 84% of the cases are a consequence of AIDS or HIV infection of a parent. IV drug users are the second largest infected group and because of the rapid accumulation of seroprevalence are seen as critical in the AIDS epidemic. Drugs users not only pose risks for each other because of the sharing of needles with contaminated blood, but they are also a primary source for heterosexual and vertical--from mother to child--transmission, through their sexual activities.<sup>15</sup> Heterosexual transmission of the virus causing AIDS, however, has only been considered a threat since 1984 (Schilz, 1988). This occurred almost at the same time that the threat of prostitutes transmitting the virus to their clients was being discussed. The first cases were reported among prostitutes and their sexual partners in Africa, while later reports followed from Western Europe and the United States.<sup>16</sup>

Some of the first reports in Western Europe were caused by transmission of the virus in Africa, e.g. among white Belgian males who worked in "colonial territories" in Central Africa.

IV drug using prostitutes are directly at risk for HIV infection because of their drug use practices and indirectly through sexual activities with other IV drug users. Non-IV drug using prostitutes seem to be at risk mainly through sexual contact with infected partners. The Centers for Disease Control estimates that infection rates among IV drug using prostitutes are four times as high as among non-IV drug using prostitutes (MMWR, 1987). These women also place their sexual partners, both paying and non-paying, at the risk of getting infected. Prostitutes are currently considered to be a reservoir for HIV transmission (Day, 1988; Padian, 1988; Rosenberg et al., 1988). Surveys done among female prostitutes show a range of seroprevalence varying among them from zero to sixty-five per cent (Smith and Smith, 1986; MMWR, 1987; Padian et al., 1987; Fischl et al., 1987; Wallace et al., 1988). The studies indicate that the single most important risk factor among prostitutes in the United States is intravenous drug use (Darrow et al., 1988). Extensive research is ongoing to gain more insight in this issue. The degree of risk attributable to the prostitutes' sexual activities remains questionable.

Unfortunately, data about customers of prostitutes are even more scarce than data about prostitutes. Two recent studies among paying male partners of prostitutes with no other risk factors than their sexual contact with these women (Chaisson et al., 1988; Wallace et al., 1988) found approximately 1.5 percent of these men to be HIV infected. The probability of the spread of HIV from women to men is unclear. Current knowledge indicates that male to female transmission of HIV occurs more frequently than female to male transmission (Friedland et al., 1987; Levy, 1988).

Risk and co-factors should not be confused. The inhalation of nitrates among homosexual men was thought to have an etiological significance for HIV infection among these men. Inhaling "poppers" was highly correlated with those who developed AIDS. It became clear that inhaling nitrates, while a risk factor in sexual promiscuity, which increases the likelihood of HIV infection, was spuriously related (Auerback et al., 1984).

Studies among prostitutes not only add more knowledge about heterosexual transmission but also they determine the degree that condom use reduces the risk of HIV transmission. Research indicates that more and consistent condom use is related to lower infection rates (Krogsgaard et al., 1986; MMWR, 1987; Mann et al., 1987; Day et al., 1988). Valid information about condom

use has not been systematically gathered. Available research does indicate that condom use varies with the context of the sexual encounter: the use of condoms is the most prevalent with casual paying sexual partners and the least with non-paying steady boyfriends (MacCormack et al., 1985; Cohen, 1987; Darrow et al., 1987; Day, 1988; Philpot et al.). Dutch researchers (Hooykaas et al., 1989) reported that despite frequent condom use, prostitutes and their customers are at higher risk for HIV than heterosexuals with multiple private partners. The exact role of prostitution in HIV transmission is still unclear. The relevance of prostitution studies seems to be to get more insight in heterosexual transmission of the virus and to develop effective prevention strategies for sexually active persons.

### Hypotheses

Based upon the previous literature review, the following hypotheses can be formulated:

1. If there is an overlap between the worlds of street prostitution and drug use--women enter prostitution to support their drug habit or women who already worked as prostitutes started using drugs as a form of self-medication--the majority of the study participants will be more likely to use drugs than to be drug free.

2. If the type of drug used is related to the number of sexual partners, then crack using prostitutes will report a higher rate of sexual activity with multiple sexual partners than those prostitutes who use drugs intravenously or who do not use drugs.

3. If intravenous drug use is a risk factor for hepatitis B infection, then intravenous drug using prostitutes will be more likely to show seromarkers for hepatitis than those prostitutes who use drugs non-intravenously or who use no drugs at all.

4. If drug use, both intravenous and non-intravenous, has an impact on issues related to the prostitutes' reproductive functioning, then the non-addicted prostitutes will report less problems in this area than those prostitutes who are addicted.

5. If engaging in "safer sex" practices is influenced by craving for drugs then drug using prostitutes tend to give up their intentions to engage in "safer sex" more frequently and easily than their non-drug using peers.

6. If drug use, both intravenously and non-intravenously, constitutes a risk factor for HIV infection, then prostitutes who use drugs will be more likely to show HIV antibodies than those prostitutes who do not use drugs at all.

7. If seromarkers for hepatitis B constitutes a risk factor for HIV infection, then those prostitutes who have a hepatitis B infection will be more likely to be infected then those who do not have seromarkers for hepatitis B.

8. If HIV risk reduction occurs more frequently and more consistently among those prostitutes who consider themselves at high risk than among women who consider themselves to be at low risk, then protective behavior is not necessarily related to a HIV seronegative status.

## CHAPTER ONE

### METHODOLOGY

#### Introduction

Data were gathered about the lives of one hundred and twenty female heterosexual prostitutes in "Northeast" between November 1986 and November 1987. In the following section the focus will be on various problems encountered while conducting field research among female prostitutes and ways in which a researcher can resolve these problems. It takes a special attitude and considerable time to gain entrance in the world of prostitution and one has to be prepared for all kinds of reactions from both "in"- and "outsiders". The researcher must be willing to interact with prostitutes and others on the "stroll", and must feel relatively comfortable among them. At the same time the group under study needs to be willing to communicate with the researcher. How this was done in this study is described below. Several research techniques were applied to gather data, but the key method was ethnography: observations of incidents in the field and informal interviews with respondents. The researcher also used a formal interview instrument, obtaining the prostitutes' medical and reproductive history, their drug use and their sexual activity (see Appendix

B). A rather limited and superficial physical examination (see Appendix C) was conducted and a blood sample of 10 ml was drawn.

#### Stages in the Research Effort

Most research in the world of prostitution has been conducted in institutional settings such as prisons, treatment programs and clinics, and not in the prostitutes' natural setting.<sup>17</sup> In contrast, this study was mainly done in the everyday work environment of the prostitutes. Using ethnographic research techniques makes it possible to focus on the lives of people studied from their own perspective, which provides an "insider's" view of their values, norms and actual behavior. Research, however, is only possible if the group under study trusts and accepts the researcher. If the researcher is not trusted and is seen as somebody who does not know about the relevant issues, e.g., aspects of being a prostitute or a drug user, the answers given by respondents could be "dishonest", answers that they think they are expected to give, or they themselves wish were true. The validity of answers increases the more the researcher knows about the lives of those studied, and the more the researcher has relationships with others, which make it possible to cross-check findings. This kind of research is almost impossible without the cooperation of insiders. The researcher must show interest in the individuals involved and be open to becoming involved in

their problems. Patience is indispensable as well as the ability to listen, even if the subject of the conversation is not relevant for the study. Additionally, the researcher benefits from being open about the project's goals, being honest, and avoiding over-identification with the group under study.

Ethnographic research methods have been critiqued, especially by quantitatively oriented social scientists (Agar, 1986). The main objections are the difficulty in accessing the validity of the information gathered and the fact that personal characteristics of the researcher can have a significant impact on the results of the study. It is true that the individual researcher operates in a certain way, based upon personal style and probably gives a personal interpretation to the data gathered (Douglas, 1970; Feyerabend, 1972). The probability of this happening is greater in qualitative research because the researcher develops a closer bond with the respondents than an interviewer in a survey study does. It should be noted, however, that most ethnographers are able to distance themselves from the "field situation" and form their own personal feelings and opinions in regard to a research project (Adler and Adler, 1987). In Merton's (1957) terms one can say they are able to come to a "post-factum" sociological interpretation. Furthermore, assuming the situation does not change, verification of the data and the results is possible through

careful replication of the research. This, however, is more difficult if the setting or the situation of the group under study has changed drastically over time. In the next sections the researcher will frequently refer to her personal research experiences. Methodological issues are very often seen as a personal issue and put in the context of anecdotes, while these are valuable for the reader of a study to understand the framework within which the research is done and valuable for other researchers who want to conduct similar studies.

The first step a researcher has to take is finding what Merton (1987) calls strategic research sites. Before one can start a study, in this case among female prostitutes, one has to find out where to reach the group one is interested in. In this study the researcher discovered the relevant prostitution sites by driving around through "Northeast", reviewing newspapers and magazines, looking for addresses and phone numbers of escort services in the yellow pages, talking with colleagues, medical and social service providers, taxi drivers, bar and hotel managers of places known for their prostitution activities, and drawing upon some previous contacts the researcher had with individuals active in "the Life". Once potential research sites were located, the researcher started going out at various times of day and night, and mapping out areas where prostitutes congregate and ply their trade. Although a few contacts were made, the main focus at this point was to get to know the area.

During the next phase the researcher focussed more on events and contacts. Prostitutes are not receptive to people, e.g. outsiders, who want to know about "the Life". As the researcher could feel very clearly, their attitude toward strangers is characterized by suspicion. Why should anybody, even for scientific reasons, be interested in them? According to the prostitutes, nine out of ten times such a person had ulterior motives. Being a woman made them consider the researcher a potential competitor or an undercover police officer. The following excerpt from the researcher's fieldnotes shows part of the process.

I have been out there now about eight times, during day and night, in the rain and on sunny days. It is frustrating to see how people constantly walk away from me, stare at me, and then look at me again and start talking...A potential customer stops his car in front of me. I tried to be cool...He picked up the girl who was standing by herself and to whom I referred him...All of a sudden everybody disappears, and I soon found out why. A police car comes around the car and stops. The officers tell me to get the hell away from there...In the neighborhood bar I have a drink. Some of the prostitutes are sitting at one of the tables. One of them walks pass me and asks how I am doing. I tell her not too good and she answers: Hey babe, that's where life is all about. Cheer up...

After this day things started moving. More and more of the "street" people expressed their curiosity about the researcher's presence in the area. The researcher began hearing questions like: "Who are you?", "What are you doing here?", "What do you

want from us?", and "Why are you here if you don't turn tricks?" Both the researcher's (Dutch) accent and the fact that she had previous experience doing this kind of research facilitated the responses. It is important for a researcher to explain as clearly as possible why he or she is there, and what the respondents can expect from a researcher. In this case, the researcher remained a relative outsider, although, at the same time she became a familiar figure. People accepted her presence, however, this was relative. Unexpectedly, at times the researcher's integrity is tested. During this study, women would ask for favors or offer opportunities to make extra money by getting involved in illegal activities, or tell stories and check if the researcher would gossip. The researcher's reactions always would be observed by the prostitutes and others out on the street. Frequently a potential customer stopped his car in front of her and approached her as one of the working girls. The researcher realized she had to be friendly so the customer would stay, but was not supposed to work out a deal with him, nor tell him her role as a researcher. Most of the time one of the women would walk up after a few minutes, approach the potential customer and "take him over". An older experienced "lady" taught the researcher to tell the men she was sorry she could not go with them because she had a night off, and next refer them to one of the prostitutes. Once this almost led to the arrest of the researcher, because the man approaching her was an undercover police officer.

Being an outsider was accentuated by the fact that the researcher could leave the field and return to her world. The prostitutes never left the "scene" completely. Titty, one of the street prostitutes once noticed:

You are lucky. I know you try to feel how it is to be out here. You get cold and tired like we do. But hey, that's nothing. I deal with this mess and them suckers all day seven days per week. You have a place to get away from this. You get a paycheck and you have friends who have a decent job...I think it great that you try, but you'll always be better off than we.

After the prostitutes got to know the researcher better some women attempted to benefit personally for providing her with information. In return for their stories and time they would ask for cigarettes, coffee, food, drinks, money or assistance in dealing with the welfare department or the police. Many of these incidents were acceptable to the researcher and sometimes they would even border on comedy as is apparent from an encounter with Bottle B.

Bottle B., also called BB, waited as usual at the corner for me. She jumped in front of the car, and would always expect me to have a sandwich and a soda for her. Next, she wanted to know how I was doing, how long I was planning to stay and what I wanted to do...She would go around in the area and tell people about me and the research and refer them...At the end of such a period she herself would show up again and ask if she did a good job. It became a ritual. Until now I always gave her little things, like a pack of cigarettes, but today I decided to break through this routine. We joked with each

other and me not giving her a compensation for her effort did not seem to cause any tension. BB sees all this as part of her game, and you either win or you lose. She was just waiting for me to figure this out, and to show where my limits were.

Bottle B's role is like a "tout" in the world of drugs. This is a person who locates potential buyers for drugs and then steers them to a dealer in exchange for money or drugs from this dealer. BB located potential respondents, steered them to the researcher and expected a compensation for this.

Judy, on the other hand, made life more difficult for the researcher. She always wanted something for free; at least a pack of cigarettes and some matches. The cover of the matches was used to snort cocaine. The moment her expectations were not fulfilled she got very upset.

Bitch, who the hell do you think you are? You come here and go back to your nice life. Fuck you...I'll tell my old man about this. You better watch yourself and your pretty face. I'm not busting my chops for nobody.

Incidents like this were more threatening. A researcher must constantly be alert and develop strategies to counter this behavior. As soon as the researcher knows a few people better, the so-called key "respondents"<sup>18</sup>, these types of situations decrease in frequency because there is some kind of "back up", there is somebody "to watch your back". In one city a former drug dealer and well-respected man on the streets, protected the researcher, while in another city this position was taken by one

of the pimps and his "main lady". It is typical for those in the "street life" to always be alert and never to trust another person completely. This was frequently pointed out to me, as well as the fact that those individuals trusting me were taking chances themselves by doing that. Ann explains:

We like you and what you are doing. You are wild... I keep on telling you to watch out for them hoodlums...We tell them you are okay. Don't bullshit us now. We'll get in trouble, and you are gonna pay for that. You know what I am saying?

After three months the researcher reached a point at which it became possible to start doing more formal interviews, to go out with an interview schedule and to be accompanied by a nurse who would do a limited medical examination and draw a blood sample. The researcher had been mentioning this part of the project to potential study participants. A participant consent form was verbally explained to the participants, and confidentiality was guaranteed, the prostitutes were asked to agree to participate in this more formal part of the project. Participation was voluntary and respondents could withdraw. Only one woman terminated the process after questions were asked about her possible drug usage.

No structured data were gathered about non-participants. The researcher collected information through informal conversations with women who participated and with those who were not interested. No clear reasons for non-participation were

defined, although some women mentioned that they did not trust the researcher and the nurses and thought they would give out information to the police, the welfare office or others. The researcher knows at least twenty-five prostitutes who are non-participants. This may introduce a sample bias, however, the non-participants did not appear to differ from the participants in terms of race, drug use, age or type of prostitution.

After the formal part of the study was explained in detail and the consent form was signed, the medical examination was conducted. Next, one of the two female or the male nurses would draw 10 ml blood specimen from the study participant by venipuncture. In twenty-seven cases the prostitutes could not be enrolled in the study because the nurse was unable to collect a blood sample. Veins were particularly difficult to locate among the drug users or would collapse. If this occurred this could result in considerable tension, because the prostitutes realized they would not receive the twenty dollar study participation fee. Many women wanted to draw the blood themselves. Those women who were intravenous drug users would very often know exactly how to find their "good" veins. The most extreme situation occurred after the nurse could not get a blood sample from one of the prostitutes and would not allow her to draw her own blood. The woman started yelling and screaming, and she refused to leave the van. Finally, she left but was back within five minutes. This time with her boyfriend and some

of his friends. The situation became very chaotic and the police had to intervene. The woman told everybody that the researcher promised people money for blood. In her case, however, "we stuck six needles in her and refused to pay." On a later occasion the researcher had a long talk with her about the research project and she became very supportive. She even started referring other prostitutes to the study. The Centers for Disease Control tested the blood samples for hepatitis B seromarker, antibody for syphilis and HIV antibodies.

After a blood sample was drawn and the 15 minute medical exam was completed, the interview schedule would be introduced and administered. Although some of the questions were sensitive, especially those about drug use and sexual behavior, all the women with the exception of one agreed to participate.

There are several reasons for the high level of respondent cooperation: (1) the researcher already had developed relationships and trust with the respondents and could fall back upon key respondents, (2) many of the prostitutes and their friends were concerned about the AIDS epidemic and wanted to know more about AIDS, and (3) the prostitutes were paid twenty dollars for their participation in the study. This twenty dollar participation fee may have caused a bias. Unfortunately, researchers have started paying respondents for participation in research projects, and it has become almost impossible to

conduct a study without reimbursing the respondents (Elifson et al., 1989). Elifson and his colleagues also report the risk of unknowingly re-interviewing a respondent, who is seeking an additional participation fee. To minimize this possibility basic data were compared when two interviews appeared similar, and observation sheet with physical characteristics of the respondent were checked. Once the prostitutes learned that multiple participation had been detected on a few occasions, they seldom sought to be re-interviewed. The researcher asked the women to respect her "hustle" as well as the research team did theirs. On three occasions pressure was put on the researcher by a pimp to pay a prostitute twice. Each situation was resolved with minimal trouble because of the researcher's "back up". Although it was known on the street that the researcher carried money, this fortunately never caused problems.

Interview Sites

One of the most important issues to consider when conducting formal interviews is to find an appropriate location. The sites at which interviews were conducted for this study are presented in Table 1.2.

**Table 1.1: Number of Interviews by Site**

SITE	NUMBER OF INTERVIEWS
Methadone Clinic	15
Motel/Hotel or Bar	27
Brothel	4
Escort Service	9
Mobile Fieldstation	65

(1) Methadone programs and clinics. Most of the prostitutes interviewed at these programs and clinics were (ex-)intravenous drug users, participating in out-patient methadone programs.

(2) Motels/ hotels and bars. The researcher would first approach the manager and explain the research. Eight hotel/motel managers refused to participate and did not grant permission to talk with the prostitutes on their premises. Most feared that others would learn of their involvement in prostitution activities. One manager was afraid the researcher would try to tell the women to leave "the Life" and destroy his business, while another thought the research team was going to inspect the hotel for hygiene, and two other hotel managers were concerned the researcher would learn about their drug trade. On one occasion the researcher was followed by car for miles, while the two men in the car screamed obscenities. These men, as the researcher later heard from some of the prostitutes, were friends of a particular pimp who feared the researcher would talk the women into leaving him. Three other hotel/motel managers were very helpful and one gave the researcher a complimentary room in which to conduct interviews. The manager stated: "What is going to happen to my business if this AIDS epidemic comes through?" The researcher made contacts with the help of the manager, through prostitutes she previously knew, by

hanging out at the bar or in the lounge.

(3) Two brothels. One of the pimps owned several houses of prostitution and invited the researcher to talk with his "ladies" after he first consulted them. The researcher and he already had established contact during the initial research period.

(4) Call- and escort services. After leaving messages on the answering machine for about three weeks, one of services called back. After a meeting with the management, eight prostitutes enrolled in the study;

(5) Mobile fieldstation. This mobile fieldstation was a van with four comfortable chairs and a table in the back. Sometimes the interview was conducted in this van, while the medical exam was conducted in one of the clinics, when no nurse was available to accompany the researcher. To make it convenient for the prostitutes the researcher would then transport the women between the clinic and a nearby "stroll" or be their "taxi-driver" to another location.

More than half (54%) of the interviews were done in the mobile fieldstation. This interview site had certain advantages: (a) The van became known and was easy to recognize by the prostitutes. It frequently occurred that the van was stopped by a pimp or a prostitute to refer us to other women or they would bring women over to us; (b) In order to participate the prostitutes did not have to leave their work site. They

could stay in their "own" territory, and have privacy in the van. Sometimes a prostitute would ask to leave the stroll and go to a drive-in restaurant or another location in which she felt comfortable; (c) The van provided the opportunity to follow changes in the "scene", e.g. after pressure from the police or neighbors the prostitutes might move a few blocks; (d) The mobile fieldstation became a social gathering place<sup>19</sup> during the times business was slow for the prostitutes or when it was raining or cold. While drinking coffee, informal conversations took place, or the women would just sit, rest, relax or smoke a cigarette. The relative privacy of the van also offered an ideal place to escape from the police. These moments created an opportunity to know the prostitutes better and learn additional facts about the women's lives.

#### Sociological Research during the AIDS Epidemic

As already mentioned, the main goal of the study was to determine if female prostitutes were a possible source for the spread of HIV into the general heterosexual population, and if the women them-selves were at risk of becoming infected through their sexual partners (MMWR, 1987). Of the 120 study participants 55 women or 47.8 percent were HIV positive.

Social scientists conducting AIDS-related research have to deal with specific issues. This is particularly true for qualitative researchers compared with survey researchers. The

former tend to develop an intimate relationship with the respondents. In the following section, the researcher refers to her personal research experiences as a qualitative researcher.

Soon after I entered the field, the issue of AIDS was raised with respondents. By the end of 1986 almost everybody had heard of or read about the AIDS epidemic. Many public misconceptions about the disease and the ways in which the virus can be transmitted also existed among the prostitutes. I soon became the source for answers to an overwhelming number of questions., e.g. "Do you get AIDS from having sex?" or "What about oral sex?"

One issue that came up frequently was AIDS antibody testing, especially since part of the project included HIV antibody testing for prostitutes. The women differed as to the relevance of testing, and their attitudes often changed over time. Some prostitutes opposed testing because there was no cure available for those infected. Others stressed the importance of testing because it gave the individual a chance to find out his/her serostatus. Based upon this condition those who tested negative had time to protect themselves; those who tested seropositive needed to start thinking about their future and medical care, and they needed to take preventive measures so as not to infect others.

Among the prostitutes there were also women who wondered if they still could or wanted to become pregnant. The Centers for Disease control currently coordinates several studies focussing on perinatal transmission of HIV. One of the key issues discussed internally is what advice to give to women who are infected: delay with pregnancy or get pregnant at an early state of infection (personal communication, CDC staff). The women themselves are not sure if it would be fair to take the chance of infecting their baby or get sick themselves and not be able to care for their children. As shown in the following part of the researcher's fieldnotes, these issues were frequently discussed among the women while they were sitting together in the van.

Jackie, Denise and Martha sat down and were still discussing the issue of getting pregnant. They stayed after their colleagues left. Pregnancy is increasingly discussed since the women know of AIDS. One of the women they know has a baby that has AIDS and she herself is also infected. The child is still healthy, but the mother is in the hospital and might die soon... Denise also knows she is infected. She wants to give birth to at least one child. At first her doctor told her to wait, but during her last visit he mentioned that it might be better for her to become pregnant now, rather than months later. Apparently, medical scientists do not know the right answer either. This makes Denise angry...Martha can relate to Denise's anger, but Jackie calls them egotistic. She is opposed to infected women getting pregnant, and goes as far as stating that all these women should get their tubes tied.

Another issue about which there was little agreement is emphasized in the next section of the researcher's fieldnotes.

The issue of today was mandatory testing. None of the women had used the word before in a conversation with me, but today I had at least six prostitutes ask me what I thought about this...Beeper is convinced that mandatory testing is used to "find out who is a hooker and might infect one of her tricks. It is to tell us we are bad girls and need to be punished". Carrie argued with her and stated that this was a chance for the prostitutes to show they were less infected than others, or as much as "those nice housewives and single girls". That afternoon a prostitute from a nearby town had given an interview to T.V. and stated that all prostitutes should get tested. That made the women I spoke with tonight furious...Due to AIDS, many controversial issues are being discussed by the women.

Some of the women would accept mandatory testing only if the whole population would get tested, others saw mandatory testing as a way to show society that prostitutes were not a source of infection, and others completely opposed mandatory testing. Related to this were debates and discussions about behavioral changes the prostitutes could take to protect themselves and sensitive issues like condom use and injecting drugs. As a researcher I was limited to giving general advice, participating in discussions, listening and trying to make appropriate referrals to medical and social service providers. Some respondents, however, expected considerable concrete help in addition to the moral support which was offered.

All 120 participating prostitutes agreed to be tested for HIV antibodies. In order to obtain test results and to receive counseling they were referred to one of the existing AIDS Test and Counseling Sites. Only a small group of the women went to

one of these sites to request their test results. This is partly because they had previously received their test results. Approximately 25% of the women (N=34) were interested in finding out their results, but did not feel comfortable going to one of the AIDS Testing and Counseling Sites. They did not want to leave familiar territory and go into a medical environment to talk with a "stranger". Pepita did seek her results, and she told of her experience:

I felt like they all knew why I was going there. People in the other waiting room looked funny at me. It made me nervous. I had to wait for hours and finally they took me into an office. There was no doctor, but some kind of social worker. You know, one of those preacher types. I could sit at his desk. He, of course, had the most comfortable chair. I think he was gay...He didn't know what he was talking about. I didn't want to embarrass him. I couldn't handle it any longer, jumped up and told him just to tell me if I had it yes or no...I'd rather talk with you. They don't have any common sense.

As a consequence of the women's resistance to visit these sites, some would try to get the test results from me. I was not in a position to provide test results. This task required a professional counselor. The researcher limited her efforts to try to seek their results, also in order to guarantee confidentiality.

Pepita was fortunate since her test results showed she was not infected. Among those who learned they were infected, the tension increased. The women did not want to tell each other their results, and I became an "on-the-stroll" counselor. Fear

and anger were shared, as well as problems in informing their partner. Three women got angry at their partner because they suspected it was through him they got infected. Others were more confused and did not know how to inform their partner. Most of the times it was the woman who would get tested. If the female partners tested negative, the men would conclude they themselves were not infected, however, if the women were positive they did not want to hear about it. Even more complicated was the issue of informing colleagues. The women were afraid they would no longer be accepted, and forced to leave "the Life". Angie went through this.

They knew I got tested and now everybody is asking me if I got my results back. I am negative but they don't want to believe me. Them bitches, only because I look ill. I just had a cold. The girls don't talk to me and the story is out I have AIDS. Can you get me a letter that explains I don't have it?

Angie indicated that she would give up her profession if she were infected. She feels responsible for her customers. In contrast some of the women are infected but continue "turning tricks". They feel the customers should protect themselves. Others, who are seropositive, indicate that they would prefer to leave the world of prostitution if they had alternatives to support themselves.

The ethic issue became complicated for the researcher when a prostitute who was known to be HIV seropositive continued sharing needles with other drug users or had unprotected sex.

Should the researcher make an effort to try to make the woman change her behavior or should the researcher just gather data? In my case, I was fortunate to have established a relationship with some of the outreach workers who were dealing with drug users and prostitutes in "Northeast". The researcher would talk with them about the situation and refer women to these outreach workers. As a researcher one can not become a counselor nor an outreach worker. Distance is needed to gather objective information.

In applying qualitative research techniques in AIDS studies, the researcher has to make conscious choices about his/her role. AIDS is a deadly disease, that changes the demands on the researcher and adds an extra dimension to sociological research (Sterk, 1989). AIDS differs from most other diseases in that there is no effective cure, and all that can be done is try to teach people about factors that put them at risk and suggest behavioral changes that are needed.

## CHAPTER TWO

### WHO ARE WE TALKING ABOUT

#### Introduction

"Northeast" has a public library with a section dedicated to information about the area. The researcher and the librarian started looking for material about female prostitution in "Northeast". The following was reported in the researcher's fieldnotes:

In the "Northeast" Room of the library one can find all the information about every subject dealing with "Northeast". We have every-thing...Prostitution you said?... Yes, we should have information about that, although I never had anybody asking for this...I am sorry, no books, no articles or reports. The only information I found are newspaper clippings about arrests and one report about venereal diseases, but that is from the beginning of the century...Do they want us to believe that "Northeast" has no prostitution?...I cannot believe this. I cannot help you...

Both the librarian and the researcher were embarrassed because they could not find any written materials focussing on prostitution in "Northeast". Except for newspaper articles mentioning police actions on "strolls" showing the number of prostitutes arrested plus one publication there dating from the beginning of the century, nothing else is available. The one and only publication deals with sexually transmitted diseases

among female prostitutes. It is clear that the phenomenon of commercial vice has been virtually ignored by the media, scholars and others. This does not mean, however, that commercial vice does not exist. Even "Northeast" has its brothels, escort services and "strolls", not to mention the numerous go-go bars. If one drives through the region one sees many signs and neon lights referring to "sexual amusement." The legislators, however, have not ignored the prevalence of commercial vice. As in most American states prostitution is a criminal offense in the state in which "Northeast" is located.<sup>20</sup>

All prostitutes upon which this dissertation is based, live and work primarily in "Northeast". "Northeast" lies along the northeast coast of the United States, and is located within fifteen miles of a major city. Actually, "Northeast" adjoins the metropolitan area of this city. Commuting to and from the heart of this city takes less than thirty minutes. It is because of the close proximity that one third of the prostitutes living in "Northeast" work mainly in the city. The prostitutes mention that it is easier to make more money in the city, and they point out that arrest warrant records are not shared by states, thus, crossing the state borders between "Northeast" and the city allows the women to work without fear of arrest due to previous offenses.

It is difficult to know definitively if this sample of prostitutes is representative for the prostitution population in general, in the United States, in the metropolitan area or even in "Northeast".

Two institutions that can provide data about the number of prostitutes are the police and clinics for sexually transmitted diseases. Estimates from both indicate that approximately one thousand prostitutes work and/or live in "Northeast". The prostitutes themselves also could only speculate about the number of women working in "the Life". They were only concerned about their numbers if too many women worked a particular "stroll". Creating competition would reduce their earnings. When Cindy, a black prostitute, spoke about this, her reaction was strong.

Stupid question! Who the hell knows? You might work today but not tomorrow. You can find me here, but you also could see me in Miami. What difference does it make anyway? Even if you do not like travelling you have to get away from the man. I don't give a damn as long as I have a place where business is good... This is a fast life and you have to know how to live it. The only important thing is money. Numbers???

Concrete and valid data about the number of prostitutes are not available because of the illegal nature of prostitution activities and the taboo on sex. Prostitutes are a "hidden population". Their visibility is decreased due to their engagement in illegal activities, but also because their working

hours vary considerably. Nearly two-thirds of the women work part-time. Twenty-four of the prostitutes interrupted their employment in "the Life" because of personal circumstances. Some served prison terms, entered a drug treatment program, or were supported by a partner for a period of time. Fourteen of these prostitutes did not use any drugs while they were not "hustling". Another group of prostitutes (N=12) worked three out of four weeks. Tracey, a mother of four children, is typical of this group. She receives a welfare check once a month, and does not work the week following the arrival of her check:

I can afford to take time off, buy food and enjoy life...At the end of the months I always have to turn more tricks. I have to feed the kids. It's not their fault.

For forty-two other prostitutes, working part-time implies that they do not have a structured work schedule. They work whenever there is a need for money. Their schedule reflects the fact that many "sexworkers" are drawn into the world of commercial vice because of its economic profits. Some prostitutes have only one customer per week whereas others see as many customers as possible for several consecutive days. These women never know when they will be working. Tania typifies the prostitutes who only work if they have an economic need:

I do it for the money. If I can get dope I'll take it easy. If not, I'll do it until I can get high...If I

want to buy something special, like clothes, I'll turn a few extra tricks. Sometimes I get myself in trouble and I've to bust my chops seven days a week, ten hours a day ... Other times I just want to get a piece of the action...I do whatever comes up in my mind. I might turn a trick on my way to the grocery store.

The prostitutes often work long hours. Many recalled or were presently working shifts exceeding ten hours per day and/or night. Women, like Tania, do not work during certain days or hours and the majority of them do not have a steady working spot. The remaining forty-two prostitutes worked more structured hours at least five days per week, at a certain location. Tania's comment also shows a possible relationship between the women's prostitution activities and their drug use.

Due to a lack of education, most prostitutes have limited choices in the labor market. One-half did not complete high-school. The primary reasons for dropping out were: (1) family pressure to leave school and start earning income to support themselves or family members; (2) peer pressure to have a "free" life, which very often meant involvement in illegal activities; and (3) a change in circumstances, of which divorce of parents and teenage pregnancy were the most prevalent.

Nineteen respondents reported working another job including: nurse/nursing aide (N=7), cleaning lady (N=2), post-office clerk (N=2), sales woman, factory worker, singer, social worker, teacher, operator, model or seamstress. Two other women

are working as a nursing aide and a cleaning lady. Twelve other women combine their prostitution activity with cleaning work in hotels where sexwork by the female employees is tolerated. Those women who left a job mention the following reasons for leaving: (1) the earnings from prostitution activities are higher (N=10); (2) the employer discovered drug use or prostitution activity (N=6); and (3) their involvement in both worlds causes too much stress (N=4).

**Table 2.1: Characteristics of prostitutes**

	<u>mean</u>	<u>minimum</u>	<u>maximum</u>	<u>SD</u>
Age	32.4 yrs	20 yrs.	47 yrs.	5.7
Age first sex	14.8 yrs.	7 yrs.	23 yrs.	2.5
Age prostitute	25.1 yrs.	16 yrs.	39 yrs.	4.4
Age first drug use	20.4 yrs.	12 yrs.	33 yrs.	4.7
Time involved in prostitution	87.6 mos.	1 mos.	240 mos.	48.3
Number steady boyfriends/last 5 years	1.8	0	7	1.3
Months lived with boyfriend/last 5 years	43.8 mos.	0 mos.	60 mos.	20.1
Number children	2.7	0	9	2.1

The following general characteristics of the study population are presented in Table 2.1: age, age at which they had their first sexual intercourse, age at which they identified

themselves the first time as a prostitute, age at which they used their first illegal drug, the amount of time they have been involved in "the Life", the number of steady boyfriends they had during the last five years, and the number of months they lived with this boyfriend, and finally the number of children they have.

Age is a very important issue for prostitutes. The mean age of the 120 subjects is 32.4 years. The oldest woman is 47 and the youngest one is 20. The majority (59.2%) of the women were between 26 and 35 years of age. Four women entered the "life" before they were 18 years old and ten women were older than thirty when they got involved in prostitution. The majority (70%) were between 22 and 30 years of age when they became prostitutes. There is considerable competition between the younger and the older working girls. Margie did not engage in prostitution activities until she was in her thirties. She divorced and started using heroin. Most of her customers are regulars, and she shares the following observation:

Tricks prefer those young chicks. If you do this long enough you surely pay a price, also with your body. It's hard to look good... Tricks don't really care as long as they get pussy. I've my own guys.

Like the other eleven prostitutes who are older than forty, Margie feels insecure because of her age. A prostitute's age is a key factor as she considers her future. "Until what age can a

woman be a successful prostitute?" is a question frequently raised. Two of the older women hope to become a "telephone operator" at an escort service, one wants to be a madam in a brothel and instruct new prostitutes; the others are unsure of their future. It is typical for older prostitutes to "mature out"--leave "the Life", a finding Miller (1986) also reports in her study among street prostitutes.

#### Street prostitute, prostitute in a brothel or call girl?

Within the world of prostitution several forms are distinguished depending on the place where the women ply their trade: on the street, in a hotel or bar, in a brothel or for an escort service. Both in- and outsiders see call girls as the most successful prostitutes. They are respected, seen as women who have social skills, who dress properly and who are physically attractive. The researcher talked with some of the women about this, and the following is an excerpt of the researcher's fieldnotes.

Linda is a call girl for a small escort service. She has 46 colleagues. Most of her work is in hotels. Men call in and ask for a woman with a certain color of hair and eyes and with certain sizes. Linda fits a category that is in large demand. She is always well dressed and could be a business woman who is staying in one of the hotels where she meets her customers. One night per week she answers the phone, and she and I sit down and talk. I raised the question of what she thought of street walkers and mentioned that they had kind of the same profession. She almost exploded, and told me that street prostitutes are out there because they belong in the gutter. All they need to do is fall off the sidewalk. She also looks down on their clients, and sees them as men who are cheap and looking for a

disease. She is convinced that they are all drug users, with pimps and boyfriends who abuse them. Linda is proud of the professional relationship she has with Mike, the boss. She forgets that she has been having sex with him on several occasions and that he might be using her the same way the boyfriends do.

Squash, on the other hand, is a streetwalker. She laughs about call girls and explains that they do not have anything she doesn't have. They might have a pretty face and nice clothes. But most of the sex is in the dark and without clothes. She states that call girls tend to fool themselves.

Other researchers also found that street prostitutes are talked about disdainfully, are seen as asocial, do not dress properly and are less attractive (Greenwald, 1958; Gagnon and Simon, 1973; James, 1976; Barrows and Novak, 1986). In this study street prostitutes are over-represented (84.2 % are street prostitutes), and as a consequence the form of prostitution the women worked in was never a statistically significant variable. Some of the prostitutes moved along the hierarchical continuum within "the Life". None of the respondents experienced upward mobility from the street and began working as a call girl for an escort service. Three women who started as street prostitutes worked during the research period in a brothel, and twelve other streetwalkers became go-go dancers or strippers after they left the street. Two call girls and three women who formerly worked in a house of prostitution experienced downward mobility and are now "hitting the bricks". All respondents agree that most vertical mobility is downward rather than upward. Brothels and escort services generally will not hire prostitutes who are drug addicts. Thus, it is true that drug use forces many women out on the

street. There is a small group, however, who have chosen to work as street prostitutes. Freedom is their main motive; a finding also reported by Carmen and Moody (1985).

Besides a status difference, the main distinction between the different forms of prostitution is in the setting and the circumstances under which the prostitutes work. Street prostitutes solicit customers in all kinds of weather. Although they knew they would be spending most of their working hours outside, they tended not to dress appropriately, e.g. inadequate clothing to protect themselves against rain, snow and wind. They either wanted to look "cute" in order to attract customers or spend their money on drugs rather than on clothes. Non-addicted prostitutes tended to dress more appropriately than their addicted colleagues. Those women who wear uncomfortable, tight clothes and high heels complain about back pain, especially after they had been walking around for several hours. Street prostitutes also very often work under ergonomic bad circumstances, especially when the sexual services are provided in a customer's car. "The men think we are snakes", according to Pretty Girl. She recalled an encounter in a car with a customer who wanted to "get down" fast. He pushed her back in the seat and one of her feet became wedged between the car seats. She was hurting and felt helpless. The customer would not listen to her and was only concerned with his sexual fulfillment. After this incident she could not walk for several days. Call girls and prostitutes operating in a house

work in a slightly "healthier" environment. These prostitutes did not have to recruit their customers outdoors, and had more facilities at their disposal.

Prostitutes know that being sick means no income. It is not uncommon for prostitutes, especially street prostitutes, to continue working until they are too ill to go out. Heather, a Hispanic street prostitute who is twenty-one years old, tells us:

I'm so tired. I wished I could go home, but it is too early and I do not have enough bread...I was in the hospital with pneumonia...They found me on the street corner the other night. I didn't know if I was coming or going...I had problems in the hospital...I don't have AIDS, but that older bitch was telling everybody I had...I promised the doctor I would rest at home. First, Jack (her boyfriend) took care of me, but then he got impatient...We didn't have a dime because one of his deals did not come through. I went out and started working again...I am tired.

Heather's situation is typical for street prostitutes, especially if drugs are involved. Women working in brothels or for an escort service are less desperate, and if they are fired they very often work for another agent. Katja, a call girl, who was fired because she was sick, reports:

I worked at KB's for three years, and never stayed home. I could be sick as a dog, but I would go in. Sometimes a client would not want to be with me because I had a cold or looked miserable. I would put lots of make-up on my face, but there is only that much you can cover up...I had a bladder infection and could not leave the house. I asked

my doctor for a note, so I could show them it was serious...I got fired because I did not come in for two weeks...I was afraid I would not find another job. One of KB's friends asked me to start working for him on Park. He has some classy girls out there...I did not want to be out on the street...I like this place better. They don't bother you if you have to take some sick leave.

Not all women were as lucky as Katja. Three prostitutes reported that they used to work in a brothel but they ended up on the street because they were sick too frequently or too long in duration. Related to the prostitutes' physical well-being are their eating habits. Non-addicted prostitutes were more often concerned about their diet than were the drug-using women. The drug using prostitutes mentioned that when they were not getting high they had a craving "to stuff themselves with whatever available", mainly sweets and sugar. Relatively healthy food is harder to get near a prostitution "stroll". Going to a restaurant and spending time and money are uncommon. Call girls and women working in a house of prostitution tended to be more food conscious. The women who work in a brothel are very often provided a meal "on the job". These are typically of the T.V. dinner variety heated in the micro-wave. The call girls mentioned that they were frequently invited to join their customers for dinner. Physical appearance is also related to eating habits. Clothing sizes and body weight are subjects frequently discussed, mainly among call girls. According to them, there is a clear link between "business" and appearance.

Five prostitutes reported snorting cocaine to control their weight. This was called a "snow diet" or "diet coke".

### Interaction with Others

The women must interact with each other, and their pimps, madams or agents, their customers, the police, and residents of the area in which they live and work. None of the prostitutes worked as an independent entrepreneur. The prostitutes generally noted being influenced by the men in their lives. All street prostitutes, with the exception of five women, had to deal with a pimp, who is also their boyfriend. The call girls had to obey an escort service manager and those women working in a house of prostitution worked under the supervision of a madam. While the tie between a prostitute and her manager or madam is business-like, the bond with a pimp/boyfriend is more emotional. Gagnon (1973) writes that the pimp-prostitute tie is best understood in terms of the woman's deprived emotional relationship with other males. This is one of the few "stable" figures in her life and with him she might combine feelings of sexuality and love.

Economically, prostitutes are on the supply side while their male customers form the demand side. Since prostitution is illegal the initial contact between customer and prostitute is very often non-verbal and the women always wait until the customers take the initiative. "Making a connection on the

street" is complicated: both parties are visible, sexual services and their prices are not clearly defined, and there is no designated work place for dispensing their sexual services. More than half (62%) of the respondents report that they have regular customers. Customers are mainly described as white middle-class men, between 25 and 45 years of age. The prostitutes make a distinction between different types of customers based upon the amount of money a customer wants to spend ("spenders" and "savers") or their sexual requests ("fools" and "easy going"). Another distinction made between the different kinds of customers is the following: (1) mainly white middle-class men who drive around in their cars and pick up one of the girls from the stroll; (2) truck drivers, who stay over in a nearby motel or in their truck, and who want to have sex with one of the prostitutes; (3) contract workers, who live in a nearby hotel during the months they are working on a construction project in the area, and who invite women to their room; and (4) tunnel tricks, who seek sexual services near the tunnels that connect the big city and "Northeast". They want a "quick job" and mainly demand oral sex. Tunnel tricks are from all classes and ethnic groups.

Customers, however, do not just "pick up" every prostitute available (Holzman and Pines, 1982), and prostitutes often reject a potential customer. Street prostitutes mainly work in the customer's car or in a cheap hotel room. The call girls

mainly operate in the customer's hotel room, although three of them also receive customers at home. Those working in a brothel meet and work with their customers in the house of prostitution.

Finally, the prostitutes interact with the police. This is mainly true for the street prostitutes, who are more frequently arrested than the women working in other forms of prostitution. The Uniform Crime Report shows 2,515 arrests in 1986 for prostitution and commercial vice in the state of which "Northeast" is a part. Of these arrests 1,666 (66.2%) are women. All parties involved describe the interaction between police and prostitutes as a game of "cat and mouse".

The police know exactly where the "strolls" are located and if they wanted to they could organize a "sweep" every night, arrest prostitutes and not have adequate space to hold them in correctional institutions or a holding area. The police realize that sweeps are not going to change the situation drastically: prostitution is not going to disappear. Police actions have only a short term influence. Every action results in the arrest of prostitutes, but within 36 hours they are again working. Those who are not arrested might move to another street or go home. In the end, however, it looks as if nothing ever happened. The "players" of this game accept the situation for what it is, and as a police officer pointed out: "Every few weeks we organize a sweep and between ten and twenty women are

arrested. They are going to be away from the stroll for let's say one day, but prostitution goes on". The customers return, and even immediately after police action they are able to find a prostitute. The prostitutes know that their work places them at risk to be arrested once in a while. Bootsie remarked: "It was my turn last week. I hate it when they pick me up before it is my turn". The fact that every potential customer also can be a potential undercover police officer makes the dynamics of this "deviant sale" extra complicated (Heyl, 1979; Luckenbill, 1984).

### Violent encounters

Two-thirds of the prostitutes (62.5%) have been involved in violent situations during their work. Despite the high rate of violence it is not an issue openly discussed among the prostitutes. Talking about violence is too much of a confrontation with reality. One of the prostitutes who has been harmed several times, puts it this way: "If you start thinking about it you might as well forget the work. You cannot go out anymore. It would drive you nuts. Why scare others with your stories?" The women, however, would answer questions of the researcher dealing with violence.

As already mentioned, most female prostitutes feel emotionally attached to their male pimps who very often are also their steady male partner. The women will do everything possible and will accept considerable abuse from these men to

continue the relationship. Topsy, one of the street prostitutes, who works in a brothel during the weekends, talks about her situation. She and her pimp/boyfriend Caddy have been together for six years.

Caddy and I are tight. He knows how to con folks and I know he cons me too. If I don't bring in enough dough he doesn't want to see my face. He hits me...Later he feels lousy and buys me a gift...I paid for that gift, but what the hell. He is tough with other guys around. Inside he cares and loves...He tells me we can't be together if I don't turn tricks. I would like to stop and I can once we have enough money. Caddy is strong. He plays with my mood...It is difficult for him too to know I fuck other guys. You have to be able to forgive. He knows I need him and so do I.

Caddy, like other male partners, know that they have power and use this power as a control mechanism to force women like Topsy to remain a prostitute. The same "love power" is used by pimps if they want a new girlfriend to enter "the Life".

Prostitutes and individuals engaging in other illicit activities like drug dealing gather at and near "strolls". The environment is relatively dangerous, and for the women this means they need a big, strong man to protect them. Gender roles on the street are defined as such that a woman cannot operate independently of men (Maglin, 1974). The women refer to this as the need for somebody to "watch their back".

Daisy, a prostitute in her late twenties, related an incident in which one night she came home without any money

because she was raped by a customer who had also robbed her. She returned home and sought protection from her boyfriend. He simply sent her out again. Daisy left feeling desperate, but at the same time she defended her boyfriend because she understood how much they needed the money. He had borrowed "on the street" and was under pressure to pay off his loan. Daisy's experience shows that prostitutes not only have to be prepared for violence by their boyfriend/pimp, but also by their customers. If a prostitute's clientele is mainly "regulars", it is easier to control the situation and violence occurs less. The problem occurs most frequently with "strangers". All prostitutes believe they develop a special sense to deal with their "tricks". Some of them refuse a customer because they feel something is wrong with him.

Not only street prostitutes, but also women working in bordellos and for escort services face violence (5 out of 19). Although they are less susceptible to situations mentioned by the streetwalkers, they are required to engage in free sexual encounters with friends of managers and madams. Escort services try to protect their female employees by using the following strategy: once she enters a customer's hotel room she is required to call the agency and has to call again upon her departure. Most agencies and brothels also keep a record of problematic customers. Women working in a bordello are in the safest position, although safety cannot be totally guaranteed

for any prostitute.

No matter if there is a pimp around to protect them or not, in the end all prostitutes are on their own. They constantly have to be alert and seek to minimize mistakes. Joyce and Dolores have been working over ten years and they related their collective experiences:

Even after ten years you still can make mistakes. You never know. I have learned not to use a weapon. I use my own common sense. You learn about different characters and what they expect. It is like instinct. There are always lunatics. It has gotten worse. The johns want to pay less than years ago but also want you to do all those crazy things. I'm not gonna piss in somebody's mouth. They are ratpackers. Girls get killed, but who cares?

Both Joyce and Dolores feel that violence has increased and that prostitutes command less respect than they were accorded in the past. They advise younger prostitutes to establish a circle of "regulars". Most prostitutes prefer to work with older customers because of their demeanor. Older men are viewed as easier and do not feel they have to prove their masculinity.

As a consequence of increasing violence, the strolls get very quiet after dark. The only prostitutes out are those who are desperate, the ones who need money badly. They are mostly drug addicts. In order to protect each other, the prostitutes started paying more attention to their colleagues customers and the car in

which they leave. They also warn each other about "dangerous tricks".

Police data about violence against prostitutes is incomplete. It is known that during 1986 five prostitutes, all streetwalkers, were killed in "Northeast". It is typical for street prostitutes while they are plying their trade to stay in the customer's car, and to drive to an isolated area, where nobody is around to protect them if the customer causes problems. Other than the women who died, no concrete information is available about sexual harassment. The women all fear being forced to engage in certain deviant sexual activities. About one third (37.5%) of the prostitutes have been hurt during an encounter with a customer to the extent that bleeding resulted. There is more than physical violence. The prostitutes are also psychologically abused by the language the customers use and the image these men have of them. As one woman put it:

You have to take all their sh--it and they treat you like a dog. At the same time they expect you to smile.

In order to deal with the threat of violence the prostitutes were constantly reminding each other not to show emotion, particularly anger and fear, to their customers. They felt a need to constantly play roles. They were especially bothered when a customer wanted them to have an orgasm. Most customers know that they are engaged in a "game". There are

men, however, who do not want to face reality. The prostitutes socialized each other concerning tactics they could use with their customers. It is interesting that they talked with each other about having to act as if they have an orgasm, but never talked about actually having one. This subject is taboo. In talking with the prostitutes, they are troubled when they have had an orgasm during a paid sexual encounter. They did not want to display this emotion since this was viewed as unprofessional, and because they can not allow themselves to become emotionally attached to a customer.

The prostitutes were less interested in talking about violence committed by the police. According to them that was part of the "cat and mouse" game mentioned earlier, and they were also convinced that police officers were "mentally sick and addicted to power and violence."

Generally, the respondents concluded that they had to take care of themselves. They disagreed with the concept of prostitution being a "victimless crime". One of them asked: "Is it because a whore can never be a victim?"

#### Prostitution and Addiction

The link and overlap between the world of prostitution and the world of drug use has been mentioned previously. Prostitution has been defined as an exchange of sexual services

for money and/or drugs. The customer generally agrees to pay a prostitute a certain amount of money for the sexual services she provides within a set period of time. If the woman is a drug user, she will use her earnings to purchase drugs. It is less common for a customer to pay a prostitute directly with drugs. In regard to those women who are simultaneously a prostitute and a substance abuser, questions have been raised not only about the probable causality but also about the dynamics of the connection (James, 1976; Goldstein, 1979; Silbert, Pines, and Lynch, 1982; Marshall and Hendtlass, 1986; Van de Berg and Blom, 1987). No conclusive evidence for either of the competing hypothesis (involvement in prostitution leads to drug use; drug use leads to involvement in prostitution) is found. It becomes clear that one should not be looking for a limited cause-and-effect link between involvement in prostitution and drug use among women (Inciardi, 1986).

A relatively small subsample of thirty-three (27.5%) of the prostitutes interviewed engages in prostitution activities but does not use drugs. Of those prostitutes who use drugs the majority (70.1%) used drugs prior to their entrance in the world of prostitution. Eight women got involved in prostitution and drug use simultaneously, and the remaining group began prostituting themselves before they started using drugs. From interviews with the women it became clear that although drug addiction and prostitution are strongly interconnected, they see

the connection as mainly dependent on social circumstances at a certain period in their lives.

All the women, as Inciardi (1974) also found in his study among drug users, mention that their participation in "the Life" is more related to their general social-economic situation than to their drug use. Even the drug users tend to mention that "poor" social circumstances rather than their drug use forced them into the financially attractive world of prostitution. In general, prostitutes are recruited from the poor and uneducated (Gagnon, 1977; Rosenbaum, 1981). Involvement in one activity does not necessarily lead to participation in the other. We also have to be aware that the women did not start using drugs and/or begin prostituting themselves overnight. They were occasionally involved before becoming full-time prostitutes. Boggs(1979) describes this process when reporting on Danish women and their entrance in the world of prostitution. They started out "dating" American service men who were on leave in Denmark and who had lots of money to spend. After "dating" several men who only spent a few days or a weekend in Denmark, the women realized they could make considerable money. Gifts were not enough, they wanted to get paid. It took time before the women self-identified as prostitutes. The first times they received money did not mean they saw themselves as "whores". The same is true for those who ultimately identified as drug users. The drug using women reported that in the beginning they

would only use when they got drugs for free or if they were in the company of certain friends. Later they became more independent and active users. The dynamics of self identification as a prostitute or a drug user are similar. The mean time between occasional drug use or prostitution involvement and more frequent participation was 2.5 years for the "Northeast" sample. Unfortunately, the ongoing dynamics make it difficult to place these events into a causal context.

Drug use needs to be specified more precisely. In this dissertation drug use is operationalized into mainly intravenous and mainly non-intravenous drug use. General information about the different drug-use practices will be provided.

#### Dopefiend or Crackhead

##### INTRAVENOUS DRUG USE

Of the one hundred twenty subjects, sixty-eight women (56.7%) reported they were intravenous drug users. The drugs injected were mainly heroin or cocaine, or a combination of the two. Three prostitutes mentioned that they tried heroin the first time while they were "chasing the dragon" (inhaling the smoke melted from heroin which has been heated); one third of the women started snorting heroin, which after a while caused problems with the mucous membrane in the nose. Compared with substance abusers injecting heroin, those who used it in another way required considerable larger quantities. Fifteen women

started "skinpopping" (injecting subcutaneously) after first experimenting with other ways of taking the drug, while for twenty others it was their first experience with drugs. "Skinpopping" is seen as a way of getting used to the "needle". Twenty-five prostitutes always injected heroin intravenously. Marsha, one of the intravenous drug users who has prostituted herself for seven years, described how she moved from snorting to injecting.

You kind of forget...I didn't use much and thought those folks shooting up were nuts. I hated needles and snorted my dope. I had to use more but didn't get high...My nose was all fucked up. I had to get medicine...I didn't have a choice if I wanted to get high...I got my own works but didn't know what the hell to do. I wanted the real deal...Velissa ( a girlfriend) and I did it together. She knew.

Like the majority (75%) of the intravenous drug-using prostitutes, Marsha learned how to "shoot up" herself. Seventeen of the intravenous drug-using prostitutes needed the help of a friend to get high and if no friends were around they had to pay an experienced injector, a "doctor", to "hit" them. This is another form of needle sharing. The experienced user would self-inject and then use the same syringe with the remainder of the "load" to inject the "newcomer".

It is common among intravenous drug users to get high together in "shooting galleries". The term "shooting galleries"

has been widely used, and the first description was provided by Fiddle (1967). Des Jarlais and colleagues (1985) state that "shooting galleries" exist because intravenous drug users need a place where they can inject without fear of interruption, where they have some privacy, where water is available, where they can interact with other intravenous drug users and where they, if necessary, can buy drugs and rent "works". They found "shooting galleries" in homes, abandoned buildings and cars, and report that users had to pay to use the (relatively) safe place. The following descriptions of a "shooting gallery" were given by the respondents: (a) an abandoned building where people buy and inject drugs and where some of the users may live; (b) a dealer's apartment where users only can inject the drugs bought there, although some dealers allow the users to shoot up drugs they purchased; and (c) an apartment where intravenous drug-using friends get together and get high on drugs bought elsewhere. Only eight of the 68 intravenous drug-using prostitutes never visited a "shooting gallery".

Characteristic for the behavior of intravenous drug users in "shooting galleries" is the sharing of "works".<sup>21</sup> Sharing of syringes is very important. Sharing occurs for practical and symbolic reasons. Practically speaking, syringes are scarce and the possession is illegal. Additionally, as already documented in the early seventies by Smith and Gay (1972), are the emotional or ritualistic meanings of sharing works. Seventy-two

percent of the prostitutes who use drugs intravenously mention that they used another person's hypodermic set and/or let others use theirs. They state that sharing creates a special bond and is part of getting high. The following fieldnotes were taken after a visit to a "shooting gallery".

The "doctor" had a good night. Two of his clients came in and they had high quality dope. He always hits them, and is proud to show others that his needle sticks almost do not leave any marks. He almost got into a fight with one of them. Peps wanted him to hit her first, but he never does that. He once confessed that he sometimes did not understand how people still could get high, since there was not much left in the needle after he hit himself...

Peps has been getting shots from "Doc" for over a year. In an earlier conversation she had already explained that she just could not do it herself. She gets too excited thinking about getting high, and cannot concentrate. She is also having trouble because her hands get too sweaty. She is experienced enough though, to know that, as she says, "Doc is screwing her over"...She needed "Doc" for her second shot. He told her earlier tonight she had some "good shit". Peps is telling him that she goes first or otherwise he can "fuck off". He tells her with a sarcastic undertone to think about it and walks away. Peps walks around looking for somebody else to hit her. The only other person she is close to is too high, and she is afraid nobody will do as good a job as "Doc"...She is still arguing with him...She is willing to compromise. He can go first, but she is not going to wait five minutes to wait till he is ready to hit her and to watch him enjoying his high...Finally, Peps gives up. She waits for him. Now that she is high she turns around and tells me how great "Doc" is and how important he is for her. While she and "Doc" were arguing the three guys sitting near a few boxes that function as a table, have been injecting several times. Two of them are "speedballing". They share the same needle, although they each have their own dope. The third guy looks unfamiliar. He also uses their needle, but asks for it every time he want to use it. He is like a "stranger". It makes me think about people in a bar. Two know each other. They smoke and share their matches. A third person is sitting at the same bar, but does not have matches. He has to ask for them every time he wants to light a cigarette.

Among intravenous drug users the relationship is the strongest between the novice, who very often does not own works, and the person who teaches the new user how to inject. Later more attention will be paid to the impact of the AIDS epidemic on drug-using behavior, especially needle-sharing practices, among intravenous drug users.

#### NON-INTRAVENOUS COCAINE USE

A subsample of nineteen women snorts the white powder, freebases it, or smokes crack. Basically crack and freebase are the same (Friedman et al., 1988): a rock of crack is already prepared before bought by the user, while the freebaser "cooks up" the cocaine powder him- or herself. Reagents like ether and baking soda are used to remove the hydrochloride from the cocaine powder. The result, an alkaloidal base, is heated and the fumes are inhaled. While the purity of a rock of crack is questionable, the freebaser can assess the quality during the process of "cooking" the cocaine. The freebaser also decides him/herself the quantity of the reagent used. Pony, who has been using cocaine for over ten years, tells us:

Cocaine always has been my favorite...but it's so damned expensive. I did speed because that is cheaper. If my money was good I would buy cocaine...Over the years it became harder to get speed and cocaine became cheaper. I snorted until I thought my head was going to explode and my nose couldn't take it any longer...Next I started freebasing...I always do the cooking myself. Crack, I do not trust somebody else cooking...

Like heroin, the user needs a greater quantity if cocaine is snorted. If cocaine is snorted frequently it also causes problems with the mucous membrane in the nose. More critically, however, are the effects on the psyche, e.g. depression, hallucination and psychosis (Inciardi, 1987).

These users, similar to the intravenous users, mention that "getting high" is a social activity. Places where they gather to get high are called "base or crack spots". These spots can be (a) a dealer's apartment where crack is bought, cocaine is "cooked up" and sometimes used; (b) a friend's apartment where cocaine, bought somewhere else, is prepared to be smoked and used together; (c) public places, e.g. street, stairwells, elevators, roofs, where crack or cocaine powder is used and sold (Friedman et al., 1988). Most of the prostitutes like to go to a place where they know others.

Gina is afraid to have to give up her relationship with Pat. Pat has a basement apartment and he always has people over to smoke crack with. He has several pipes, and most of those are smoking 24 hours/day. Gina has been having some trouble. She told me: Pat is being an asshole. He is arrogant as hell. He thinks he can run the show, because he has a place. He thinks he is slick...I know I was wrong. I shouldn't have taken an extra hit. I was out of it. Gina was part of a group getting high at Pat's place the night before. They were smoking together and were handing the pipe to each other, keeping the clouds in it, and if necessary putting a new rock on. Gina took three hits in a row, and that was one more than the norm allowed...She had similar problems in the past and is afraid that she'll end up having to smoke in the elevator of the building. As she says, "that's where the throw-aways are".

A crack high causes paranoia and the user feels more comfortable if surrounded by acquaintances. This is one other reason why Gina prefers to be with Pat and others she knows. Elsewhere, she has to deal with people she does not know, who might "steal stuff or do other things".

The most important paraphernalia for crack users are a crack pipe and a stem with which they clean the pipe. Pipes are only shared among users who arranged this in advance and most of the time these arrangements are between a man and one or more women, although users of the same sex also get high together. Freud was the first to report that cocaine use creates a physiological desire for sex and getting high creates a need for affection. Users do not only share the "cloud in the pipe" but also "bodies". Beverly tells us:

I get turned on from smoking. Scotty makes me wanting to do it. I don't care with whom. You cannot get into that. The man has the rock and decides who sucks him or the pipe...I've been jealous about other girls, but that's the way it is. We always work it out before we get high so it won't cause any shit later...If just men or women share the cloud they don't get into sex. It is harder to feel the monkey coming down. You cannot feel each other and enjoy it. What happens is that you fill the pipe to, how do you say that...yes, compensate for the sex.

Physical contact becomes important, but sexual feelings and

acts are always less relevant than getting high.

Users, mainly women, also engage in sexual acts because it provides a means of obtaining money or drugs. The smoking of base or crack causes an intensive, but short high. Craving, "the monkey coming down", occurs within five minutes. Users want to continue getting high until the whole supply is gone. Once this point is reached women search for opportunities to give sex in return for another "hit". The most common form of sex while getting high on sex is called the "double master blaster" (Friedman et al., 1988): a woman performs oral sex on a man and he smokes some crack when he starts feeling that he is reaching an orgasm or when he gets strong sexual feelings. A "master blaster" refers to the crack, the "double" refers to both a drug and sexual high. Through these sexual activities, STD, including HIV, can be transmitted among the users. Female crack users frequently have sex with multiple partners, without practicing "safe sex". The possible relationship between sexual acts among crack users and the transmission of HIV will be discussed more extensively later.

### Summary

In this chapter a brief description is given of the characteristics of the female prostitutes upon which this dissertation is based, and of "Northeast", the area where the women live and work. Since prostitutes form a "hidden

population" it is hard to determine if this sample of prostitutes is representative for the prostitution population, elsewhere or in the region.

Although all respondents are involved in "the Life", there are differences, e.g., based upon setting and status. Differences among street prostitutes, women working out of a house of prostitution and call girls are presented. Next, interactions of the prostitutes with others, e.g. pimps and customers, were described as well as violence the prostitutes may encounter.

The majority of the women are not only "sexworkers", but also drug users (72.5%). The overlap between the worlds of prostitution and drug use is discussed, as well as are the dynamics of the links between these two worlds.

## CHAPTER THREE

### OCCUPATIONAL TYPES IN THE WORLD OF PROSTITUTION AND DRUG USE

#### Introduction

While in the previous chapter more general characteristics of the study participants are discussed, the focus of this chapter will be more specific. The interviews with the women revealed two salient dimensions for their careers: (a) involvement in drug use, and (b) length of involvement in prostitution activities.

As already mentioned, drug use is trichotomized into intravenous, non-intravenous and no drug use. The length of time involved in "the Life" is operationalized into less than and longer than five years. The variable ethnicity and form of prostitution are excluded from the analysis due to the over-representation of blacks (80%) and street prostitutes (84.2%).

Analysis of variance revealed significant differences among the types regarding their age, the age at which the women self-identified as prostitutes, the number of sexual partners during the last five years, geographic mobility, the rate of violence related to their work, and for the drug using prostitutes the age of first drug use and the path into the worlds of

prostitution and drug use. The analysis will be further discussed after a description of the six types of prostitutes is presented in Table 3.1.

**Table 3.1: Occupational Types in the World of Prostitution and Drug**

DRUG USE CATEGORY	TIME INVOLVED IN PROSTITUTION	
	less than five years	longer than five years
mainly intravenous (IV) drug user	Type 1: "the syringe user" (N=29)	Type 2: "the more experienced IV drug using prostitute" (N=39)
mainly non-IV drug (cocaine) user	Type 3: "the non-IV cocaine user" (N=9)	Type 4: "the more experienced non-IV drug using prostitute" (N=10)
non-drug using prostitute	Type 5: "the beginning prostitute" (N=21)	Type 6: "the more experienced prostitute" (N=12)

**Type 1: Thee Syringe User**

All type 1 women, with the exception of one study participant of this type, were using drugs prior to entering the world of prostitution. The life histories of these women support the hypothesis that drug use precedes prostitution. Before becoming a substance abuser these women all report having used

alcohol, marijuana and "pills", mainly benzodiazopines. They were already part of a drug using subculture and were familiar with the "street life". The time between their experience with these drugs and the first time they injected drugs varies from less than a week to several years. No trend was apparent which indicated that a certain time period was more common than another. The main reasons the women began injecting drugs were curiosity and peer pressure. The tolerance level for drugs of new users is lower and they need a smaller quantity of drugs in order to achieve a high, thus their drug habit is cheaper. Many of them, like ten of the prostitutes, began as weekend users. Once they used drugs for a longer period of time and started using more frequently they learned that injecting drugs was most cost effective. If a user injects drugs the quantity needed to get high is smaller. At the same time, by observing and talking with other users and through their own experiments, the women became familiar with the special effects of injecting drugs. Topsy, an addicted prostitute, started using drugs at the age of sixteen and injected the first time when she was seventeen years old:

I always looked forward to the weekend. Together with Terri (her girlfriend) I would buy drugs for the weekend. The place we went to had heroin...Everybody was using it. We snorted and one night tried skinpopping. Terri couldn't stand it and quit. We are no longer friends. I used more than anybody but didn't get as high...I started shooting up. It feels great. I feel like I wasted grams in my nose.

All women mentioned that the longer they used, the more drugs they needed to get high. Three women were in the "fortunate" position of having a boyfriend who was a dealer who supported them. They had what the prostitutes called a "home habit". The others were forced by the expense of their addiction to start earning money through illicit ways like shoplifting, fraud, larceny and drug dealing. They all knew about women who were prostituting themselves to support their habit, and remember how they kept on believing that they would not end up "turning tricks". In the end, however, they all are women became involved in prostitution.

The average time between their initial drug use and their first prostitution activity for the type 1 prostitutes is eight years and three months. Their entrance in the world of commercial vice took place in stages. The women reported that they would only exchange sex for drugs on those occasions when they were feeling desperate. Topsy again:

I always looked down on street ho's and swore myself I would not turn tricks. I busted my ass boosting (shoplifting)...They knew my face and I got busted all the time. I was hanging out and a guy offered to pay me if I would do it with him...I took me awhile to realize it, but I am a ho.

Gradually the type 1 women got more involved in prostitution activities in order to support their drug addiction. The eleven women who already had an intimate relationship with an intravenous drug using partner ended up not

only supporting their own habit but also his. Six women developed a relationship with a male IV drug user after they were already working as a prostitute. They met their partner in the area where they were working and copping. One of them had a male partner for three years during which time he tried to get her off drugs. He gave up once he discovered she was also working as a prostitute. Of the remaining twelve women, six have a relationship with a non-IV partner, and the other six do not have a steady male partner.

#### Type 2: The More Experienced IV Drug Using Prostitute

Twenty-three of these women used drugs prior to their involvement in prostitution, eleven worked as prostitutes before they started using drugs, and five became engaged in both activities at approximately the same time.

Those women who were prostitutes before becoming drug addicts entered "the Life" because of curiosity. They wondered about commercial vice and were attracted to it by the amount of money that they could make in this profession. Prostitution is intertwined with other subcultures, of which the world of drug users is one. Drugs were available for the women and they had adequate money. Being part of the "street world" almost naturally led them into drug use, especially intravenous drug use. Judy, one of the prostitutes who worked for three years started using drugs, remembers:

I had several friends who were prostitutes and they kind of introduced me to it. They did not do any drugs, and we would always make more money than the other girls on the block...I made so much money, you wouldn't believe it. I could party forever...I got into drugs. You could buy some real good stuff and since I knew most of the guys [drug dealers, C.S.] I could get good quality. They don't fool me. I started with cocaine...I mainly shoot up speedballs. You have to understand, if you are out here it is so easy to end up at this point...I know, my friends still don't do drugs. This is not common ... Besides that, it might still happen to them. They have a man who cares, but who knows what the hell will happen once he is gone.

Nine of the type 2 prostitutes had a professional relationship with a pimp until he discovered she was "shooting up". Stone, the pimp of Judy's friends, points out:

You have to understand one thing: the ladies have to produce to be mine. I make some nice dough, but I take care of them. You know, a hug, a present, some attention...You have to make them need you. Some suckers don't know what they are doing. She controls him. Ain't that a shame.

Pimps do not trust women who inject drugs and the women also become less valuable in their eyes because they look less attractive and spend money on drugs. As a consequence they make less money. These women move quickly from the world of professional prostitution into the world of drugs and less professional prostitution. Compared with women who were addicted prior to their entrance in "the Life", they are, however, still considerably more professional. They try to have more regular customers, refuse customers they do not trust or who have strange requests, use condoms more often, are less frequently arrested and are twice as (geographically) mobile.

Similar findings are reported by James (1976) and Berg and Blom (1986).

The situation of the women who used drugs prior to their prostitution activities or got involved in both at the same time, is similar to the situation of women of type 1. There are, however, some differences. The time span between first intravenous drug use and first prostitution activity is 3.9 years, which means they entered the "life" twice as fast. The major explanations for this are the fact that they were less successful earning money through other illicit activities and the fact that their boyfriends tolerated their prostitution activities. They (N=27) were twice as often as the type 1 women (N=11) to be introduced into IVDU by a male partner, and twenty-four of the women have a steady relationship with an IVDU man. Most of these men are both boyfriend and pimp and they live off the earnings of the women. The women deny this and emphasize the emotional bond between them and their partner. Baba, one of the women with a boyfriend, describes the differences between a boyfriend and a pimp.

If your old man allows you to work part-time he is for real. A pimp wants you out every minute and is only interested in the bread. My man sees me first and then the money...We always share. What more can I ask for? He loves me.

Titia works for a pimp, and she stated she never would work for a so called "boyfriend".

I like my relationship with Torro (her pimp, cs). We know what to expect from each other. We do business together. He tried to built a stable, but the girls were not interested. We do not want to be his lovers, we are his ladies. Of course, we'll do it once in a while...I never would have a guy sent me out in the street because he can't support his habit. I love Torro, a and would not want to work for somebody else. Pimps really care, those other guys abuse women. All they think of is drugs. They know they have to be careful otherwise they might lose their money machines. That's why they act like wimps.

For the type 2 women their relationship with a man plays a more important role than for the type 1 women. The type 2 women primarily identify themselves as drug users and not as prostitutes. Although they have been involved in prostitution activities for over 5 years, they are not more professional than the women who have been working a shorter period. The main distinction is between women who first used drugs and then became prostitutes or women who followed the other route.

### Type 3: The Non-IV Cocaine User

With the exception of one woman, these prostitutes all used drugs before they started working as a prostitute (the average difference in time is 5 years). Their favorite drug is cocaine, which they freebased or smoked as crack. As already mentioned, cocaine is known to cause sexual arousal and it is not unusual that users engage in sexual activities with each other. Exchange of sex for drugs is inherent to the situation and it is not uncommon for women to offer their body in exchange for "free" cocaine powder or an already prepared rock of crack.

While the women in reality already work as prostitutes, they do not define their sexual activities as such, and do not realize that they are involved in prostitution until the moment they start having trouble finding customers among the visitors of a certain "crack spot". Beeper smoked cocaine for two years before she realized what she was doing:

If a guy offers you a few lines or a hit for free you want to show respect. He might ask you a favor and you go for it. Some girls also flirt with the guys hoping they get some of his dope. It comes from both sides... You try not to get into it, but I don't know many bitches who never got desperate... It gets on your nerves... It took me long before it dawned on me what I was getting into. You don't have to hustle tricks outside, besides that...Once they are used to your cute face and know you are not going for everything [every requested sexual act, C.S.] they turn you in for a new one.

As Beeper already mentioned, "new faces" have less trouble finding male drug suppliers. Frequently these are women who only recently started using drugs and as a consequence need a smaller amount to get high. Novices in the scene are also less likely to refuse a request from one of the men, because they do not want to lose their contact and are not familiar with the rules of the place. Three other women, like Beeper, were exchanging sex for drugs for about two years before they realized they were prostituting themselves. They all had their first customer in a crack spot, and continued to recruit customers who would be users like themselves. Nancy is one of them.

I never used any drugs. It never was my cup of tea... I need to suck on the pipe until I almost get a heart attack. I have a pussy and that helps. I used to turn tricks at Jay's [a crack spot, C.S.]. He always had guys over who wanted to share some cloud for a good head... You won't believe this, but I didn't see I was a ho. One girl called me a whore, and we got in a fight... That is when I realized it...

Once the women realize the situation, they try to avoid reality by smoking more crack. They end up in a vicious circle, and are forced to break through this once they cannot find male customers who are willing to support their habit. They had to expand their recruitment territory. Two women moved their operation to another crack spot, three women were referred to potential customers by their dealer and the other four women started recruiting customers in areas known for prostitution activities. These women all work part-time and "turn tricks" only when they need money to buy cocaine. For them it is less usual than for the women of type 1 and 2 to support a boyfriend's drug habit. They work for their own habit. They are also not linked to a pimp. At the moment all nine are more involved in the cocaine scene than in the world of prostitution. Once they get more involved in prostitution chances are this might change, as was the case for women belonging to type 4.

#### Type 4: The More Experienced Non-IV Drug Using Prostitute

Five of these women worked as prostitutes before they started using drugs, while five other women already used drugs before they got involved in prostitution activities. The position of the latter is comparable with the one of the women of type 3, although

these women are in "the Life" longer. They were mainly freebasing cocaine, since crack was not a well-known and popular drug until the mid-eighties. Also, crack dens did not exist. They smoked in the company of other cocaine users and had to support an expensive habit because of the higher prices and the luxurious lifestyle associated with cocaine use at that time. Cocaine could only be purchased in relatively large quantities, compared with the small amounts sold today in crack vials. After the female cocaine users exploited all the possibilities to pay for their drugs, they realized that prostitution activities were their last resort. Due to their drug use they ended up working on the street. In this ambience most drug use practices are intravenous, and the temptation to start injecting drugs themselves increases. During conversations with the type 4 women, they mentioned that this had happened to a few prostitutes. Although this is only a speculation, the same could happen to the women of type 3 once they get more involved in prostitution. Recent research (Friedman et. al. 1988) alerts us to this. Freebasing and/or smoking crack are hard to combine with prostitution activities, due to the side effects of the drugs (activity, nervousness, paranoia) and the paraphernalia needed; it is not easy to cook powder and walk around with a pipe and stem. Squeezie, one of the crack using street prostitutes, loves to tell stories about this.

Man, Scottie does not want to be out on the street with you. I like to smoke the pipe, but you just cannot do it. If I have to go out to turn some tricks I'll smoke at home until I am a zombie and I'll take a few spicy joints with me... How the fuck can you walk on the street and carry powder, baking soda, a stem, a

lighter, a pipe, water and all the other shit you need... I don't smoke stuff that is cooked up by somebody else. But even if you could take your store out on the street, you don't know what to do if the monkey comes down your back. You'll be crawling over the floor and might forget you are with a trick... I always bite my lip when I'm with Scottie. I try not to do it...On the subway people look at you if you cannot stop chewing your lips. They might do it themselves and you can tell if somebody else does it. Think about this, I could chew a trick's dick off. As they say, you have to stay inside with the monkey...Scottie wants you to pay attention to him, and you cannot do that if you are turning tricks. If I would have my pipe with me that's all I could think about.

One of the women who worked as a prostitute before using cocaine mentioned that she tried cocaine out of curiosity, while the four other women got cocaine from their pimp or one of their customers. Gradually they developed a cocaine habit. Mo, one of the women whose pimp gave her cocaine, ultimately became a poly drug user:

I like good things and lots of money. That's what brought me to work for X (escort service). I knew my old man was using cocaine and once in a while he would give me a few lines. He loved it because I would take and wouldn't mind extra johns...I would supply cocaine for them, through my man, if they asked for it... You also stay slim, because you don't eat... Things got out of hand because I used too much. The service and my man dropped me...A high doesn't feel good if you are out on the street. Those girls nodding their heads drive me nuts...it seems that smack makes life easier.

#### TYPE 5: The Beginning Prostitute

The women belonging to the last two types differ from the other women because they do not use drugs. They, more than the addicted prostitutes, see their prostitution activities as

professional work and not a "hustle to get drugs". Their main motives for entering "the Life" are curiosity and financial attraction. They tend to work for a pimp, who is not their boyfriend and who has more than one "lady" working for him. The relationship between these women and their pimp is rational rather than emotional. At the same time, however, they all mention having sex with their pimp and hope that one day they will be his only woman. Goldcurl is one of them, and she continues hoping to become her pimp's only "lady".

He has six women. I always get extra attention, and I try to make more money than they do. Their relationship with him is like he is their boss. He still is my boss, but we have more...One day I'll be his, and he won't send me out again. I have to be patient. One time I pushed for this, but he got pissed. I had to suffer for a while. He would ignore me...I thought about leaving him, but I just cannot.

Three prostitutes are disappointed because their pimp did not keep his promises and they mention that they want to leave him. Two of them are still planning but do not take action, while the third woman came back after three weeks because she missed his attention. Her pimp also kept all her money after she left him. As she puts it: "I had to start from scratch. I'm not gonna go through that".

Among non-drug using prostitutes the drug using peers have a reputation of not being very selective with their customers and the services they provide. Also their prices vary. The

price is relatively low and the selectivity with customers becomes less as the craving for drugs grows stronger. Non-addicted prostitutes, on the other hand, charge higher prices and are more selective. Their standards can be higher because, in general, they look more attractive than their addicted colleagues. Their potential to earn money by prostituting themselves is higher. Non-addicted prostitutes also ask additional money from a customer if he wants to spend more time than arranged and/or want to get paid for additional services. The main complaints of these prostitutes about their drug-using peers is that they disturb the market. Half of the non-addicted prostitutes mentioned that they sometimes feel like trying drugs themselves. Jessica is one of them.

You know it is really hard. I want to have class and do not want to be in the gutter. It drives me up against the wall. Those bitches make life impossible for us. They get high and do whatever a john asks them for. They are too high to keep track of the time... The johns know this and look for a girl who looks decent but is going to be his slave... It is bad enough for a girl like me. I know I should not be out here. I could have a job and maybe be married... I think about taking drugs. You don't know what is going on and get less upset. They say it makes you enjoy life. I know where to get some good dope... If I only knew I would only use it if I needed it...I don't want to become one of them hoodlums.

Most of these prostitutes have enough money to pay for drugs and drugs are easily available all around them. They, as Jessica indicated, might end up in one of the drug-using categories, and gossip about those peers who became drug users.

#### TYPE 6: The Experienced Prostitute

The situation of these prostitutes is similar to the type 5 women, with the exception that they have been working for a longer period of time. They also have accepted the fact that they will be working for a pimp. The difference between the type 5 and 6 women is that fewer type 6 women have plans to leave their pimp, and their expectations of one day becoming the pimp's "main lady" are gone.

Most of the type 6 prostitutes do business with regular customers. They provide a steady income for eight women who feel "settled" in "the Life", the other four women have also irregular and new customers. All twelve women, like Gina, mention that they hope to leave prostitution and get married, buy a house and have children.

I have been working for years and still haven't saved enough money. I'm trying to save as much as I can. The problem is that I have regulars and they don't want to hear about a higher price...Everything else is getting more expensive. I always thought that by now I would be married, have a baby and live in a nice house with a yard. I love the country, and every day I hate the city more. I've been dating a few guys, but things didn't work out...I don't want to be messing around with a pimp. A good john is the best deal. They know who you are and that makes life easier. I have been too aggressive with one guy I like. I need to give him more time...I don't want to run out of time. I'm almost thirty-five and it's not good to be too old when you get a baby.

The future perspective of most of these women is conventional. They look forward to the days of being "nice housewives".

The type 6 prostitutes complain more than their younger drug free colleagues about the drug-using prostitutes. The gap between both worlds is wide and the experienced prostitutes refuse to talk with a "dope ho". This can cause tension between the women if the pimp of the non-addicted prostitutes supplies drugs for the drug using women.

Comparing the types

It should be clear that the position of a prostitute in a certain cell is not fixed.

**Table 3.2: Characteristics of the Prostitutes by Type**

TYPES	CHARACTERISTICS			
	age	age self-identified as prostitute	number of sexpartners last 5 years	mobile* (%)
Type 1	32.6	28	1,974	37.9
Type 2	33.9	24	10,305	51.3
Type 3	30.4	24	2,472	33.3
Type 4	33.2	26	5,109	50.0
Type 5	28.3	24	1,387	38.1
Type 6	33.2	23	4,211	58.3

\* This refers to the geographic mobility of the women and is based upon the question if they ever worked as prostitutes in one or more other cities.

The non-addicted prostitutes who have been working for five years or longer are seen as the most successful by in- and outsiders and are in the most respected and stable position. Tables 3.2. gives an overview of the characteristics of the prostitutes by type.

The prostitutes can move from one type to another, with the exception of a shift from longer than five years in "the Life" to shorter than five years (from type 2, 4, or 6 to 1, 3, or 5), or a shift from drug using to never used drugs (from type 1, 2, 3, 4, to type 5 or 6). As already mentioned, a major shift would be from non-intravenous drug use to intravenous drug use or from no drug use to drug use. More recently, due to the AIDS epidemic, more intravenous drug using prostitutes have started using drugs non-intravenously, because they realize the danger of injecting drugs, while needles are shared and not cleaned.

The non-drug using prostitutes (types 5 and 6) are 1.8 years younger than the other prostitutes, who all use drugs ( $F=3.9$ ,  $p<.05$ ). Those prostitutes who self-identified themselves as entering "the Life" less than five years ago (types 1, 3, and 5) started their prostitution activities at an older age than those who have been working longer than five years ( $F=10.6$ ,  $p<.01$ ), and the non-drug using prostitutes, who have been working for a period of time longer than five years

(type 6) started at the youngest age ( $F=4.6$ ,  $p<.01$ ). The number of sexpartners during the last five years is higher among intravenous drug using prostitutes (Types 1 and 2) than among the others ( $F=3.6$ ,  $p<.05$ ).

**Table 3.3: Characteristics of drug using prostitutes**

TYPES	CHARACTERISTICS	
	age first drug use	from drugs to prostitution
Type 1	19.3	28 out of 29
Type 2	20.4	28 out of 39
Type 3	21.1	3 out of 9
Type 4	23.5	5 out of 10

Intravenous drug using prostitutes started using drugs at a younger age than the others, and twice as many (83% versus 42%) intravenous drug using prostitutes were using drugs prior to their entrance in the world of prostitution than non-intravenous drug using prostitutes. Unfortunately, data are lacking but this could be an indication of the short period of time between drug use and prostitution activities for the non-intravenous cocaine using women. Type 1, 3, and 5 women worked longer than 5 years and were more mobile than their senior colleagues ( $F=2.6$ ,  $p<.01$ ). The non-drug using prostitutes reported greater mobility than drug using women, although the difference is not statistically significant.

## CHAPTER FOUR

### PROSTITUTES AND THEIR REPRODUCTIVE FUNCTION

#### Introduction

Linda, a street prostitute, who began working five years ago at the age of nineteen, does not remember having to deal with serious health problems. She has two children, both of whom were wanted by her and her boyfriend at the time. She has never had an abortion or miscarriage. Linda is known to be concerned about health issues. She constantly warns everybody to live healthy lives, and thus her nickname on the "stroll" is "Mother". She offered these thoughts in one of the conversations with the researcher:

You only have one body and you better try to keep it in good shape. You only can make it if you know how to stay healthy. This is true for everybody, but especially for people like us. As a hooker you have to deal with a lot of BS [bullshit, C.S.] and there is always stress... Straight people might put us down, but they would not be able to deal with all this shit themselves... On top of that, we are women and have to deal with getting our period and if you don't get your period, you probably get a child.

Linda already indicated that being involved in commercial vice puts a burden on one's health condition. In this chapter the focus will be on the prostitutes' reproductive functioning. During the formal interview process the prostitutes were very closed about giving any additional information about issues

related to their reproductive function. In depth background data were mainly gathered during informal conversations when the prostitutes were more candid about their problems. During these conversations the women would elaborate about such topics as their menstrual period, abortions, pain and depression. Although most of the prostitutes mentioned some minor health complaints, they saw themselves as essentially healthy persons. Unfortunately, due to lack of data, no formal comparison with non-prostitutes and non-drug using females from the same socio-economic strata was possible.

#### Health status and social-economic class

With the exception of less than twenty women, the majority of the prostitutes were from the lower socioeconomic strata. Studies from the beginning of the 20th century already indicate a relationship between one's socioeconomic status and (mental) illness (Faris and Dunham, 1939; Hollingshead and Redlich, 1958). Life chances for the poor are limited compared with those of the rich. The poor are more likely to have unhealthy lifestyles and are, therefore, in a more vulnerable position (Waitzkin, 1983). Social inequality as well as the related health differences continue to exist between the social classes (Susser et al., 1983; Cockerham et al., 1988). Several reasons can be given for the reduced life chances of the lower socioeconomic strata. First of all, growing up in the lower class is concomitant with poorer nutrition, which has adverse consequences for an individual's

health status. A balanced diet is indispensable. Belonging to the lower class very often also means leading a "tough" life involving hard physical work in irregular shifts. This kind of occupational labor places more a burden on the poor. Members of the working class also continue working until retirement age, because they can not afford to stop working. They have little job security. Serious illness may result in unemployment. They have inadequate or no health insurance. The United States is the only industrialized nation in the world that does not provide financial coverage of the medical care for a majority of its citizens. Medical care, although programs like Medicaid and Medicare exist for the poor and aged, is more a privilege than a right (Cockerham et al., 1988). Finally, the poor are very often less prepared to deal with the medical system. Summarizing, there are many barriers for those who live under poor circumstances. The prostitutes, due to their position, face the same barriers. In addition, they have to deal with the stigma of being a prostitute, which places them under even more severe physical and psychological pressure.

#### Issues related to reproductive health

##### **MENSTRUAL PERIOD**

As is true of all women the prostitutes' menstrual period can interfere with their sexual activity. For some women their menses cause more problems than for others. A key issue is the regularity of the menstrual cycle. While one group of women knows exactly when their menstrual period will commence, others can not

anticipate the onset of their menstrual period. Knowing when to expect their menses is an important facet in the lives of sexually active women. It is typical among the prostitutes not to talk about their menses as a serious matter, but to tease, if they talk about the subject at all. They all know they have to deal with the same reality, but it is an unwritten rule not to talk about this. Similarly, as already mentioned, informal norms prohibit expression of ones (sexual) feelings with a customer. One-third of the prostitutes reported an irregular menstrual cycle. According to them, this irregularity may be due to stress caused by their profession, or due to their drug use (Gaulden et al, 1964; Blinick, 1971). Two prostitutes reported no longer to menstruate, and thought this is due to their age (43 and 47 years). They were kidding about being in menopause and emphasized that the cessation of their menses does not imply the end of an active sex life. Nilda is one of them, and she noted:

I am getting older and I'm in the years in which women can go crazy easily [menopause, C.S.]. I don't get my period any longer, and I love it. It makes life a hell of a lot easier. I can tell you that. Most girls think you can't be good anymore, if you get my age and don't get your period...I love it. Those hormones used to mess me up. I don't have to deal with that part any longer. And believe you me, sex still feels good. I get dry more often, but if you get too dry, you use KY [a lubricant, C.S.]. I'll be out there for a while. Young girls look at us as old bitches that don't function, but they'll learn.

An issue related to this is having vaginal intercourse during the menses. Anecdotal reports indicate that different opinions exist about having vaginal intercourse during menses. Some people

refuse to have intercourse during this time, while it does not matter to others. In general, most people do not like to see blood. These negative feelings might even become stronger if the blood is associated with a female body and sex.

The respondents were asked about their sexual activity during their menses. The majority (83%) never had intercourse during this time, although, this does not mean that they do not work. They develop strategies to be able to continue their sexual activities, as one of them tells us:

You must be a woman to raise this issue. Yes, it is a problem. I don't want a mess, and most tricks don't like the idea either. You understand? People are afraid of blood. I think it is disgusting to do it while you have your period...but I also need the money. Nobody is gonna give money to me because I've my period. I learned from another girl what she did: start giving a blow job, and while he is still talking of fucking, go on sucking his dick and most of the times he'll come. One time it happened to me that a guy didn't want to pay because I had my period.

The prostitutes were asked about having vaginal intercourse during their menses in general and about their own sexual activities during this period. The responses did not vary among the types distinguished in the previous chapter. Nineteen prostitutes reported vaginal intercourse with a customer and twenty-seven with a non-paying sexual partner during their menstrual period. Half of them use a prophylactic while having sex. Rat Lady has mixed feelings about all this.

I don't know...I need the money, and my old man and I make love every night. He needs it, since I'm fucking guys all day long. It's a sign of my love for him. I don't always like it... I hate to see my own blood on a trick's dick and I tell him to use a rubber. Some tricks want a blow job if you tell them. I always carry a towel with me.

Having their menses caused problems for those women working in one of the brothels in which the policy was that women would not come in if they were menstruating. They would not get paid during these days, and as a consequence would lose income. In another brothel the women were not allowed to stay home because they had their period. They were expected to come in and work. If a customer requested to have vaginal intercourse they had to inform him about their condition. Did he still wish to have sex, then they had to perform in whatever activity he requested. The majority of the women in this brothel had regular customers. Their manager, an older woman who used to be a prostitute in her younger years, told the researcher that most customers knew the girls well enough to know their menses cycle. Some men would ask for another girl if their favorite one had her menstrual period, while other men did not mind having sex during this time. The manager was convinced that some of the customers liked having sex with a woman while she had her period, mainly because their own wives would not be willing to engage in sex while they were menstruating. Queenie, who works in another brothel, tells us:

You are not supposed to say no to a john. He is the one who pays and sets the rules. We have to satisfy him and make him come back. I have a steady cycle and I'll take four days off after I've been working for ten days, but not every girl can do that.

Compared with women working in a house of prostitution, most call girls are flexible in their working hours and work part-time, and this makes it easier for them to schedule their lives around their period. One call girl arranged with her agency to be able to answer the phone during the days she has a period. Also street prostitutes prefer to continue to work during their menses, because they do not want to lose income. In general, the prostitutes try to substitute oral sex for vaginal intercourse.

Menstruation not only has a physiological, but also a psychological impact on the females. Some women face a period of neuro-endocrine imbalance, which causes feelings of depression, anxiety and guilt. Others feel unstable during the days before their period, and this phenomenon is called the Pre-Menstrual Syndrome (Friedman, 1982).

#### **CONTRACEPTIVE METHODS**

The availability of more effective birth control methods allowed women to separate their reproductive function from their sexual activities. The most drastic procedure to avoid

pregnancy is sterilization. Thirty-nine of the prostitutes had a laparoscope or tubal ligation. No statistically significant differences were found among the six types distinguished in Chapter Three. Almost half of the respondents (40.8%) did not use birth control methods during the past five years. Of those women using contraceptives the primary method, with paying and non-paying sexual partners, was condoms (50.7%), followed by the pill (16.9%). The other women mentioned using an IUD, a cervical cap, a post-coital douche, a sponge (5.6%) or a combination of these methods (26.8%). These percentages do not represent consistent use of the particular birth control method.

The use of contraceptives is not always without negative side-effects. Those who take oral contraceptives complained about weight gain, headaches, and depression. They also disliked the fact that they, like "sick patients", needed to take a pill every day. Those women who used an intra-uterine device mentioned that this caused bleeding and infections. Those using a cervical cap or diaphragm disapproved of this method because of difficulties with the insertion and removal. Post-coital douches, foam, jelly or sponges are formally not considered contraceptives and are not appropriate for prostitutes because they engage in multiple sexual encounters in a relatively short period of time.

The general opinion of the prostitutes is that the existing contraceptives are not satisfactory. Prophylactics are the most frequently used birth control method. Sixty-five percent of the prostitutes answered that they used a condom at least one time during the past five years. In Table 4.1 the number of months condom use has been reported during the last five years is presented.

**Table 4.1: Frequency of Number Months Condom Use**

NUMBER OF MONTHS	FREQUENCY	PERCENT
never	41	34.2
less than one month	1	0.8
between 1 and 12 months	16	13.3
between 13 and 36 months	24	20.0
between 37 and 59 months	8	6.7
60 months (all the time)	30	25.0

mean=25.3; SD=24.4

Table 4.1 shows that one fourth of the prostitutes used a condom all the time during the last five years. There is no peak of number of months that condoms are used. The standard deviation of 24.4 indicates a great variability in the number of months condoms are used. The data in the table do not imply consistent use of condoms. The use of a prophylactic depends on the nature of the relationship between the sexual partners and their respective attitudes. Condoms are used with steady non-paying sexual partners for birth control, however, they are also used to prevent STD with paying sexual partners. Sixteen

prostitutes stated clearly that they did not like to use a condom, but more frequently they mention resistance from their partner. Men tell them that they only want the "real thing". Customers do not want to use a condom because they feel they are being "ripped off"; they are paying for sex and want it their way. Non-paying partners do not want to use a condom because it creates distance. They prefer the women to use a condom during their work, but not with them. Almost all prostitutes report arguments with partners about the use of condoms as well as discussion with their colleagues. The opinions about condom use vary as much as in society in general. A more detailed discussion follows at the end of this chapter, when the focus will be on "safer sex practices".

#### **PREGNANCIES**

As already mentioned, one of the main reasons for women in general, including prostitutes, to use contraceptives is to avoid pregnancy. The risk of becoming pregnant concerns the prostitutes much more than anything else. Having children changes the life of every parent. The impact increases if the pregnant woman is single and has a professional life. Prostitutes have their (illegal and stigmatized) work to do, rarely have a steady income nor are they generally involved in a stable relationship with a man. All this causes complications. Despite the consequences of pregnancy all but eleven respondents consider it important for a woman to become pregnant at least

one time in her life. Having children or being able to bear them is seen as a sign of being a "good, productive" woman.

Sammy tells us:

I know what you are talking about. I am a working girl and I know that one of these days I want to leave the life. I want to have a family and enjoy life. I had three serious relationships but the men left me. That happens all the time. There are not enough men around... It is important for a woman to get a man attached to her. If you have a child by him you always have a tie. I think all those methods are bad for your body and I do not want to take a chance of not being able to have children anymore. A real woman needs to have kids.

Four of the prostitutes were never pregnant, while half of them (50.1%) had between one and three pregnancies, 41.6% between four and ten and six women were pregnant more than ten times. Table 4.2 shows the number of pregnancies and the number of deliveries among the six types of prostitution.

**Table 4.2: Mean number of Pregnancies and Deliveries among the Prostitutes**

TYPES	Pregnancies	Deliveries
Type 1	3.9	2.9
Type 2	4.1	2.6
Type 3	2.0	1.8
Type 4	2.7	2.5
Type 5	2.9	2.5
Type 6	5.6	4.4

The average number of pregnancies among non-addicted prostitutes is slightly higher, although not significantly

different, than the average among drug-using prostitutes (4.3 versus 3.2; data not shown).

#### **ABORTIONS AND/OR MISCARRIAGES**

Pregnancy does not necessarily have to result in the birth of a child; abortions and miscarriages are common among the prostitutes, as shown in Table 4.3.

**Table 4.3: Frequency of abortions/miscarriages**

NUMBER ABORTIONS/MISCARRIAGES	FREQUENCY	PERCENT.
never	57	47.5
1	31	25.8
2	15	12.5
3	7	5.8
4 or more	8	6.7

missing cases 2  
mean=1.05; SD=1.5

The rate of abortions/miscarriages does not differ statistically by type of prostitution. The prostitutes were more willing to talk about miscarriages than about abortions. The latter is a more sensitive issue. Most of the women who admitted an abortion had an illegal abortion, done by unqualified persons whose lack of skills can cause infections and sometimes even death.

As might be expected, the prostitutes feel very different about becoming pregnant by a boyfriend or a customer. One prostitute had a child fathered by one of her customers, whom

she does not know by name and has not seen since their only encounter. Two other women suspect that a customer might have made them pregnant, but are not sure. Seventeen prostitutes mentioned that the reason for an abortion was the fact that they were unsure of the father.

#### **PROSTITUTES AS MOTHERS**

Related to this is the situation of prostitutes as mothers. With a few exceptions (7.5%), the respondents all have one or more children (mean=2.7; range 0-9;). The analysis of variance did not detect a statistical significant difference between the prostitution categories. The children delivered by one prostitute do not necessarily have the same father. Actually, three-fourths of the women (N=83) delivered children from more than one man. As already mentioned in talking about pregnancies, the reality of being a mother is more complicated for the prostitutes than for other women. Prostitution activities, managing a household and taking care of children are difficult to combine. In order to cope, those prostitutes who have a relationship with relatives, most notably a mother or sister, seek their help. Squash, a street prostitute without a steady male partner, and the mother of a five year old daughter and a three year old son, gets support from her sister.

I don't know what I would do without my sister. She does not have a man either, but she knows better than I how to manage life. She has three kids herself, her baby boy is as old as mine. She gets up in the morning, brings them to the day-care center and picks the kids up. I don't know how she does it. She is on disability and

gets a pay check from them. I have to hustle...Yeah, she is an angel. I can't manage a household. I go and see the kids at her place. We are planning of moving into a new apartment were we can live together. The kids would love it.

Many prostitutes have no one to assist them. Recently the prostitutes started organizing a system in which they care for each other's children. Once the children get older, the women's schedule became more flexible, and they try to work while the children are at school or sleeping.

Most prostitutes do not want their children to know about their work. This concern grows as the children get older. Most feel that a child should not have to suffer because their mother works as a prostitute. Nearly all prostitutes who are mothers, of which Ruth is an example, plan to leave the "life" once their children are older.

I still want to leave "the Life". I was hoping to stop working when the baby was born, but I couldn't make it. I'm saving every penny, and sooner or later I'll be able to get us out of this mess. I should have waited with my first baby, until I had enough money. I should quit drugs, and use that money for us. While I was pregnant and just after the baby was born I would do no drugs. I would turn tricks to get some money, but no drugs...I had to turn tricks, and just couldn't do it without drugs. Now I do both again...I have to get my act together before the baby gets older. You don't want a child to know his mother is using dope.

Children are viewed as a stimulus to change their life. Since these plans seldom work out in reality, this causes considerable frustration. Many of the females are not able to stop working as prostitutes, mainly for economic reasons. They

try to hide their activities and feel ashamed.

Related to this is the fear that they might lose their children. This fear was mentioned by the prostitutes more than any other problem. They fear that once the "system" learns of their sexual activities, their children might be taken away from them and placed in a foster family. More than fifty percent of the respondents mention having children living in foster homes or having lost custody of their children until they could prove to be taking life "seriously". Their husbands, boyfriends and pimps are aware of this fear and the women are placed in a vulnerable position, thus increasing their dependency. The men may threaten to inform officials or tell the children about their mother's activities. The men try to "buy" the children's sympathy by offering them presents. The money very often comes from the women. While some neglect was observed, it should be emphasized that the prostitutes generally feel responsible for the welfare of their children and they do everything possible for them. This is especially difficult for those women who are addicted. They have to buy food for the children but also want to buy drugs. They want to pay attention to their children, but get distracted by their craving for drugs.

## CHAPTER FIVE

### **PROSTITUTES AND INFECTIOUS DISEASES**

#### Introduction

The focus of this chapter will be on several infectious diseases common among the prostitutes, mainly syphilis, hepatitis B (HBV), and human immunodeficiency syndrome (HIV). The key questions are: "What are the seroprevalence rates among the respondents?", and "What can be said about the risk of transmission?" From a health care point of view, being involved in the world of commercial vice implies an increased risk of getting certain infections. More than half of the respondents complained about salpingitis and vaginitis. Nylon underwear and tight pants cause a burning irritation around their genitalia. The same kind of irritation can occur when the women use too much jelly, foam, sprays or other "cosmetics" to prevent an unpleasant odor. Also, urinary tract infections are not unusual. The most common infections are urethritis, cystitis and pyelonephritis. Some of the prostitutes attribute these infections to limited hygienic care and due to lack of shower facilities. Others who have bathing facilities, report irritated skin from taking too many showers. These discomforts and illnesses are viewed by the prostitutes as "professional" risks.

Throughout history a possible link between prostitution activities and the spread of STD into the general population has been debated.<sup>22</sup> One has to realize, however, that the main source of a prostitute's income, as already mentioned several times, is her sexual activity for which she needs a healthy body. The more healthy and the more good looking a prostitute is, the higher her earnings will be. She can not let herself contract an STD or infect her customers without hurting her business. As a consequence prostitutes are very concerned about STD, probably more than non-prostitutes who also are sexually active.

Syphilis and gonorrhoea are the most common venereal diseases. Gonorrhoea, caused by the bacterium *Neisseria gonorrhoea*, does not often show symptoms of infection. The usual signs for men are severe burning when urinating and a yellowish discharge from the penis. The symptoms are less visible for men than for women. Pharyngeal gonorrhoea, infection after oral-genital contact, can cause a sore throat. Diagnosis can be made with a bacterial culture that takes two days. In most cases an infection can be treated with antibiotics.

Syphilis is caused by *Treponema pallidum*. One of the first signs for both men and women, is an ulcer or sore at the site of infection. Syphilis can also be cured with antibiotics. Table 5.1 reports data on self-reported gonorrhoea and syphilis

infections among the study participants, and the results of the laboratory test conducted for syphilis (RPR, MHA-TP, FTA-ABS). The test results of 5 persons are not available.

**Table 5.1: Syphilis and Gonorrhea Infection among the Respondents**

NUMBER SELF-REPORT GONORRHEA		NUMBER SELF-REPORT SYPHILIS		RESULTS TEST SYPH.	
never	105	never	109	Neg.	96
1 time	12	1 time	7	Pos.	19
2 times	2	2 times	2		
3 times	1	3 times	1		
		6 times	1		

Four-fifths of the study participants reported that they never had a doctor or health care worker tell them they ever had syphilis or gonorrhea. If these data are valid only one-fifths of the prostitutes ever had gonorrhea or syphilis. There is a correlation between the data on syphilis infection by self-report and the laboratory results (Chi Square=8.1; df=3; p<.05). Multi-variate analysis did not reveal predictors for syphilis infection, although the rate of women with antibodies for syphilis was slightly higher among non-intravenous drug using prostitutes (26.6%) than among the others (16.9%). No significant association was found between time involved in prostitution activities and syphilis infection. The finding that syphilis infection might be related to crack use is also reported by others (Joachim et al., 1988; Rolfs and Cates, 1989).

More than half the respondents did not consult a doctor or visit a STD-clinic over the past two years to get checked for venereal diseases. The women are convinced that they are capable of identifying an infection. They also try to prevent infections by self-medicating with antibiotics they have purchased on the street.

Besides checking their own bodies for possible signs of infection, they also examine their customers for possible signs, and assess their personal hygiene. Occasionally a customer is refused by a prostitute because he is not "clean". Jackie summed up experiences in the following manner:

Some johns are terrible. If you touch their cock you can feel the dirt. I try to freshen them up and talk them into using a rubber...You can't always do that. It's even more trouble to tell them to leave...I'll try to use a rubber without telling him.

Prostitutes are sometimes accused by a customer of infecting him. The prostitutes feel strongly that they cannot be blamed for spreading STD. If one of them is known to be infected, her colleagues will not allow her to work. One of them, Randy, had second degree syphilis and continued working. She told her colleagues about her infection after she feared customer repercussions. She could not work until she had a doctor's note that she was healthy. Randy's colleagues stated: "We do not need this; we already have a bad reputation".

## Hepatitis B

Rates of HBV infection have been high for several decades, and are reaching an endemic high among blacks in the United States (Alter, 1989). In order to deal with this problem some scientists (Caterall et al., 1978; Alter, 1989) proposed treating HBV infection as a sexually transmitted disease. The prostitutes were asked if they were aware of any hepatitis infection (Hepatitis A, hepatitis B or hepatitis non-A, non-B) in the past and a sample of their blood specimen was tested for seromarkers for hepatitis B virus (HBsAg, anti-HBs, anti-HBc). Hepatitis B causes serum hepatitis, and this virus can be spread through blood and semen, e.g. blood transfusions and anal sex. Table 5.2 gives an overview of HBV infection among the study participants. The respondents were asked if they had learned they had hepatitis B from a doctor or a medical health care worker. The responses are presented in the column "self-report". The results from the laboratory test are presented in the column on the left. The laboratory test results of five respondents are missing, while four respondents did not answer the self-report question.

**Table 5.2: Hepatitis B Infection among the Respondents**

FREQUENCY		PERCENTAGE	BLOOD TEST	
SELF-REPORTING OF HEPATITIS B			FREQUENCY	PERCENTAGE
never	104	89.7	negative 35	30.4
ever	12	10.3	positive 80	69.6

Table 5.2 shows that many respondents were unaware they carried seromarkers for hepatitis; only 12 respondents were aware of a previous infection, while approximately seven times as many respondents are diagnosed with seromarkers for HBV. Logistic regression analysis was employed to determine which variables are predictors for seromarkers for hepatitis B.

**Table 5.3: Seromarkers for hepatitis B associated with Drug Use and Time involved in Prostitution**

	BETA	Std. Err.	Chi Sq.	p
drug category*	1.445	0.29	25.1	0.00
time in prostitution	0.506	0.50	1.0	0.5
intercept	-3.820	0.74	26.1	0.02

N infected=80; N not infected=35;

\*Intravenous drug use versus non-intravenous drug use and no drug use.

The analysis revealed that there is no significant association between time involved in prostitution activities and HBV infection. Among those women involved in "the Life" for a period of time shorter than 5 years, 81.9% showed seromarkers for HBV, while seromarkers were found among 83.4% of the prostitutes who had been working for a period of time longer

than 5 years. Among the drug categories distinguished a significant difference was found between prostitutes who never used drugs (infection rate 24.8%) versus drug using prostitutes (82.5%). No significant difference was found between intravenous and non-intravenous drug using prostitutes. This may be explained by the relatively small sample of non-intravenous drug users (N=19). No significant association was found between visiting a shooting gallery and sharing hypodermic sets and HBV infection. While seromarkers for hepatitis B among intravenous drug using women can be explained by the phenomenon of needle sharing, transmission among the other women occurs due to their sexual activities. The same is true for spreading HIV, which causes AIDS, as will become apparent in the next section, in which an extended discussion of HIV infection among the study participants will be presented.

### HIV infection

During the past century medical science advanced enormously, and by the middle of the twentieth century the Western world could not imagine having to deal with a new epidemic that could not be stopped. In the early 1980s a new infectious disease shocked the Western world. A "strange" virus killing human beings was discovered. The first HIV infected person in the United States was identified in 1970. Intensive research showed that the first case probably occurred in 1959 in Zaire, a Central African nation.

At first medical and public health experts found indications that the virus only spread among networks of homosexual men, and the disease was called Gay-Related Immune Deficiency (GRID). Infected men showed signs of unique and rare diseases like pneumonia caused by pneumocystis carinii, Karposi's sarcoma and toxoplasmosis (Schilz, 1987). In studying possible links between those infected individuals as well as ways of transmission it became clear that the disease was sexually transmitted and had a lengthy incubation period of up to ten years. Some persons only exhibited certain symptoms related to AIDS, and they are diagnosed as having AIDS Related Complex (ARC) (see Appendix D).

Early in the 1980s new groups were identified as at risk for HIV infection such as hemophiliacs, Haitians and intravenous drug users (Schilz, 1987). The virus is spread among intravenous (IV) drug users through the sharing of "works", especially needles and "cookers" (Battjes and Pickens, 1987). It is common among drug users that a syringe is used by somebody else after one person has injected the drugs. This needle can contain traces of contaminated blood of the first user. Chances of spread increase as more users inject with the same syringe. "Booting", the drawing of blood into the syringe to mix with the drug solution before injecting completely, further increases the risk of infection if the needle is used by another user. The injection of drugs which have been processed into powder form

requires them to be dissolved in water. Mixing takes place in "cookers", which are shared among users, and in which needles are emptied and filled. Research focussing on the dynamics of the interactions between the users and their actual behavior has increased (Des Jarlais and Friedman, 1988; Feldman and Biernacki, 1988; Mata and Jorquez, 1988; Wiebel, 1988). Without detailed knowledge about their behavior no effective intervention strategies can be developed to combat the spread.

IV drug users not only put each other at risk for HIV infection but also their sexual partners since the virus can be transmitted while engaging in sexual activities. These sexual partners are frequently not aware of the fact that they are at risk and are hard to include in risk reduction intervention efforts (Sterk, 1989). Also, cases of perinatal transmission (from mother to child) were identified during the eighties (Schilz, 1987). Simultaneously with an increase of groups identified as being at risk for HIV infection the fear of spreading the virus into the general heterosexual population grew tremendously.

Heterosexual transmission of the virus is related to: (1) A high frequency of sexual contact; (2) Sexual contact with multiple partners; (3) Engagement in high-risk sexual activities as anal sex, and (4) Sexual activities with partners belonging to a risk group (Piot, 1985). Since prostitutes engage in

high-risk sexual activities with multiple partners, who might be at risk themselves, they are seen as a possible source for the spread of HIV into the heterosexual population. This is not surprising since prostitutes were also considered responsible for the spread of STD (Brandt, 1988). In the case of transmission of HIV, however, available evidence indicates that female-to-male transmission is low compared with other STD (Friedland, 1987; Padian, 1987; Levy, 1988). This could imply that prostitutes are at higher risk of being infected by their customers than are their customers at risk of being infected by the prostitute.

The African situation indicates that HIV spread through prostitutes (Van de Perre, 1985; Kreiss et al., 1986; Melbye et al., 1986). Infection rates among prostitutes in Africa seem to be markers for infection in the general population (Padian, 1988). From this finding no generalizations can be made for the situation in Europe and the United States where transmission is mainly homosexual. Several surveys conducted among female prostitutes indicate that much of the infection among European and North-American prostitutes is related to intravenous drug use (Darrow, 1988; Padian, 1988). The Centers for Disease Control estimates that the HIV infection rate among IV drug using prostitutes is three to four times higher than among non-IV using prostitutes (MMWR, 1987). In conclusion, one can say that prostitutes are primarily at risk through drug use and

also through their sexual activities.

#### HIV Infection among the 120 Study Participants

Many of the prostitutes in this study are drug users (72.5%) and about half of the prostitutes report having engaged in sexual activities with partners belonging to a risk group, e.g. intravenous drug users or bi-sexual men. In this study a distinction is made between women who mainly inject drugs intravenously, those who primarily use non-IV drugs, and those who do not use drugs. Table 5.4 shows the laboratory results of the infection rate among the prostitutes. In order to detect AIDS antibodies the laboratory staff used the Enzyme-linked immunosorbent assay (ELISA), and if the results were positive they were confirmed with the Western blot test.

Table 5.4 shows that the infection rate among thirty-three non-addicted prostitutes (N seropositive=5 and N seronegative =28) is 4.5 times lower than among their drug using peers (N=80). This finding confirms results of other research projects among female prostitutes (Darrow, 1988; Siedlin, 1988) in which infection rates among non-addicted prostitutes were considerable lower than among drug using women.

**Table 5.4: HIV Infection among Prostitutes (N=113) by Drug Use Category**

	seropositive		seronegative	
	n	%	n	%
mainly IV drug use	36	57.1	27	42.9
mainly non-IV drug use	14	82.4	3	17.6
no drug use	5	15.2	28	84.8

missing cases=7  
Chi Square=22.9; df=4; p<.01

The table also indicates that not only are mainly IV drug using prostitutes are at risk but also those women who use drugs non- intravenously. The latter group, however, is ignored in prevention campaigns. While needle sharing among IV drug users puts them at risk, non IV users are at risk through the sharing of "bodies" (Sterk, 1988). Until now, this trend is mainly observed in the United States. If infection rates among drug users in Europe increase, and if crack use becomes more prevalent, this might change the European situation drastically. The high frequency of sexual encounters with multiple partners among young women in crack dens was described in the previous chapter.

In order to determine characteristics of both drug using and non-using prostitutes who have AIDS antibodies the variables were studied for association with seropositivity. These

variables included demographic data, medical/reproductive history, drug use history, sexual history and laboratory results for seromarkers for HBV and antibodies for syphilis, were studied for association with seropositivity. Significant variables were identified by conducting chi square analysis. No significant association was found between the presence of AIDS antibodies and age, ethnicity, geographic mobility, number of pregnancies/abortions/ miscarriages, children, use of contraceptives in general, type of sexual activity with both paying and non-paying sexual partners, having an (intravenous) drug using steady partner, and syphilis markers. Table 5.5 presents those variables which are significantly associated ( $p < .05$ ) with HIV infection. These include: drug user prior to entrance in the world of prostitution, involvement in prostitution activities for over five years, the number of customers during the last 5 years and the months condoms were used during that same period of time. Most highly associated with the presence of AIDS antibodies are seromarkers for hepatitis B (87% versus 52%) and a history of drug use (90.9% versus 51.7%).

Table 5.5 shows that those prostitutes who were drug users prior to their entrance in the world of prostitution are more likely to be HIV infected than those women who became prostitutes prior to their first experience with drugs (58.2% versus 41.8%). The first group of women started prostituting themselves to support their drug habit. They see their

involvement in commercial vice as a way to make money and not as a profession. As a consequence they tend to be less selective with their customers and charge lower prices for their sexual services, especially if the craving for drugs is strong.

**Table 5.5: Characteristics of Prostitutes significantly associated with HIV Seropositivity**

RISK FACTOR	HIV positive (n=55)	HIV negative (n=58)
Addicted to drugs prior to prostitution	32 (58.2)*	23 (41.8)**
Time working as a prostitute: longer than 5 years	31 (56.4)	26 (44.8)
Number sexual partners (paying)/last 5 years: more than 1000	43 (78.2)	43 (74.2)
Number of months condom used/last 5 years: longer than 3 years	23 (41.8)	11 (19.0)
Seromarkers for hepatitis B	47 (87.0)	28 (50.0)
History of drug use	50 (90.9)	30 (51.7)

Missing cases=7

\*the percentages in this column are % of HIV seropositives

\*\*the percentages in this column are % of HIV seronegatives

One of the heroin using prostitutes talks about the frustration related to her drug addiction and the craving for drugs.

Normally, I have a set price for everything I do. Sometimes I have to lower my price, because I need the money badly. If you need a dose of dope, you don't give a damn. Every trick who has a dollar bill becomes attractive. I never charged less than 10 dollars for a

blow job (oral sex), but last week I needed a shot so badly...I did it for five bucks. The guy looked ugly, and had a strange look in his eyes. He scared me, but I didn't have time to fool around. It's so frustrating. If I need dope I'll do anything. Man, that shit really gets you in the gutter.

The craving for drugs also explains why the women engage in sexual activities in which their colleagues refuse to involve themselves. These sexual activities include acts in which one partner urinates over the body of the other, or are sado-masochistic. Drug using prostitutes are also less likely to require that their customers use a condom. They tend to protect themselves less from becoming infected and take a less professional approach toward their occupation.

A second level of analysis, multiple logistic regression (using Statistical Analysis System) was performed in order to determine which of the significantly associated variables are predictors for HIV infection. During this step of the statistical analysis a model containing the potentially important variables was examined, and the final model shows three variables with a significant predictive value. This final model is presented in Table 5.6. The analysis does not include the path through drug use into "the Life", the number of customers a prostitute had during the past five years, and the length of time she has been working as a prostitute. These three variables were no longer statistically significant.

**Table 5.6. Logistic Regression Model of Risk Factors for HIV Seropositivity among Prostitutes**

RISK FACTOR	BETA	ODDS RATIO	C.I.	p
seromarkers for hepatitis	1.56	4.8	0.5 -14.0	0.005
months condom use/ last 5 years	-0.396	0.7	0.5-1.0	0.01
drug use category*	0.571	1.8	1.1-2.9	0.04
intercept	-0.908			

\* Intravenous drug use versus non-intravenous drug use;

Model Chi Square=28.76, df=3 (-2 log L.R.), p<0.00  
 C=.772, Somers D sub YX=.544, Gamma=.592, Tau-A=.377

Seromarkers for hepatitis B had the strongest association with HIV infection: odds ratio 4.8 (95% confidence interval, 0.5 to 14). This association is followed by the drug use category, with an odds ratio of 1.8 (95% confidence interval, 1.1-2.9), and by the number of months the prostitutes reported to have used condoms during the last 5 years: odds ratio 0.7 (95% confidence interval, 0.5 to 1). This last odds ratio is relatively low because there is a curvilinear relationship between condom use and HIV infection. The adverse relationship between the number of months condoms are used during the past five years and HIV seropositivity (negative beta of -0.396), can possibly be explained by contrasting the attitudes held by those women who consider themselves to be at risk compared with the attitude among those women who see themselves at relatively low risk to get infected. Attitudes, norms and beliefs among

individuals who see themselves at risk might cause these persons to be more willing to take protective measures than those who do not see themselves at risk, and therefore do not have reasons to change their behavior. One of the street prostitutes, who uses drug intravenously and has an IV drug using boyfriend, notes:

As soon as I heard about AIDS, about four years ago I started using rubbers, and I only shoot up with my old man. We don't use bleach. We both got tested and were healthy. NO trick is gonna have sex with me without a rubber. I don't always use one if I give'm head [oral sex, C.S.]. I know I am at risk. I need to turn tricks to get money for my drugs, and I'm not planning to stop shooting up. That's the only good thing me and my man have going for us. We love to get high.

Other prostitutes do not see themselves at risk, and are less willing to even think about "safer" behavior. Denise, a street prostitute who does not see herself at risk, has a different attitude.

I don't believe in all that shit. Hookers have been turning tricks for ages. If you check the guys out, and clean yourself all the time, changes that you catch something are small. I don't shoot drugs, and that is how you get AIDS. They say that hookers should use rubbers, and at some places they give'm to you for free. Hey, I'll take those...If I really think a guy looks sick I might use one. I can't be worried about this AIDS disease.

Those prostitutes who consider themselves at high risk to contract AIDS, e.g. through their own or their partner's drug use and through their sexual activities, seem to be more willing to engage in "safe sex" practices. They might start using condoms more frequently, both with their customers and their non-paying sexual partners, than their colleagues who do not recognize themselves to be at risk for HIV infection. Those women who are

modifying their behavior, however, might already have been infected before they started practicing safe sex. Their behavioral change may have come too late, although not too late to prevent them from infecting others.

Of the study participants who reported condom use for a period between three and five years, 67.6% are HIV seropositive, compared with 44.6% of those who used condoms less than 12 months and 30.4% of those who used condoms between one and three years. The validity of data gathered on condom use will be further discussed at the end of this chapter.

Table 5.6. shows that the association between HBV and HIV infection is higher than between HIV infection and the category of drug use. There is also an indirect association, through drug use, between HIV and HBV infection. Intravenous drug use is highly associated with HBV infection (Chi Square=35, df=2,  $p<.000$ ). While 68.8% of the intravenous drug using prostitutes showed seromarkers for hepatitis B, the infection rates among non-intravenous drug users and prostitutes who never used drugs were lower (20% resp. 11.3%).

The analysis as presented in Table 5.6 showed six significant characteristics for those prostitutes who are HIV infected (drug use prior to prostitution, drug use, length of time worked as prostitute, number of customers and months condoms used during

last five years). Three of these variables (see Table 5.6) had a predictive value for HIV infection.

Based upon these data, the probability of a prostitute being HIV infected can be estimated using the odds ratios of the variables comprising the "ideal types" (different combinations of independent variables with HIV infection as dependent variable). Table 5.7 presents a summary of the expected probabilities of HIV infection among the ideal types. Specifically, shown are the expected probabilities of HIV infection under the various combinations of drug use, the presence or absence of seromarkers for hepatitis B and moderate or long time of condom use during the last 5 years. The table demonstrates the relative magnitude of each variable's effect on the HIV serostatus of the prostitutes. Drug use is divided in mainly intravenous, mainly non-intravenous and no drug use and condom use is divided in moderate--between 12 and 36 months during the last 5 years--or long--between 37. Intravenous drug use was reported by 56.7 percent (N=68) of the respondents, non-intravenous drug use by 15.8 percent (N=19) and no drug use by 27.5 percent (N=33). Seromarkers for hepatitis B were identified among 66.7 percent (N=80) women and were not found in 29.2 percent (N=35) of the respondents. Approximately 40.9 percent (N=49) of the subjects reported long condom use compared with 20 percent (N=24) who reported moderate condom use. The first three groups fit the profile of prostitutes who are considered to be the most at risk. They have seromarkers for

hepatitis and used condoms between three and five years. The remaining three groups with more protective characteristics are less expected to be infected.

The cumulative effects of the three predictors are surprising. Prostitutes who do not use drugs and whom we would predict to be the less likely to be HIV seropositive are 1.3 times (0.83 vs. 0.65) as likely to be infected as prostitutes who use drugs mainly intravenously, and 1.6 times (0.83 vs. 0.51) as likely as prostitutes who use drugs mainly intravenously, if seromarkers for hepatitis B are present and condoms have been used during more than three years within the last five years. One would expect to see the highest probability among the intravenous drug using prostitutes. The explanation for the high probability among those prostitutes who do not use drugs, have seromarkers for hepatitis B and used condoms for more than three years, might be that among non-drug using prostitutes, hepatitis B infection is only associated with HIV infection, while among drug using prostitutes the presence of seromarkers for hepatitis B is not necessarily related to HIV infection, but with their drug use. As already mentioned, there is a significant relationship between drug use and seromarkers for hepatitis B.

**Table 5.7 Probabilities of HIV infection for selected groups of respondents**

Group Characteristics	Probability of HIV infection
1. Prostitutes who do not use drugs, who have seromarkers for hepatitis, and used condoms for a period of time between 36 and 60 months during the last 5 years	0.83
2. Prostitutes who mainly use drugs non-IV, who have seromarkers for hepatitis, and used condoms for a period of time between 36 and 60 months during the last 5 years	0.65
3. Prostitutes who mainly use drugs intravenously, who have seromarkers for hepatitis, and used condoms for a period of time between 36 and 60 months during the last 5 years	0.51
4. Prostitutes who mainly use drugs intravenously, who have no seromarkers for hepatitis, and used condoms for a period of time between one and three years during the past 5 years	0.24
5. Prostitutes who mainly use drugs non-IV, who have no seromarkers for hepatitis, and used condoms for a period of time between one and three years during the past 5 years	0.22
6. Prostitutes who do not use drugs, who have no seromarkers for hepatitis, and used condoms for a period of time between one and three years during the past 5 years	0.17

Among those prostitutes who do not have seromarkers for hepatitis B and who used condoms for a moderate period of time the likelihood of being infected is the highest among those who use drugs intravenously: nearly 1 time higher compared with non-

intravenous drug users and 1.4 times higher compared with those prostitutes who do not use drugs.

Prostitutes need to be taught what behavioral changes are needed regarding both their sexual and drug using practices in order to protect themselves. In addition, both their paying and non-paying sexual partners need to be educated. Data collected on condom use in this study suggest that non-paying partners feel offended if the women propose using a condom, that some customers refuse to use a condom because they are paying for the sexual services provided by the women, and that other customers are willing to practice safer sex if requested.

#### Prostitution and Safe Sex Practices

In this section the emphasis will be on the behavior of the prostitutes and their own experiences and opinions. During the period of data collection AIDS was a frequent subject of discussion as was sexual behavior and, if relevant, drug use practices. The women are not used to discussing sex and drugs, but the threat of AIDS makes it easier to raise these issues, even among themselves.

It became clear that prostitutes distinguish several types of sexual partners. One group of men the women deal with are their boyfriends and/or husband and other non-paying sexual partners. Another group are their paying partners, who can be divided into

regular and casual partners. While the non-paying partners are part of the prostitutes' private life, their paying partners are part of their professional life (Daniels, 1984; Day, 1988).

Depending on the status of the sexual partner, the prostitutes engage in various sexual activities. Oral sex is slightly more often provided to customers than with non-paying partners (83.3% versus 75%), and the women are slightly less likely to engage in vaginal intercourse with customers than with their boyfriends (90.8% versus 96.7%). Anal intercourse is less prevalent, both with paying and non-paying partners (11.7% versus 12.5%). Although anal sex is practiced, the prostitutes do not like to admit that they engage in activity. The Hispanic prostitutes reported that in their culture anal sex was accepted as a way to prevent pregnancies, and they are far more willing to talk about this activity than were non-Hispanic women. The number of Hispanic study participants is too small to see if they are more likely to engage in anal sex than are their non-Hispanic colleagues. Two percent of the prostitutes engage in oral-vaginal sex with their customers versus 63.3% with their boyfriends/husband. This indicates that this sexual activity is reserved for men with whom the prostitutes have an intimate relationship. Sue, who has been working as a street prostitute for seven years in several major American cities, confirms that sex with a customer differs from sex with a boyfriend.

If I am with a trick, I only think of the money. I like fast hand and blow jobs. You get less tired, don't have to act as much, and are done faster. I never undress completely if we go to a hotel. Most of the times I wear a skirt and I only take my panties off. I hate it when they want to touch you...My regulars can touch my tits, but no hands between my legs. That is for his dick when he wants to fuck...When I started one of the girls told me never to accept kisses from tricks. Some fools want to kiss you all over. I'm not into that. Most girls won't let tricks touch them. If they want you to come you fake it...I turn my brains and my feelings off. With my man I want to come badly and he can do whatever he wants. I like to do things with him I don't do with my tricks.

Sue also mentions that drug using prostitutes more than their non-addicted colleagues are willing to provide whatever sexual services their customers desire. They also have more problems staying alert and satisfying the customers, e.g. faking an orgasm. The prices addicted prostitutes charge vary depending on their craving for drugs. Their relationship with a boyfriend is very often more centered around drugs than love: making love is part of getting high. More than half of the drug using women (57.1%) have a boyfriend who also uses drugs. Surprisingly, one-third of the non-using prostitutes have a steady relationship with an IV drug using boyfriend.

All 120 prostitutes were aware of the fact that they might be putting themselves at risk for HIV infection through their sexual activities with multiple partners and through their own

or their partner's drug use. The majority said to have learned about this through newspapers and magazines (76%), street outreach activities (73%), or at an STD or family planning clinic (41%). The women trusted information targeted at the general population more than information only or mainly developed for drug users. Kaplan and colleagues report similar finding for Dutch drug users (Kaplan et al., 1986). Three-fourths of the women reported talking with colleagues, friends and family members about AIDS, while twenty women refused to discuss AIDS. Most of the conversations about AIDS were in terms of jokes. This did not vary among the types distinguished in Chapter Three or among the risk profiles presented earlier in this chapter. The discussions became increasingly more serious after more and more people the prostitutes knew became sick or died because of AIDS.

The study participants knew that a condom provides an effective barrier to HIV, and that consistent use of a prophylactic with every sexual partner is needed. Like others, prostitutes have mixed feelings about the use of condoms and do not use them consistently with all sexual partners. Prostitutes were already familiar with the importance of condom use before the AIDS era. Condoms were used as a contraceptive, and as a way to protect themselves from getting infected with STD. Condoms were also used with customers to create a symbolic distance (Day, 1988). With regular customers, however, the prostitutes

tend to use condoms less frequently and consistently than with new and casual customers. Regular customers play an important role in the prostitutes' life. From an economic point of view they guarantee a regular income, since they come at specific times and pay a given amount of money on which the prostitute can count. From an emotional point of view, the relationship between a prostitute and a regular customer evolves over time. Both partners get to know each other better. The women report that it is common for regular customers to discuss all kinds of personal issues with them. Some regular clients hope to establish a steady relationship with the women and help them to leave "the Life". On the one hand, the prostitutes like the economic stability and the attention, but on the other hand they do not want to become too attached to these men. This would destroy their working relationship, e.g. she would feel bad charging him for the sex they have together and she would lose control over the situation. Some prostitutes fantasize about meeting a rich customer who is going to marry them and take care of them for the rest of their life.

Condom use is most prevalent with new and casual customers. The prostitutes reported that the majority of their clients prefer not to use a prophylactic. They feel they should not be paying for "sex with". Other men, according to the prostitutes, are not capable of getting an erection with a condom. Since the AIDS epidemic, it has become easier for the women to mention

condom use in their negotiations with their customers. Condoms are also more easily available, e.g. at STD clinics and through outreach workers. Nevertheless, the women mention that even since the AIDS epidemic occurred, the majority of the customers do not want to use a condom as a way to protect themselves and the women. The prostitutes report that their clients get less upset than in the past when they mention condom use, but that this does not imply that the men want to use a condom. They try to convince the women that they are "safe". In order to cope with the resistance among their clients, the prostitutes started sharing strategies with each other to make a customer change his mind, or they tried to use a condom without the customer knowing this, e.g. have a condom in their mouth before they start oral sex with a customer. The prostitutes also started charging a higher price for "sex without". Nowadays, escort services will only dispatch a prostitute to a client if he agrees to use a condom, although the partners have the right not to engage in safe sex practices if they both agree. Since the AIDS era, condom use is also usually required in brothels.

Unfortunately, not all prostitutes are willing to try to convince a customer of the importance of engaging in safe sex. These prostitutes assume that a customer who opposes the use of a prophylactic will just turn around and look for a prostitute who is willing to have sex without a condom. These varying attitudes among the women cause tension. Those who want to

protect themselves from getting infected report customers turning to women who do not use a condom and do not charge more for "sex without". The latter state that they are protecting themselves by checking to be certain the client is "clean". They assume that if a client looks healthy, wears clean clothes, has a middle-class car and is willing to pay, he does not have AIDS. The misconception that one can look at a person and see if that person is sick is widespread.

During several informal conversations the prostitutes would get upset: "Why should we have to go through this and provide rubbers?", "Why bother if the men do not want to protect themselves?", and "Why talk about girls infecting clients and not the other way around?"

Condom use with boyfriends is uncommon. As Sue notes below, she only wants the "real deal" with her boyfriend. She has been and still uses condoms with most of her clients since the day she had her first customer. She never makes an exception, not even for regular customers. With her boyfriend, however, she does not use a condom. She knows he is injecting drugs. Her fear of losing him as her partner or of making him angry stop her from raising the issue.

I love him and do not want to argue all the time. We have been together for three years now. I knew all the time he was shooting up, and he knew I was a whore. The two of us together is not always easy, but we work

things out...He always uses his own set and I always use condoms with my tricks. We want a baby...He does not want to get tested. I know I can get it from him but he does not want to hear about condoms. I don't like it either, so I don't push the issue too much...I tried, he went off and disappeared for days.

Sue's situation is representative for most of the women. Fifteen prostitutes report condom use with their boyfriend most of the time they have intercourse. Ten other women tried condoms a few times and the others used a condom less than five times or never with their steady. Condom use while engaging in oral sex is rare. Although the prostitutes, and very often their partner, know they should protect themselves, they do not change their behavior. Consistent condom use, both with paying and non-paying sexual partners, is only reported by a small group (less than 3%) of the prostitutes. Key reasons for the women not to negotiate safe sex practices are their fear of losing their personal relationships and their fear losing their customers.

Drug using prostitutes report having more problems adapting their behavior than non-addicted women. It is not because they do not want to change their behavior and protect themselves, but craving for drugs makes them forget their "protective intentions". Melissa, a street prostitute for five years, started using drugs six years ago. She got involved in commercial vice to support her expensive heroin habit. Two years ago she was approached by an outreach worker who gave her

condoms for free. Since then she always carries condoms in her purse which she sometimes uses.

I have to stop messing around. Max (outreach worker) has been great for me. He got me in a methadone program, but they found out I was using on the side. He is also the one who told me about rubbers, and he always carries some extra. It's for free...I had to tell him that I'm not always using those. I carry rubbers with me and show them to Max to prove that I am doing what he is telling me to do. In reality, I don't. I'll carry rubbers in my purse, but not use'm. I put new ones in once the packages start looking old. As long as I don't get high I will tell a trick that I'm one of them good girls who only does it with, but man...I need dope and there is no time to fool around...Tricks look for women who need the money... Sometimes I think they can smell it when you need them. I'll do it without, make money, get high and be in my own fantasy world. I'm still negative, but I've to watch.

Melissa is prone to accept every customer and engage in whatever he desires when business is slow, she needs drugs and has not earned much money. Women like Melissa end up in a vicious circle. This is even more true for crack users. Blowy puts it this way:

When I started out I did not see myself as a whore. I would go to my usual spot (crack house) and get high. The spot was my friend's apartment. If I would run out of money I would give one of the guys a blow job and he would share his rock (crack). These double master blasters keep you going for a while. The folks around here know each other and you help each other out...After a while I could not get the guys to buy me cocaine any longer. They used to buy it and let me cook it up. What helped me for so long was that I'm a good cook (for crack). I never had to buy stuff myself...I started smoking at the factory (street with abandoned factories) ...If I really did not come up with something else I would turn a trick. The factory is also where girls turn tricks. You always had guys

driving around and looking for a ho. I used to get upset if one of them thought I was a streetwalker...I was turning tricks for months. One of my buddies and I got into a fight and he called me a hooker. I was shocked but it was true...I always used rubbers. The cutey from the clinic (outreach worker) comes by and gives them to us for free. If I need the money badly, like when the monkey is on my back (craving for crack after getting high) I'll just go for it. I don't give a damned. Now, I am scared I might have it. It's like I can't get my brains to work. Being hooked on crack is a slow way of dying. I think it is like having AIDS.

Crack users have more problems protecting themselves frequently and consistently. Addicted prostitutes in general are in a more difficult position than their non-drug using colleagues. They not only have to adapt their sexual practices but also their drug using practices. Some cease using drugs, others stop sharing works and/or clean their works. As reported earlier, most prostitutes are familiar with the use of condoms as a protective measure. They also know that bleach can be used as a decontaminant to clean syringes. In accordance with the findings of Des Jarlais and colleagues (1987), the prostitutes report that changes in their drug using behavior are easier to make than changes in their sexual behavior. Forty-seven prostitutes mentioned changes in their drug using behavior (less sharing, more cleaning with bleach, and less injecting) versus twenty-three percent who changed their sexual behavior (more frequent condom use, less high risk sexual activities, more selective with customers). The Type 6 women, non-drug using prostitutes who have been in "the Life" for five years or longer tend to engage more in safer sex than the others (difference is

not statistically significant), while behavioral changes are found the least among the non-intravenous drug using prostitutes (Types 3 and 4).

## CONCLUSIONS

This dissertation is based on data from 120 female prostitutes living in "Northeast". The primary issues discussed are the women's perception of their position in "the Life", their reproductive role, and the connection between their professional activities and infectious diseases. Quantitative data were collected using a structured questionnaire, qualitative data were gathered applying ethnographic research techniques, and, in addition, seroprevalence data (syphilis, hepatitis B and HIV) were obtained via venipuncture. The quantitative and qualitative data were analyzed jointly and thus allowed careful assessment of the data's validity. Quantitative data gave a structured overview of relevant information, but contributed little to understanding the women's activities from their perspective. This study is an example of bridging both sets of data.

It is unclear how representative the sample described is for the prostitution population. The researcher applied the technique of chain referral sampling which implies that the cross section of prostitutes studied resulted from the networks the researcher entered.

Although, the focus of the study was not to identify why some women become prostitutes and other who live under similar circumstances do not, this was frequently discussed with the

prostitutes. The literature offers mainly psychological, psycho-analytical, economic and/or social explanations. These same reasons were given by the study participants, however, none of them mentioned or attributed their entrance in "the Life" to a single cause. Economic reasons were mentioned the most frequently. Overall, the women's entrance in the world of prostitution stemmed from multiple factors. As one of the prostitutes stated: "A lot of it depends on who you run into, at what point in your life."

Prostitution was not a full-time activity for the majority (65%) of the women. Working part-time could mean working a few hours per day or per week or working certain days or weeks of the month. The study participants mentioned they worked when they needed money and/or drugs, or that they worked hours which did not conflict with the needs of their children. Prostitutes are more than "whores", they are women with a life outside the world of prostitution, including family, friends and acquaintances. In other words, they do more than sell sex.

Within "the Life" several forms of prostitution can be distinguished by examining the work situation, e.g., street, bar, hotel, brothel or escort service. A hierarchy with call girls at the top and drug using streetwalkers at the bottom is generally accepted by in- and outsiders.

Not only does the work setting vary among the prostitutes but so do the kind of customers and the likelihood of interaction with the police. Street prostitutes are mainly approached by men who want "cheap and quick" sex, and whose high visibility results in the clients' and prostitutes' arrest. Call girls deal foremost with "sophisticated" customers and experience less police harassment.

The overlap between the world of prostitution and drug use (hypothesis 1) is substantial as evidenced by the fact that 72.5% of the study participants were drug users. Slightly, over 70 % of the drug users reported that their addiction led them into prostitution. This indicates that these women became prostitutes in order to support their drug habit. The prostitutes, however, tend to attribute their entrance into "the Life" jointly to drug use and their disadvantaged social situation. Drug use was trichotimized in no drug use, mainly intravenous drug use of heroin and/or cocaine, and non-intravenous use of cocaine/crack. Twice as many intravenous drug using prostitutes reported drug use prior to their entrance in the world of prostitution than non-intravenous drug users. The latter might have been prostituting themselves without labeling their activities as such.

Based upon the type of drug use, if any and the time the women have been working in commercial sex, six types of

respondents are distinguished: (1) the syringe user, (2) the more experienced intravenous drug using prostitute, (3) the non-intravenous cocaine user, (4) the more experienced non-intravenous drug using prostitute, (5) the beginning prostitute, and (6) the more experienced prostitute. Several variables differentiated the six types of prostitutes: current age, the age at which they identified themselves as prostitutes, the number of sexual partners they had during the last 5 years, and their geographic mobility. Non-drug using prostitutes are younger than their drug using peers. Women working in commercial vice for a period of time shorter than 5 years identify themselves at an older age as prostitutes than those who have identified themselves as a prostitute more than 5 years ago, and who are an average of three years older. The number of sexual partners during the last 5 years increases with the time active in "the Life" and is the highest among intravenous drug users. Among those prostitutes who have been in commercial vice for less than 5 years, the number of sexual partners is the highest among non-intravenous drug using prostitutes. This finding is consistent with ethnographic reports that female crack users engage more frequently in sex for drugs with multiple sexual partners than their intravenous drug using peers (hypothesis 2). The respondents belonging to type 3 have been using crack and exchanging sex in return for money and/or drugs for an average of two years before identifying themselves as prostitutes. Their self-identification as prostitutes occurs

frequently at the moment they must begin recruiting paying sexual partners outside the network of crack users with whom they are familiar.

Hepatitis B is significantly associated with drug use. The infection rate among non-drug using prostitutes was 24.8% compared with an infection rate of 82.5 % among their drug using peers (hypothesis 3).

Drug using prostitutes tend to be less geographically mobile than their non-drug using colleagues. The difficulty of reestablishing ties with another drug scene precludes an easy transition to a new (metropolitan) area. They reported to dislike having to move to another city and having to identify other users and dealers that can be trusted.

Independent of the type of prostitution in which the study participants engage, all respondents have to deal with certain issues related to their reproductive health. One of the aspects is dealing with their menstrual period. Drug using prostitutes reported more frequently an irregular menstrual cycle (hypothesis 4). Due to the irregularity of this cycle, which is reported by 33% of the drug users, the myth exists that drugs work as a form of contraception and prevents pregnancy. This was reported by several women, even although they knew that some drug using women they knew became pregnant. This was

particularly true for crack using respondents. Related to this is the belief that extensive crack use ensures a miscarriages.

The majority (83%) of the study participants would not engage in vaginal intercourse during their menstrual period, however, they continue to work. The street prostitutes reported engaging more frequently in oral sex while menstruating, while call girls mentioned working as a phone operator for the escort service during these days. Vaginal intercourse during menses appeared to be a controversial issue among these sexually active women.

Sexual activity, particularly vaginal intercourse, increases the chances of becoming pregnant. Only four respondents had never been pregnant, while half of them had one, two or three pregnancies. The number of pregnancies did not differ significantly among non-drug using and drug using prostitutes but was somewhat higher among the first group (4.3 versus 3.2 pregnancies) (hypothesis 4). No differences in the number of abortions were identified. With the exception of nine women, all respondents are mothers. Combining the role of mother and prostitute is a difficult task, and almost all study participants complained about this.

In order to prevent pregnancies, 59.3% of the respondents reported using a birth control method some time in the last 5

years. No statistically significant differences were found among the six types of women. The primary used method of birth control was the condom (50.7%), followed by the pill (16.9%). It was unusual for the women to use one method consistently. The prostitutes were dissatisfied with the available contraceptive methods. Two thirds (65%) reported that they used a condom at least one time during the last 5 years. Information regarding condom use can only be obtained from the respondent. Although the validity of self-reported data on sensitive issues such as condom use and drug use practices is not always clear (Harrell, 1985) these data remain an effective source of information that otherwise might not have been accessed.

It became clear that the extent to which contraceptives, in particular condoms, are used depends on the prostitutes' sexual partner. Sexual partners can be placed into the following categories: steady boyfriend, non-paying sexual partners, regular customers, and incidental customers. In the prostitutes' interaction with customers the use of a condom symbolizes distance between them and their male partners. The respondents all agreed that it was easier to use a condom with a client than with a non-paying sexual partner. The emotional bond with the latter would be disturbed if a condom were used. The prostitutes reported that proposing condom use with paying customers can be a problem since these men felt they can demand whatever they want because they are paying the woman. Drug

using prostitutes tend to more quickly capitulate to their customers' desires, such as sex without a condom or engaging in unusual sexual acts, than were their drug free colleagues (hypothesis 5). Their willingness is linked to their craving for drugs: the stronger the craving, the more willing they are to meet the customers' needs.

The study participants reported that the AIDS epidemic has led to more internal pressure among the women to engage in "safer sex". They all knew that HIV could be sexually transmitted. For the prostitutes "safer sex" practices was synonym with condom use. The respondents believed that it was more common for them to use a condom to protect themselves from STD than it was among other sexually active women. The AIDS epidemic brought new attention to the use of condoms, and one company is seeking to develop an acceptable female condom. More prostitutes are carrying condoms, and more negotiate condom use with their sexual partners. What upset the respondents was that a relatively large number of their customers would not agree to use a condom.

It is important that men be more directly included in "safer sex" education. Women themselves, including prostitutes, are not capable of changing sexual behaviors. Some prostitutes sought to charge a higher price for sex without a condom or to use a condom without the customers' knowledge. Sexual behavior,

however, is not going to change without the support of men. HIV prevention campaigns should also emphasize that looking healthy does not mean an individual is not infected. This misconception was mentioned by prostitutes as well as their customers.

The role of female prostitutes in the AIDS epidemic is unclear. Prostitutes, through their sexual activities, are potentially at risk to get infected and to infect others with HIV. This is because they are sexually active individuals who engage in sex, in high risk sexual activities, with multiple partners, whose risk group is unknown. Almost half (48.7%) of the respondents are HIV seropositive. HIV infection was the highest among non-intravenous drug using prostitutes (82.4%), followed by intravenous drug users ((57.1%) and prostitutes who do not use drugs (15.2%) (hypothesis 6). These data are an indication of the importance of not only intravenous drug use but also of non-intravenous drug use/crack use. One has to keep in mind, however, that these findings are based upon a small sample. Other studies in the United States and Western Europe also found low HIV infection rates among non-drug using prostitutes, and all this makes the role or prostitutes as "transmitters of HIV into the general population" questionable. Drug use seems to place these women more at risk than do their sexual activities.

Significantly associated ( $p < .05$ ) with HIV seropositivity were drug use prior to entrance in the world of prostitution, seromarkers for Hepatitis B, involvement in prostitution activities for more than 5 years, the number of customers during the last 5 years, and the number of months condoms were used during the last 5 years. Several variables were studied for association with HIV seropositivity among the 120 prostitutes. No statistically significant association was identified with age, ethnicity, geographic mobility, number of pregnancies, abortions and miscarriages, number of children, use of contraceptives, types of sexual activities engaged in with paying and non-paying sexual partners, having a steady boyfriend who is an intravenous drug user, and showing antibodies for syphilis.

Syphilis is reported to be slightly more prevalent among non-intravenous drug users than among the intravenous drug using respondents ((26.6% versus 16.9%). Rolfs and Cates (1989) also confirmed an association between crack use and syphilis. No data are available about a possible association between crack use and STD such as gonorrhea and chlamydia.

By applying logistic regression analysis a model was developed to identify those variables which were significant predictors of HIV infection. The variables retained in this final model were the presence of seromarkers for hepatitis B,

the drug use category and the number of months condoms were used during the last 5 years. The strongest predictor was the presence of seromarkers for hepatitis B (hypothesis 7), followed by the drug use category. There is also a strong association between these two variables. More detailed analysis including the number of injections, the number of times needles were shared and the number of visits to a shooting gallery did not alter the results. In the same model a negative relationship between HIV infection and the number of months condoms were used was identified.

Those prostitutes who do not use drugs, do not have seromarkers for hepatitis B and used condoms between one and three years during the last 5 years have the lowest probability of being HIV infected (0.17), followed by those women who used drugs mainly non-intravenously (0.22) and those who used drug intravenously (0.24). Among those who have seromarkers for hepatitis B the probability of being HIV infected is the highest among non-drug using prostitutes (hypothesis 7). In their case the presence of seromarkers might be solely linked to their HIV status and not to their drug use. Among intravenous drug users hepatitis B is not only transmitted through their sexual activities, but also through sharing drug injection equipment.

Those prostitutes who consider themselves to belong to a high risk group for HIV infection report to use condoms more

frequently and consistent--with their customers--than those prostitutes who do not consider themselves to be at risk for HIV infection. This implies that protective behavior is more common among the first group of study participants, and that protection is not necessarily linked to a negative status. In contrast, those respondents who tested negative for HIV during this study report to engage less in "safer sex" practices (hypothesis 8).

In order to develop effective (HIV) intervention strategies among female prostitutes further research is needed in the following areas:

- o the different types of prostitution, not only based upon differences in the work setting but also other relevant factors such as drug use and time involved in commercial vice;
- o the different drug use practices, including non-intravenous drug use among the drug using prostitutes, as well as barriers in changes and actual changes in drug use patterns;
- o the sexual behavior, including the use of contraceptives of the prostitutes by type of partner, and barriers in changing as well as actual changes in this behavior;

- o the link between intravenous drug use, seromarkers for hepatitis B, and HIV infection;
- o the relationship between bacterial and viral STD, drug use and HIV infection.

Summarizing, one can state that six different types of prostitution can be distinguished among the study participants, based upon the time they have been in "the Life" and their drug use. There are no clear differences in reproductive health among these types. Drug using prostitutes, however, tend to have a more irregular menstrual cycle than their non-drug using colleagues. No significant differences were identified in terms of pregnancies, abortions, miscarriages and number of children delivered. "Safer sex" practices were reported slightly more frequently by non-drug using prostitutes.

There is a clear overlap between the world of prostitution and the world of drug use. Drug use is strongly associated with HIV infection. Other predictive variables identified were the presence of seromarkers for hepatitis B and the number of months condoms were used during the last 5 years. The results of the study indicate that in terms of protective factors, the key is the extent to which the women perceive themselves to be at risk for HIV infection. In prevention campaigns the focus should not

just be on intravenous drug use but should also include non-intravenous drug use. Overall, the prostitutes' sexual activities seem to put them less at risk for HIV infection than risk through their own or their sexual partner's drug use.

Appendix A

Code of Criminal Justice, Chapter 34, Section 2C:34-1

Prostitution and related offenses

**a. Prostitution.** A person is guilty of prostitution, petty disorderly persons offense, if he or she is:

- (1) Is an inmate of a house of prostitution or otherwise engages in sexual activity as a business; or
- (2) Solicits another person in or within view of any public place for the purpose of being hired to engage in sexual activity. "Sexual activity" includes homosexual and other deviate sexual relations. A "house of prostitution" is any place where prostitution or promotion of prostitution is regularly carried on by one person under the control, management or supervision of another. An "inmate" is a person who engages in prostitution in or through the agency of a house of prostitution. "Public places" means any place to which the public or any substantial group hereof has access.

**b. Promoting prostitution.** A person who knowingly promotes prostitution of another commits an offense. The following acts shall, without limitation of the foregoing, constitute promoting prostitution:

- (1) Owning, controlling, managing, supervising or otherwise keeping, alone or in association with others, a house of prostitution or a prostitution business;
- (2) Procuring an inmate for a house of prostitution or a place in a house of prostitution for one who would be an inmate;
- (3) Encouraging, inducing, or otherwise purposely causing another to become or remain a prostitute;
- (4) Soliciting a person to patronize a prostitute;
- (5) Procuring a prostitute for a patron;
- (6) Transporting a person, into or within this State with purpose to promote that person's engaging in prostitution, or procuring or paying for transportation with that purpose;
- (7) Leasing or otherwise permitting a place controlled by the actor, alone or in association with others, to be

regularly used for prostitution or the promotion of prostitution, or failure to make reasonable effort to abate such use by ejecting the tenant, notifying law enforcement authorities, or other legally available means; or

- (8) Soliciting, receiving or agreeing to receive any benefit for doing or agreeing to do anything forbidden by this subsection.

**c. Grading of offenses under subsection b.** An offense under subsection b. constitutes a crime of the third degree if:

- (1) The offense falls within paragraph (1), (2) or (3) of that subsection;
- (2) The actor compels another to engage in or promote prostitution;
- (3) The actor promotes prostitution of a child under 16, whether or not he is aware of the child's age; or
- (4) The actor promotes prostitution of the actor's spouse, child, ward or any person for whose care he is responsible.

Otherwise the offense is a crime of the fourth degree.

**d. Presumption from living off prostitution.** A person, other than the prostitute or the prostitute's minor child or other legal dependent incapable of self-support, who is supported in whole or substantial part by the proceeds of prostitution is presumed to be knowingly promoting prostitution in violation of subsection b.

**e. Patronizing prostitutes.** A person commits a petty disorderly persons offense if he hires a prostitute to engage in sexual activity with him, or if he enters or remains in a house of prostitution for the purpose of engaging in sexual activity or if he solicits or requests another person to engage in sexual activity with him for hire.

**Appendix B**

**QUESTIONNAIRE (CDC Protocol 732A/AIDS Project 72)**

**GENERAL SECTION**

Where were you born (state or country)?

Which of the following categories best describes your background?

- |                               |                              |
|-------------------------------|------------------------------|
| 1. White, non-Hispanic Native | 5. American Indian/Alaskan   |
| 2. White, Hispanic            | 6. Asian or Pacific Islander |
| 3. Black, non-Hispanic        | 7. Other: (describe)         |
| 4. Black, Hispanic            | 9. Don't know                |

Have you ever worked in health care, with exposure to blood?

- 0. No
- 1. Yes
- 9. Don't know

**MEDICAL HISTORY**

Have you ever been tested for antibodies to HTLV-III/LAV, the AIDS virus?

- |                                 |                                      |
|---------------------------------|--------------------------------------|
| 0. No, I have never been tested | 3. Yes, but I never received results |
| 1. Yes, and I was negative      | 9. Don't know                        |
| 2. Yes, and I was positive      |                                      |

Have you received a transfusion of blood, or blood products, since 1978? If yes, how many months ago did you last receive one?

Have you ever had hepatitis, or yellow jaundice?

If yes, have you had hepatitis A (infectious hepatitis)?  
have you had hepatitis B (serum hepatitis)?  
have you ever had non-A, non-B hepatitis?

for each question: 0. No  
1. Yes  
9. Don't know

Have you been vaccinated against hepatitis B (Heptavax)?

If yes, how many doses of hepatitis vaccine? 1. One  
2. Two  
3. Three  
9. Don't know

Have you received any hepatitis "shots" (immunoglobulins) in the past 6 months? If yes, was it: 1. HBIG (hepatitis immunoglobulin)

- 2. IG
- 3. Other
- 9. Don't know

In the past 5 years, how many times have you been treated for:  
Syphilis:  
Gonorrhea:

Are you pregnant now? If yes, how many months have you been pregnant?

#### **PREGNANCY HISTORY AND CHILDREN**

How many times have you been pregnant?

If ever pregnant, how many children have you borne?

How old are your (three youngest) children?

Have any of your children ever been seriously ill? If yes, what was the problem?

1. AIDS related
2. Other
9. Don't know

Have you had a tubal ligation (been sterilized)? If yes, when did you have it?

In the past 5 years, how many months have you used each of the following (for contraception, or any other reason) at least once during a month?

- Oral contraceptives (birth control pills)
- Intrauterine Device (IUD)
- Diaphragm or cervical cap, with or without jelly
- Jelly, creme or foam (specify)
- Spermicide (specify)
- Vaginal sponge (specify)
- Condoms (lubricated or not)
- Post-coital douche (specify brand)

#### **DRUG USE HISTORY**

Have you ever been to a "shooting gallery"?

0. No
1. Once
2. Few times
3. Often

Have you ever injected any substance or drug under your skin or into your vein?

0. No
1. Yes

If yes, How old were you when you first injected drugs?  
In an average month when using, how many times did you inject?  
In the past 5 years, how many months have you injected drugs?  
Do you have any reason to believe that your needle(s) had been used by someone else?  
0. No  
1. Yes  
9. Don't know

### SEXUAL HISTORY

How old were you when you first had sexual intercourse (I mean his penis in your vagina, mouth or anus) with a male?

Since then, about how many different males have you had sexual intercourse with? (take average week, month or year and multiply)

Altogether, how many months have you "worked" (as a prostitute)?

During this time, how many different men paid you for sexual intercourse?

In the past five years, how many months have you worked (as a prostitute) in other cities (specify other cities):  
in this state  
in other states  
in other countries

In the past 5 years, how many different males and how many different females have you engaged in physical sexual activities with, including those that have paid and not paid?

	PAID	NOT PAID
number of different male partners		
number of different female partners		

In the past 5 years, how many steady (non-paying) boyfriends have you had?

If one or more:

How many months were you with a boyfriend in the past 5 years?  
How many times in an average month did you and he have sex?  
How many of your boyfriends have used drugs intravenously?

In the past 5 years, how many of your total sex partners were (to your knowledge)

- |                        |  |
|------------------------|--|
| 1. American servicemen | 5. From Haiti                            |
| 2. Bisexual men        | 6. From Southeast Asia                   |
| 3. IV Drug Users       | 7. Black African men from Central Africa |
| 4. Men with hemophilia | 8. Persons with AIDS                     |

In the past 5 years, what percent of your paying sexual partners did you first make contact with:

- |                               |                      |
|-------------------------------|----------------------|
| 1. On the street (in public)  | 3. By telephone call |
| 2. At a house of prostitution | 4. Other (specify)   |

**SEXUAL ACTIVITIES**

In the past 5 years, what percent of the time did you engage in each of the following sexual activities with partners that paid, and never paid?

His penis in your mouth (oral sex)?  
What percent was with condom?

His penis in your vagina (straight sex)?  
What percent was with condom?

His penis in your anus (anal sex)?  
What percent was with condom?

Your partner's tongue in your vagina?

Your tongue in your partner's anus?

In the past 5 years, did you ever have vaginal intercourse during your menstrual period, or while you were bleeding vaginally?

PAID                      NEVER PAID

If yes, how many times did you have sex:  
with a condom, diaphragm,  
sponge or other barrier?

without any barrier?

In the past 5 years, have your sexual activities included any of the following:

Your fingers, hand or fist in your partner's rectum?

Your partner's fingers, hand or fist in your rectum?

Inserting an object into your partner's rectum (or giving an enema)?

Your partner inserting an object into your rectum (give you an enema)?

Your partner inserted an object into your vagina and caused bleeding?

Any other sexual contacts involving biting, piercing or bleeding?

In the past 5 years, what percentage of the time did you use a lubricant and/or wash your partners before sexual contact?

1. Vaseline
2. KY Jelly

3. Other (specify)
4. Wash with soap and water

Appendix C

CLINICAL FINDINGS

Symptoms

In the past 5 years, have you ever had any of the following health problems or disease symptoms? If you have, please tell me when you first noticed it, and then tell me if you have it now:

- Shortness of breath, so bad that you could not walk up stairs for 2 weeks or longer
- Unexplained, unusual dry cough that continued for 2 weeks or longer
- Soreness in mouth, or trouble swallowing, that lasted for 2 weeks or longer
- White patches in your mouth that lasted for 2 weeks or longer
- Discolored (purplish) patches on skin that remained for 2 weeks or longer
- Unusual bruising, or painful blisters, that remained for 2 weeks or longer
- Fatigue, being so tired that you could not do things for 2 weeks or longer
- Unintentional weight loss (10 or more lbs.) which was not regained
- Fever or 100 degrees Fahrenheit or more that lasted for 2 weeks or longer
- Enlarged lymph nodes, swollen glands in your neck or under your arms, for 2 weeks or longer
- Unusual and unexplained drenching sweats every night for 2 weeks or longer
- Unusual, severe and persistent headaches

If one of the above is answered with yes,  
Did you consult a doctor or visit a clinic to find out why you felt sick? If yes, what was your medical problem?

What is your height?  
What is your weight?

Are any of these signs of AIDS or AIDS-related conditions present (conducted by medical staff):

- Palpable nodes (at least 1 cm in diameter):
- |                        |      |
|------------------------|------|
| cervical: right        | left |
| occipital: right       | left |
| supraclavicular: right | left |
| axillary: right        | left |
| epitrochlear: right    | left |

Skin Lesions  
Needle tracks  
Thrush (oral candidiasis)

## **Appendix D: Case definition for AIDS**

Centers for Disease Control: General Recommendations and Guidelines  
MMWR (1987) 36:1-15

For national reporting, a case of AIDS is defined as an illness characterized by one or more of the following "indicator" disease, depending on the status of laboratory evidence of HIV infection, as shown below.

### **I Without Laboratory Evidence Regarding HIV Infection**

If laboratory tests for HIV were not performed or gave inconclusive results and the patient had no other causes of immunodeficiency listed in section I.A below, then any disease listed in Section I.B indicates AIDS if it was diagnosed by a definitive method.

#### **A. Causes of immunodeficiency that disqualify diseases as indicators of AIDS in the absence of laboratory evidence of HIV infection**

1. High-dose or long-term systematic corticosteroid therapy or other immuno-suppressive/cytotoxic therapy <3 months before the onset of the indicator disease.

2. Any of the following diseases diagnosed <3 months after diagnosis of the indicator disease: Hodgkin's disease, non-Hodgkin's lymphoma (other than primary brain lymphoma), lymphocytic leukemia, multiple myeloma, any other cancer of lymphoreticular or histiocytic tissue, or angioimmunoblastic lymphadenopathy.

3. a genetic (congenital) immunodeficiency syndrome or an acquired immunodeficiency syndrome atypical of HIV infection, such as one involving hypogammaglobulinemia.

#### **B. Indicator diseases diagnosed definitively**

1. candidiasis of the esophagus, trachea, bronchi or lungs

2. cryptococcosis, extrapulmonary

3. cryptosporidiosis with diarrhea persisting > 1 month

4. cytomegalovirus disease of an organ other than liver, spleen, lymph nodes in a patient > 1 month of age.

5. herpes simplex virus infection causing a mucocutaneous ulcer that persists longer than 1 month; or bronchitis, pneumonitis, or esophagitis for any duration affecting a patient > 1 month of age

6. Kaposi's sarcoma affecting a patient < 60 years of age

7. lymphoma of the brain (primary) affecting a patient < 60 years of age

8. lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia (LIP/PLH complex affecting a child < 13 years of age

9. Mycobacterium avium complex of M. kansasii disease, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
10. Pneumocystis carinii pneumonia
11. progressive multifocal leukoencephalopathy
12. toxoplasmosis of the brain affecting a patient > 1 month of age

## **II With Laboratory Evidence for HIV infection**

Regardless of the presence of other causes of immunodeficiency (I.A.), in the presence of laboratory evidence for HIV infection, any disease listed above or below indicates a diagnosis of AIDS.

### **A. Indicator diseases diagnosed definitively**

1. bacterial infections, multiple or recurrent (any combination of at least two within a 2-year period), of the following types affecting a child < 13 years of age:  
septicemia, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses), caused by Haemophilus, Streptococcus (including pneumococcus), or other pyogenic bacteria
2. coccidioidomycosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes)
3. HIV encephalopathy (also called "HIV dementia", "AIDS dementia", or "subacute encephalitis due to HIV")
4. histoplasmosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes)
5. isporiasis with diarrhea persisting > 1 month
6. Kaposi's sarcoma at any age
7. lymphoma of the brain (primary) at any age
8. other non-Hodgkin's lymphoma of B-cell or unknown immunologic phenotype and the following histologic types:  
a. small noncleaved lymphoma (either Burkitt or non-Burkitt type)  
b. immunoblastic sarcoma
9. any mycobacterial disease caused by mycobacteria other than tuberculosis, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
10. disease caused by M. tuberculosis, extrapulmonary (involving at least one site outside the lungs, regardless of whether there is concurrent pulmonary involvement)
11. Salmonella (nontyphoid) septicemia, recurrent
12. HIV wasting syndrome (emaciation, "slim disease")

### **B. Indicator diseases diagnosed presumptively**

Note: Given the seriousness of diseases indicative of AIDS, it is generally important to diagnose them definitively, especially when therapy that would be used may have serious side effects or when definitive diagnosis is needed for eligibility for antiretroviral therapy. nonetheless, in some situations, a patient's condition will not permit the performance of definitive tests. In other

situations, accepted clinical practice may be to diagnose presumptively based on the presence of characteristic clinical and laboratory abnormalities.

1. candidiasis of the esophagus
2. cytomegalovirus retinitis with loss of vision
3. Kaposi's sarcoma
4. lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia (LIP/PLH complex) affecting a child <13 years of age
5. mycobacterial disease (acid-fast bacilli with species not identified by culture), disseminated (involving at least one site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
6. Pneumocystis carinii pneumonia
7. toxoplasmosis of the brain affecting a patient > 1 month of age

### **III With Laboratory Evidence Against HIV Infection**

With laboratory test results negative for HIV infection, a diagnosis of AIDS for surveillance purposes is ruled out unless:

- A. all the other causes of immunodeficiency listed above in Section I.A are excluded; AND
- B. the patient has had either:
  1. Pneumocystis carinii pneumonia diagnosed by a definitive method; OR
  2. a. any of the other diseases indicative of AIDS listed above in section I.B diagnosed by a definitive method;  
AND  
b. a T-helper/inducer (CD4) lymphocyte count <400/MM3

**Appendix E            GLOSSARY**

This glossary is included to help the reader understand the terms and phrases used by the prostitutes. The definitions apply only to the context in which they are presented.

Base: cocaine with hydrochloride removed

Blow job: oral sex

Boosting: shoplifting

To boot: to draw blood into the syringe to mix with drugs before injecting completely

Bread: money

To bust: arrest

To bust your chops: to work hard

Changes: problems and difficulties encountered

Cooker: usually a spoon or a metal cap of a bottle in which drugs are mixed, dissolved and heated prior to being drawn up in a syringe

To cop: to purchase drugs

Cotton: small piece of cotton through which the drug solution is stained into the syringe

Crack: cocaine base

Crack head: crack user

Crack spot: place where crack users gather to get high

To deal: to sell drugs

Doctor: experience intravenous drug user who injects others

Dopefiend: drug, mainly heroin addict

Double Master Blaster: getting high on crack, while man receives oral sex from woman.

Dough: money

To freebase: to smoke cocaine/crack

To fuck up: to make a mistake  
Game: exploitative interaction  
To get down: to have sexual intercourse  
Habit: drug addiction  
To hang out: to socialize on the scene  
Hassle: problems  
High: under the influence of drugs  
Hit: inject drugs; inhale the smoke of crack/freebase; snort line of cocaine  
To hit the bricks: to work as a street prostitute  
Ho: prostitute  
Hooked: addicted; strung out  
To Hustle: to engage in illicit activities  
John: prostitute's customer  
Lady: prostitute; girlfriend  
The Life: the world of prostitution; also the world of drug use or subcultures engaging in illicit activities  
Line: cocaine powder placed in a line, to be snorted  
The Man: the police  
Old Man: pimp; boyfriend  
Monkey coming down: craving after getting high on crack  
Players: participants in the game of the life  
Regular: regular customer of prostitute  
To rip off: to steal  
Rubber: condom  
To score: to buy drugs  
Scottie: cocaine/crack

Shooting gallery: place where intravenous drug users gather to get high

To shoot up: to inject intravenously

To skin pop: to inject drugs intramuscularly

Sleazy: cheap

Smack: heroin

Speedball: mixture of heroin and cocaine

Spike: syringe

Streetwalker: street prostitute

Stroll: area from which street prostitutes operate

Tracks: marks or scars from injecting drugs

To turn tricks or johns: practicing prostitution

Trick: prostitute's customer

To watch someone's back: protect somebody

Whore: prostitute

Works: equipment needed to inject drugs

**"IN HET LEVEN: PROSTITUTEES EN HUN GEZONDHEID"**

"In het Leven" refereert aan vrouwen die in de prostitutie werkzaam zijn. "Het Leven" symboliseert de social wereld van hoeren. Prostitutie is gedefinieerd als sex tussen man en vrouw in ruil voor geld en/of drugs. De mannelijke partners is de betalende party. De interactie is zakelijk van aard en brengt noch voor de man, noch voor de vrouw enige social verplichtingen met zich mee. De basis voor dit proefschrift vormt onderzoek tussen Juli 1986 en Januari 1988 onder 120 vrouwelijke prostituees. Deze vrouwen woonden en/of werkten allen in "Northeast", een urbaan gebied rond een grote stad aan de noordoost kust van de Verenigde Staten.

De belangrijkste onderzoeksvragen waren:

- Kunnen beroeps typen/stratificatie typen worden onderscheiden onder prostituees? Indien ja, welke typen kunnen worden onderscheiden?
- Hebben verschillende typen prostituees verschillende problemen met hun reproductieve functioneren? Indien ja, wat zijn deze verschillen en hoe kunnen die verklaard worden?
- Is er een overlap tussen de wereld van prostitutie en die van druggebruik? Indien ja, wat zijn de gevolgen hiervan?
- Lopen prostitutees relatief meer risico besmet te raken en/of anderen te besmetten met Sexueel Overdraagbare Aandoeningen

(SOA), inclusief HIV infectie? Indien ja, wat zijn de kenmerken van besmette prostituees, en welke risico en beschermende factoren kunnen worden onderscheiden?

Het is onbekend hoe representatief de 120 respondenten zijn voor de prostitutie in het algemeen, voor prostitutie in de Verenigde Staten, of zelfs voor prostitutie in "Northeast". Data over het exacte aantal vrouwen dat in de prostitutie werkzaam is zijn schaars. Dit is deels het geval doordat het een door de samenleving weinig gerespecteerde activiteit is, deels doordat vele vrouwen onregelmatige werkuren hebben. Schattingen in de Verenigde Staten worden bovendien belemmerd door het feit dat prostitutie daar illegaal is.

Datacollectie is gebaseerd op verschillende onderzoeksmethoden. De respondenten zijn allen direct door de onderzoekster benaderd in hun eigen werkomgeving of zijn door anderen naar haar verwezen, de zogenaamde sneeuwbal techniek. Kwalitatieve informatie is verkregen via etnografisch onderzoek, met name selectieve participerende observatie. Deze techniek maakt het mogelijk het perspectief van de vrouwen zelf te presenteren. Kwantitatieve data stammen van een gestructureerde vragenlijst. Deze lijst omvatte vragen omtrent demografische gegevens, medische geschiedenis, drug gebruik en seksuele activiteit. Een bloed specimen van 10 ml werd in laboratoria van het Centers for Disease Control onderzocht voor seromarkers for hepatitis B en syfilis en

voor het HIV virus. De voordelen van het combineren van verschillende onderzoekstechnieken is beschreven in Hoofdstuk Een.

In Hoofdstuk Twee wordt dieper ingegaan op kenmerken van de prostituees. Zij zijn allen 18 jaar of ouder. De meerderheid (N=96) van hen is Afro-Amerikaans en de meerderheid (N=101) "tippelt" (werkt als straat prostituee). Tabel 1 presenteert een algemeen overzicht van karakteristieken.

**Tabel 1: Kenmerken van de prostituees**

	GEMIDDELDE	MINIMUM	MAXIMUM	SD
Leeftijd	32.4 jr.	20 jr.	47 jr.	5.7
Leeftijd eerste sex	14.8 jr.	7 jr.	23 jr.	2.5
Leeftijd entree prostitutie	25.1 jr.	16 jr.	39 jr.	4.4
Leeftijd eerste druggebruik	20.4 jr.	12 jr.	33 jr.	4.7
Tijd werkzaam als prostituee	87.6 mnd.	1 mnd.	240 mnd.	48.3
Aantal vaste relaties/5 jr.	1.8	0	7	1.3
Aantal maanden samengewoond/5 jr.	43.8 mnd.	0 mnd.	60 mnd.	20.1
Aantal kinderen	2.7	0	9	2.1

In Hoofdstuk Twee wordt eveneens ingegaan op de interactie van prostituees met derden, zoals de klanten, pooiers en de politie. Ook de invloed van druggebruik komt aan de orde.

Gebaseerd op een literatuuroverzicht --prostitutie algemeen, prostitutie en gezondheid, prostitutie en druggebruik, AIDS, prostitutie en druggebruik-- werden de navolgende hypothesen geformuleerd:

1. Indien de wereld van prostitutie en die van druggebruik overlappen --vrouwen prostitueren zichzelf om hun drugs te kunnen financieren en prostituees gebruiken drugs ten gevolge van de stress in hun beroep-- dan zal de meerderheid van de respondenten drugs gebruiken.
2. Indien er een correlatie is tussen het type drug dat de respondent gebruikt en het aantal seksuele partners, dan zullen de "crack hoeren" frequenter sex hebben met verschillende mannen dan hun collega's die drugs spuiten of drugvrij zijn.
3. Indien intraveneus druggebruik een risico-factor vormt voor hepatitis B, dan zullen seromarkers meer voorkomen onder de spuitsters, dan onder de vrouwen die niet spuiten en/of drugvrij zijn.
4. Indien druggebruik een negatief effect heeft op het reproductieve functioneren, dan zullen de druggebruikende prostituees meer problemen hebben op dit vlak dan hun drugvrije collega's.

5. Indien de mate van het bedrijven van "veilige sex" beïnvloed wordt door het verlangen naar drugs, dan zullen de druggebruikende prostituees hun intenties eerder opgeven dan hun drugvrije collega's.
6. Indien druggebruik een risico-factor vormt voor HIV infectie, dan zullen meer druggebruikende prostituees besmet zijn met HIV dan hun drugvrije collega's.
7. Indien de aanwezigheid van seromarkers voor hepatitis B een risico-factor vormt, dan dan zullen meer prostituees die seromarkers voor hepatitis B hebben ook HIV infectie hebben dan prostituees die geen seroamrkers voor hepatitis B tonen.
8. Wanneer reductie van risicovol gedrag voor HIV infectie eerder voorkomt onder die prostituees die zich bewust zijn van de gevaren voor HIV infectie dan onder prostituees die zichzelf in een "veilige" situatie zien, dan gaat "veilig" gedrag niet noodzakelijk gepaard met een negatieve HIV serostatus.

Gebaseerd op het aantal jaren ervaring in de prostitutie-wereld en het al dan niet voorkomen van druggebruik werden zes typen onder de respondenten onderscheiden. Deze zijn schematisch weergegeven in Tabel 2.

**Tabel 2: Typen onderscheiden onder de respondenten**

DRUGGEBRUIK	JAREN WERKZAAM ALS PROSTITUEE	
	5 jaar of korter	langer dan 5 jaar
Voorname­lijk intraveneus druggebruik	Type 1: de spuitster N=29	Type 2: de meer ervaren IV druggebruikster N=39
Voorname­lijk non-intraveneus druggebruik	Type 3: de non-IV cocaine gebruikster N=9	Type 4: de meer ervaren non-IV gebruikster N=10
Geen druggebruik	Type 5: de beginnende prostituee N=21	Type 6: de meer ervaren prostituee N=12

Deze typen (hypothese 1) worden meer gedetailleerd beschreven in Hoofdstuk Drie, evenals de verschillen tussen deze typen. Enige verschillen zijn: drugvrije prostituees zijn jonger dan hun druggebruikende collega's; zij die langer in "het Leven" werken identificeren op oudere leeftijd als prostituee dan zij die vijf jaar of korter werken; hoe langer in het vak, des te meer klanten; en het aantal klanten is hoger onder de druggebruiksters, met name de non-IV gebruiksters, dan onder drugvrije prostituees (hypothese 2). Het moge duidelijk zijn dat de vrouwen van type kunnen veranderen wanneer de omstandigheden wijzigen. Zo schuiven zij die vijf jaar of korter werken na verloop van tijd naar de rechter kolom. Drugvrije prostituees kunnen in een van de bovenste vier cellen belanden wanneer zij drugs gaan gebruiken. De druggebruikende prostituees onderscheiden zich eveneens van hun

drugvrije collega's in termen van hepatitis B infectie (82.5% versus 24.8%) (hypothese 3/Hoofdstuk Vijf).

In Hoofdstuk Vier wordt het reproductieve functioneren van de prostituees beschreven. Aspecten die aan de orde komen zijn de menstruatie cyclus, geboorteregeling, zwangerschap, abortie/miskraam en het hebben van kinderen (hypothese 4). Druggebruikende prostituees hebben te kampen met een meer onregelmatige menstruatie cyclus dan hun drugvrije collega's. De meerderheid (83%) heeft geen sexuele gemeenschap wanneer zij ongesteld zijn. Zij prefereren orale sex gedurende deze dagen. Ongeveer de helft van de respondenten (59.3%) gebruikt contraceptie. Het condoom is het meest populair, gevolgd door de pil. Condooms worden vaker gebruikt met klanten dan met niet-betalende partners. Het komt regelmatig voor de prostituees een condoom willen gebruiken, maar dat hun partner weigert of protesteert. Vooral de mannen die betalen stellen dat zij slechts willen "investeren in sex zonder". Druggebruiksters rapporteren dat zij geneigd zijn hun principes om alleen "veilige sex" te hebben opgeven wanneer het verlangen naar drugs te sterk wordt (hypothese 5).

Prostituees gebruiken condooms ter preventie van zwangerschap, maar ook ter bescherming van infecties (SOA, inclusief AIDS). In hoeverre zij het risico lopen besmet te raken of anderen te besmetten vormt het thema van Hoofdstuk Vijf.

Slecht 19 prostituees testten positief voor syfilis. Deze infectie komt lichtelijk vaker voor onder non-IV druggebruikende prostituees dan onder hun collega's en hangt waarschijnlijk samen met de seksuele activiteit onder crack gebruiksters. De rol die prostitutie speelt gedurende het AIDS tijdsperk is nog onduidelijk. Ongeveer de helft van de respondenten (48.7%) testte positief voor het HIV virus. De infectiegraad was het hoogste onder non-IV druggebruiksters (82.4%), gevolgd door IV druggebruiksters (57.1%) en drugvrije prostituees (15.2%) (hypothese 6). Behalve druggebruik is ook de aanwezigheid van seromarkers voor hepatitis B een predictor voor HIV infectie (Hypothese 7). De beste voorspellers voor HIV infectie werden via logistische regressie geïdentificeerd en zijn: seromarkers voor hepatitis B, druggebruik en condoomgebruik. Alhoewel ook de tijd werkzaam in de prostitutie en het aantal klnaten significant geassocieerd zijn met HIV status was deze link niet sterk genoeg om in het model gehandhaafd te blijven. Prostituees die zich bewust zijn van de risico's die zij lopen zijn eerder geneigd maatregelen te treffen dan zij die het risico negeren of zich er niet van bewust zijn. Vrouwen van de eerste groep zijn echter vaak al geïnfecteerd voordat zij "veiliger sex" bedrijven (hypothese 8).

Een van de belangrijkste uitkomsten van dit onderzoek is dat de aanwezigheid van HIV onder prostituees voornamelijk gerelateerd is aan druggebruik en niet aan seksuele activiteit.

## NOTES

1. The definition of female heterosexual prostitution as presented is based upon guidelines from the Centers for Disease Control. In their nationwide study, under supervision of Dr. W. Darrow, only women older than 18 years of age are included. As a consequence the study participants are all older than 18 years of age.

2. Examples are Barrow, 1986; Bell, 1987; Benjamin and Masters, 1964; Van de Berg and Blom, 1986; Boggs, 1987; Bullough and Bullough, 1972; Carmen and Moody, 1985; Choisey, 1961; Cohen, 1980; Davis, 1971; Ellis, 1937; Exner, 1975; Flexner, 1914; Gagnon, 1973; Glueck and Glueck, 1934; Goldstein, 1979; Greenwald, 1958; Groen, 1987; Hall, 1973; Heyl, 1979; Hirschi, 1962; Hollender, 1961; James, 1976; Kemp, 1936; Kinsey, Pomeroy and Martin, 1948; Longstreet, 1970; Miller, 1986; Pomeroy, 1965; Rosen, 1982; Schulman, 1981; Winick and Kinsie, 1971; Young, 1964; Zausner, 1986;

3. The term "sexworkers" is used more frequently to refer to those women working in the sex industry, e.g. prostitutes, varying from call girls to street prostitutes, go-dancers/erotic dancers/strippers and pornographic models. In 1987 a book called "Sex Work" was published. The authors are all (in-)directly involved in the sex industry, and express that they prefer the term "sexworkers" instead of prostitutes (DeLacoste and Alexander, 1987).

4. The structured research instruments were developed by the Centers for Disease Control. The blood testing took place at the CDC laboratories, under supervision of M. Parvan.

5. Adler and Adler (1987) give an overview of qualitative research techniques.

6. Call girls and street prostitutes and their different status are discussed in Greenwald, 1958; Cavan, 1970; Gagnon, 1973; James, 1986; Barrows and Novak, 1986; Miller, 1986.

7. Examples of the structuralist approach are found in Flexner, 1914; Bonger, 1916; Cloward and Ohlin, 1961; Davis, 1971.

8. Examples of the psychoanalytic approach are found in Greenwald, 1958; Choisey, 1961; Hollender, 1961; Exner, 1977.

9. Examples of the interdisciplinary approach can be found in Hirschi, 1962; Benjamin and Masters, 1964; Young, 1964.

10. See for articles dealing with male customers of female prostitutes: Kinsey et al., 1948; Gibbens and Silberman, 1960; Winick, 1962; Pomeroy, 1965; Gagnon, 1977; Delacoste and Alexander, 1987.

11. See for discussion of the social control of prostitution: Sterk, 1984; Brandt, 1985; Hobson, 1987.

12. See for examples of different pathways into both the world of drug use and the world of prostitution: Chambers, 1970; Winick and Kinsie, 1971; James, 1976; Datesman and Inciardi, 1979; Rosenbaum, 1981; Miller, 1986; Berg and Blom, 1986.

13. Grund and his colleagues describe "front loading" as a technique in which each user injects with his or her own syringe, while the drug supply is "cooked up" as one load. Des Jarlais reported the "sharing of a load". In this case the drug solution is drawn into a syringe and several users shoot up with the same needle.

14. See for description of shooting galleries Cohen et al., 1985; Chaisson, 1986; Des Jarlais et al., 1986; Schoenbaum et al., 1986.

15. In the following articles IV drug use and heterosexual transmission of HIV are discussed: Harris et al., 1983; Friedman et al., 1986; Newmeyer, 1986; Des Jarlais et al., 1987; Ginzburg et al., 1987.

16. See for examples of reports linking the heterosexual spread of HIV to prostitution activities: Luzi et al., 1985; Papaevangelou et al., 1985; VanDePerre et al., 1985; Quinn et al., 1985; Redfield et al., 1985; Kreiss et al., 1986; Melbye et al., 1986; Piot et al., 1986; Darrow et al., 1987.

17. E.g. Davis, 1978; Goldstein, 1979; Rosenbaum, 1981.

18. Key respondents are indispensable in ethnographic research. The researcher needs a few special "research friends" who can provide him/her with relevant background information and who can introduce the researcher to those individuals who normally not would have trusted the researcher (that soon). Examples of the importance of the role of key respondents can be found in Whyte (1955), Becker (1963), Liebow (1967), Boggs (1979), and Adler (1985).

19. In the Netherlands gathering places for drug users and prostitutes are more common, e.g. de Bulldog in Rotterdam and the Keet, and "Huiskamer Project" in Amsterdam and Utrecht. Medical service providers have also started using this technique. A clear example are the so-called "methadon bussen" in Amsterdam. These are methadone programs in which it is easy to get admitted. Methadone is given to drug users in a bus that is parked for several hours each day near a drug copping area. See also Hughes, 1972 for the use of a mobile fieldstation in epidemiological studies.

20. In the state "Northeast" is part of article 2C.34 1 of the Code of Criminal Justice deals with prostitution and related offenses like promoting prostitution, living off prostitutes or patronizing prostitutes. See Appendix A for the Criminal Code.

21. See the NIDA monograph (80) titled "Needle Sharing Among Intravenous Drug Users: National and International Perspectives", edited by Battjes, R. and Pickens, R., Rockville (MD), DHHS.

22. Examples of these discussions can be found in: Stein, 1974; Rosen, 1982; Darrow, 1984; Brandt, 1985; Krishan et al., 1986; Hobson, 1987

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