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Thesis Title

The psychosocial experiences of women involved in prostitution: an exploratory study

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PhD in Health Promotion

Discipline of Health Promotion

School of Medicine, Nursing and Health Sciences

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In memory of

My mom

Gemma Sweeney

If you are brave enough to say goodbye, life will reward you with a new hello...

-Paulo Coelho-
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This thesis centres on the voice of the women involved in prostitution who were brave and kind to share their stories. Although I cannot provide them true recognition of name, I know them by name, I know them as people and as women, each woman I had the privilege to talk with taught me along the way. Thank you...

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The Researcher

As a social care practitioner working with homeless teenagers in Dublin in the mid 1990s, I came to meet young girls experiencing homelessness and engaging in juvenile prostitution. Later, when I became a qualified social worker in practice, those memories remained with me. While working in University Hospital Galway (UHG), in a medical capacity in 2007, I continued to be aware of women service users who may be vulnerable to, or directly involved in, prostitution. It became clear, that I or my colleagues and indeed local healthcare professionals around me lacked the specific knowledge or expertise to address this issue.

I decided that training was a necessary requirement. In the capacity of a medical social worker, I invited the Women's Health Project (HSE) to Galway to provide training for myself and my colleagues (Social Work Department UHG). We decided to open this training to other community agencies who were providing the health needs of women in Galway city, to begin by incorporating a multidisciplinary approach to practice. These agencies included: The Galway Rape Crises Centre, Cope, homeless services for women, Waterside House, domestic violence unit, Youth services, Galway Refugee support group, The Gardai and Nurse Specialists from The Infectious Disease Clinic (UHG), acute setting. The house was full and the enthusiasm for information and the expressions of concern from individual agencies spilt over to an active working group which attempted to meet quarterly. As the coordinator of this group, we shared stories, concerns, explored options and so on, but it always came back to the same point, we needed formal, objective research to be completed locally.

What was the true nature of prostitution in Galway? Who were the women? As we could not answer these questions and relied only on hearsay, anecdotal evidence and professional speculation, I decided then that I would dedicate my time to this research. This is how this PhD came to evolve. Throughout my professional career I have brushed against prostitution but never met my desire to penetrate this world and come to fully understand the lives of the women within it. Thus, this PhD title and path became the obvious choice and has remained a privilege throughout the entire process.
Abstract
This exploratory research examines the barriers that prevent women in prostitution in Ireland from accessing co-ordinated health services. Through the examination of the experiences of women engaged in prostitution, by using an adapted voice centred relational model of analyses, underpinning a feminist standpoint epistemology theoretical framework, the research contributes to Irish knowledge and, in particular, pertaining to the psychosocial experiences of women involved in prostitution and the Irish healthcare service. Women in prostitution in Galway and its environs were interviewed using a biographical narrative approach. A further seven agencies in the field of prostitution were interviewed using a semi-structured interview format. These agencies’ were local, national and European and were included to support the research in locating prostitution within a wider ecological perspective and to identify the current socio-political realities. The findings indicate that women involved in prostitution are primarily working indoors, hold precarious legal status and are in Ireland as a response to global migration and economic necessity. The women discussed their fears in respect to clients and organisers of prostitution and the impact of minimal supports available to them. Street prostitution, too, remains evident with a strong link to family breakdown and addiction. The research concludes the need for further service development throughout the country of Ireland that is respectful to the various social determinants which impact on the lives of women in prostitution. Poverty, migration and the global trends of the sex industry can be addressed through a gendered reform of policies using an ecological framework for health. A review of current services nationally of healthcare providers in health, social work and community development fields is required. This research has profound implications for future studies in the field of Irish prostitution to inform practice and broaden the debate on prostitution here.

Key words: prostitution, psychosocial experiences, health promotion, ecological theory, feminist theory
1.1 Introduction

‘Female prostitutes are legally and socially constructed as a separate class of persons, and as such are subjected (to varying degrees) to a range of civil and human rights abuses’ (O’Connell Davidson, 2002, p.84). For this view to be understood, prostitution must be placed in context, considering the ‘why’, ‘when’ and ‘where’ in order to formulate a perspective. The perspective that is decided upon in this research will not be shaped by the researcher’s world view, rather, through the medium of the participants themselves: the women involved in prostitution in Ireland today. Sanders (2009) sets the scene for moving away from the many ‘deviant’ prostitute theories and towards drawing on ‘individual’ experiences and their narratives about being involved in the sex industry. To do this allows room for Pateman’s (1976) analysis of institutional and political forces, centred on patriarchal capitalism, all of which can, and do, resonate current Irish culture as it moves away from a catholic corporatist position to a now hybrid neoliberal state.

1.2 Prostitution in context

Ireland is exposed to global trends and influences. Therefore, what is happening globally impacts on what happens nationally. For example, according to Ward (2010), from the early nineties, Ireland saw a new sex industry emerge in the form of sex shops, lap dancing clubs, escort websites and increased interest in pornography. This shift, along with the movement of women into the country, provided a new landscape for Ireland’s sex industry. This is supported by a report from The Immigrant Council of Ireland (2009) which stated that there are 51 different nationalities of women available to men in Ireland. Nevertheless, Ward (2010) argues that the consequences of globalisation are beyond the traditional reach of the state’s capacity to maintain surveillance and/or enforce the law, but rather examines a social policy framework as a tool for tackling the gender inequalities of prostitution. As according to O’Connell Davidson (2006) inequalities permeate the industry nationally and globally, which capture the complex continuum of oppressions facing women in prostitution. This approach is inclusive of supporting a
health promotion approach in locating the psychosocial experiences of women involved in prostitution.

1.3 Rationale for the study

There are compelling reasons to do this study. Despite public disapproval of prostitution and substantial legal provisions criminalising prostitution related activities, individuals continue to sell and buy sex and it is an activity that has existed over the millennia (Department of Justice, 2012). Assuming that individuals will continue to engage in prostitution, consideration needs to be given to the specific health needs of women involved in prostitution. Ireland currently has only one government funded facility for women involved in prostitution primarily focusing on their health. This one unit is located in the capital city of Dublin and was originally opened to meet the sexual health needs of this population. There are no immediate plans to extend this service throughout the country and the government is still acting on outdated statistics gathered almost twenty years ago in 1995 which indicate minimal activity throughout the country (EUROPAP, 1996). Although statistics have been gathered by the Department of Justice from 2004 to 2011, these figures are being considered in respect to reviewing the law on prostitution with no provisions for simultaneously reviewing health services or addressing the health needs of this population. Therefore this research is deemed necessary and timely.

1.4 Terminology- `prostitution` as opposed to `sex worker`

In Ireland, it is not legal to practice prostitution under the Sexual Offence Act, 1993. Therefore, to engage in work that is not legally recognised does not provide the women with the same rights as other workers in the State such as prescribed by the relevant statutory employment legislation. Women who engage in the sex industry cannot seek legal redress, claim for non-payment by a client or protection from assault. For these reasons the term ‘sex worker’ will not be used in the research as their work is not recognised. Therefore, the term prostitution will be used throughout this study when referring to women involved in the sex industry in Ireland.

keeping with Sanders’ (2009) position of drawing on ‘individual’ experiences and their narratives about being involved in the sex industry, and to support health
promotion principles to advocate, enable and mediate (Ottawa Charter, 1986), the researcher will not align with a polar view on the subject of prostitution. It is not for the researcher to stand within the debate of ‘prostitution’ or ‘sex work’ ideologies but rather to draw on the experiences of the women themselves experiencing prostitution. Feminist standpoint epistemology is the feminist framework used as it is women’s position in society that explains oppression (Hesse-Biber, 2006) and which determines their access to healthcare services (Oleson, 2004).

1.5 Theoretical frameworks for the research

According to Mc Murray (2006) Health Promotion frameworks seek a socio-ecological focus on health. If we are to consider women involved in prostitution as participants within society and within its structures such as the family, community, and citizens of a wider society, then it becomes necessary to locate the women’s experiences and voices with an ecological framework context. The research seeks to understand how individuals interact with their environments and how this environment shapes their decisions and choices. To develop this framework further from a gender perspective, as the participants in the study are all female participants in the sex trade, and that it is women who continue to dominate prostitution within the sex trade (Smart, 2013), a feminist theory needs to be included to further indicate the strong parallel between women’s lived experiences and gendered structural inequalities imbedded in society; the ‘personal is political’ (Hanisch, 2006). The research will use feminist standpoint epistemology and ecofeminism.

1.6 Feminist perspectives

Simone de Beauvoir (1949) stated that ‘One is not born but rather becomes a woman’, and it is a worthy statement for entering a gendered discussion. To ‘do gender’, means to act in accordance with our socially constructed being. She tells us that as long as the prostitute is denied the rights of a person ‘she sums up all forms of feminist slavery at once’ (p. 569). Prostitution was no new phenomenon, simply an existential philosophical feminist approach which began back even within the teachings of Aristotle: women are indeed the inferior sex and prostitution itself violates the Aristotelian ideal of virtue being the golden mean between two vices (Malatesta, 2008). Hence, it is neccessary to discuss the subject of prostitution
inclusive of gender ideology and feminist discourse. In current times the discussion continues back and forth amongst feminists, according to Ekberg (2004) who stated that prostitution is normalised by neoliberals as a form of sexual entertainment, with equal players exchanging services for money. Working as a ‘sex worker’, is seen as a legitimate career path for women. What could be viewed as a severe form of sexual exploitation is now a woman’s right to do what she wants with her body and a way of sexual liberation and self-determination. This change is a contemporary and pertinent example of the revival of a stagnant, repressive political agenda, which now permeates virtually all current political, academic and popular discourses on prostitution and trafficking in human beings’. The ontological feminist standpoint here places the historical context of prostitution not as a separate entity but takes this journey into the current nature of prostitution today. It is only then that the research can acknowledge and identify its own position within feminist discourse and among the differing prostitution perspectives as discussed by academics in this field.

1.7 Health promotion

This research lies within the discipline of health promotion. Health promotion shares its principles to advocate, enable and mediate (Ottawa Charter, WHO, 1986) with other disciplines such as social work, family support and community development. In embracing a health promotion perspective it is wholly compatible to seek a multidisciplinary approach to practice which, indeed, crosses disciplines as it seeks to engage in a holistic ecological framework conducive to the service user. Health promotion impacts at all levels with a commitment to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies (Naidoo and Wills, 2009). Also, to acknowledge people as the main health resource and to support and enable them to keep themselves, their families and friends healthy, through financial and other means, to accept the community as the essential voice in matters of its health, living conditions and well-being and to recognise health and its maintenance as a major social investment and challenge to addressing the overall ecological issue of our ways of living (Ottawa Charter, WHO, 1986). This research adheres to this by creating a voice for women involved in prostitution and, thus, seeking solutions to their health requirements from their perspective. It is critical to evaluate this using an
ecological perspective as women interact with their environments. But it is clear that these environments are often predetermined and shaped from family function to the broader social determinants such as cultural norms, laws and policies which impact on the family and the individual. An ecofeminist layer will be incorporated to understand from a feminist standpoint how environments can remain not always adaptable of change to meet the needs of its individuals (Besthorn, 2008).

1.8 The research question

The research question; ‘the psychosocial experiences of women involved in prostitution’, accords with a qualitative approach and with the flexible nature of a qualitative paradigm (Robson, 2002; Sarantakos, 2005). As the researcher is interested in probing the meaning(s) of stories (Creswell, 2013), certain questions need to be addressed. A central question was decided upon, what are the health needs of women involved in prostitution throughout Ireland and are they being met? This question will be set against the backdrop of the current socio political climate which acts in accordance with neoliberal political ideology, current legal frameworks and a health framework which exists within this. All these phenomena shape the stories and psychosocial experiences of women involved in prostitution.

1.9 The aims of the research

• To examine the reported experiences of women involved in prostitution by investigating the current nature of prostitution in Ireland today
• To access the attitudes and perspectives of the agencies representing the women involved in prostitution.

The objectives of the research are:

• To identify and discuss the socio political reasons for entering prostitution
• To identify the specific health needs for women involved in prostitution in Ireland
• To identify the barriers which could impede or prevent women involved in prostitution from accessing health care and support.
Chapter One: Introduction

1.10 Thesis layout

Chapter two explores the literature on prostitution taking into account the historical development of prostitution in Ireland to its modern demographic form which is subject to globalisation and human trafficking. Here the researcher introduces and assesses the role of ecological theory both in its original determined form by Bronfenbrenner (1986) but also to include a feminist ideological perspective; eco feminism. The literature extends from Irish, and International perspectives with a view to including ‘The Swedish model’ on prostitution as Ireland is currently legislatively advocating for such a model.

Chapter three provides the methodology for the study. In keeping with a feminist theoretical framework (Feminist standpoint epistemology), phase one: the interviews with women involved in prostitution were biographical narrative accounts of their experiences. It was not the intention of the research to impose a set of questions aimed at seeking a particular response, but rather to record events important to the interviewee. The data was analysed using an adapted voice centred relational model to reinforce the voice of the participant as central to the research. It is their story that predetermines the findings and leads the discussion. In phase two methods, agencies were interviewed using a semi structured interview style and analysed thematically. Phase two is not central to the research as is phase one, but rather used to gain perspectives on the ecological implications for prostitution health.

Chapter four provides the findings for the research. This is presented in keeping with an adapted voice centred relational model of analyses. It is written to reflect the narrative, main events of the stories, relationships, cultural context and importantly how they tell their stories considering particular language as ‘I’, ‘we’, you’, which reflects their association of being present in the story when they discuss certain topics such as family or indeed abuse. The findings project the new phenomenon of indoor migrant women working in Ireland against the backdrop of a legal framework not conducive to protecting the women or indeed providing adequate healthcare provisions. The findings phase two provides answers to why?

Chapter five places all the above chapters within a discussion and analyses predominantly placed within an ecological/eco feminist framework. The findings led
the research to conclude, there are multiple barriers for women in prostitution to meeting their health needs. These barriers require further research, a re-evaluation of social policy from an ecological perspective. Moreover, a shift is required within societal assumptions and perspectives which reinforce negative gender discourse and poor health provisions. This can be achieved through training and information of healthcare providers and a platform for broader debate and discussion from the perspective of those currently involved in prostitution in Ireland today.
Chapter Two: Literature Review

2.1 Introduction

This chapter explores the theoretical context and literature on prostitution. The study will introduce and assess the role of social ecological theory both in its original form by Bronfenbrenner (2009) and also from a feminist ideological perspective, ecofeminism (Besthorn, 2002; Fox, 2008). The literature will outline the historical development of prostitution in Ireland to its modern demographic form, subject to globalisation and human trafficking. The literature will include Irish, and International perspectives with a view to including ‘The Swedish model’ on prostitution because the Irish State is currently legislatively advocating for this model. Ireland is unique in its historical development and has progressed slowly from a Catholic, corporatist State to a hybrid/neo liberal State which has had a direct impact on women involved in prostitution and those who are attempting to provide services to them.

2.2 The theoretical context of the study: ecological theory

In Bronfenbrenner’s model, the ecology of human development, is viewed as being affected by multiple levels of influence (2009). Specifically, Bronfenbrenner divides environmental influences on behaviour into the micro, meso, exo and macro systems levels of influence. The micro system refers to face-to-face influences in specific settings, such as interactions within ones immediate family, informal social networks, or work groups. The meso system is the interrelations among the various settings in which the individual is involved. These may include family, school, peer groups and church. The meso system is the system of micro systems whereby individuals interact via face-to-face with peers or individuals surrounding the immediate family unit. The exo system refers to the forces within the larger social system in which the individual is embedded. Examples in this case might be; the link between two or more settings. The macro system refers to cultural beliefs and values that influence both the micro system and the macro system. Examples include policies and legislation. Not only does each of these subsystems affect behaviour, but the subsystems themselves may change as their members are replaced or altered.
Thus, an ecological perspective implies a reciprocal relationship between the individual and the environment. Although, to critically assess this model, reciprocal relationships do not always occur depending on the individual and their social circumstances; women in prostitution can exist outside the law, citizenship and health (Farley, 2006).

A variation of Bronfenbrenner’s model for health promotion has been used drawing on the work of Belsky (1980). Within this thinking, patterns of behaviour are the outcome of interest, which holds resonance for this study to understanding the experiences of prostitution. Mapping, behaviours suggested within this model are viewed as being determined by the following:

1. **Intrapersonal factors**: characteristics of the individual acknowledge attitudes, behaviour, self-concept, skills etc. This includes the developmental history of an individual.

2. **Interpersonal processes and primary groups**: formal and informal social networks and social support systems including the family, work group and friendship networks.

3. **Institutional factors**: social institutions with organisational characteristics, and formal (and informal) rules and regulations for operations.

4. **Community factors**: relationships among organisations, institutes and informal networks within defined boundaries.

5. **Public policy**: local, state and national laws and policies.

However, according to Healy (2005), an implicit assumption of these levels of analyses is that social and health promotion interventions are based on our beliefs, understandings, and the theories of the determinants of behaviour. These levels of analyses reflect the range of strategies available to health promotion programmes. When considering beliefs and so on, other levels of analyses could also be employed to understand the causes and effects of prostitution to develop the tradition framework of social ecological theory. Ecological theory is no doubt the starting point, however in order to capture the true essence of what it aims to achieve we must also understand the environment as it is; a modern phenomenon of social and political norms which encompass patriarchal thought and structures. In this sense,
language and terminology must also reflect a woman centred approach, so this model needs to be tweaked accordingly to include a feminist ecological interpretation.

2.2.1 Critical overview of ecological theory

The aim of the research is to locate the ‘voices’ of women involved in prostitution in Ireland and to identify their health needs and whether they are being met. The research seeks to identify an integrated framework of person-environment transactions. In keeping with a proposed feminist standpoint epistemology, it was decided that the ‘voices’ would be explored seeking an ecological/eco-feminism framework. This is justified because, according to Besthorn and McMillen (2002), there is a need to bridge the gap between new developments in general systems thinking, and emerging trends to conceive the world in holistic, ecological terms.

Ecological/system frameworks have ranged from William Gordon’s (1969) and Harriet Bartlett’s (1970) goodness-of-fit model, the general systems perspectives of Hartman (1970) and Janchill (1969), the situational approach of Siporin (1972), the systems/ecosystems perspective of Meyer (1970), the ecological/life models of Germain (1973). Later, environmentally focused frameworks such as the structural approach of Middleman and Goldberg-Wood (1974, 1989) and the empowerment/social justice oriented models of Judith Lee (1994). However, theorists such as Saleebey (1990) and Mol and Spargaaren (2000) have been critical of ecological/systems frameworks for having an inherently conservative socio-political orientation and lacking a comprehensive critical perspective. One of the most poignant critiques of conventional ecological/systems theory rests on its heavy reliance upon personal or individual adaptive processes as the corner cornerstone of stable system functioning while disregarding the notion of the environment adapting to the individual (Besthorn and McMillen, 2002). On this notion of ‘adaptation’ an important, contemporary environmental philosophy known as ecological feminism or ecofeminism offered an important conceptual assistance as it searched for language and descriptions to help it better depict and explain the relationship between ‘person and the natural realm’.
Attempting to understand the complexity of interrelationships between person and nature may be indispensable to practitioners engaged with women involved in prostitution and continuing their commitment to a social justice and empowerment approach of oppressed persons and groups (Healy, 2005). Since the nineties, because of the increasing association between individual, economic, and political upheaval and environmental degradation (Besthorn, 1997; Besthorn & Tegtmeier, 1999; Twine, 2001; Kovel, 2005), ecofeminism has been identified as the way forward to challenging the notion of adaptation and calling for environments such as micro, meso, exo and macro systems to be examined with respect to their responsibility for adaptation.

2.2.2 Ecofeminism

Ecofeminism describes the movements and philosophies that link feminism with ecology. Ecofeminism connects the exploitation and domination of women with that of the environment and gives increasing attention to the twin oppressions of women and nature within the dominance structure of patriarchal social conventions. What has evolved is a feminist/ecological dominance theory rooted in the destructive ethos of patriarchy. The key point here is the ability to adapt a framework on one’s own life experience which is similarly being used to identify the life experiences in this research of women involved in prostitution. It will be their narratives which direct the research, therefore it becomes clear that an ecological- ecofeminism framework should be explored. The literature review will assess an ecofeminist perspective in support of a holistic framework for women and prostitution.

Besthorn (2003) and Fox (2008) discussed ecofeminism as a framework for an expanded ecological (service provider/social work) practice. This analysis considered the oppression of women as a recognised ‘other’ within structural society. Health and social disciplines aim to address the psychosocial experiences of women and in this case prostitution, holistically and with a shared objective for a multidisciplinary approach to practice. Practitioners at the core of their practice are health promoters; likewise health promotion practitioners endeavour to understand the social determinants of health as key to appropriate service delivery.
The major contribution of ecofeminist philosophy is its focus on a new language and new ontology of person and nature, and interrelationship between the two. Ecofeminist thought suggests to practitioners an alternative ontology as a basis for understanding person, nature, interrelationship, and issues of empowerment that diverge significantly from the profession conventional ecological/systems models. It offers practitioners an opportunity to construct an expanded ecological model more consistent with professional values and practice commitments to social justice and efforts to end discrimination and oppression (Code of Ethics, 1996).

While ecological theory focuses on personal or adaptive processes, ecofeminism argues that within this model alone, the responsibility appears to remain with the individual to adapt to a changing environment. ‘Such environments are inherently conservative socio-political orientations which focus on narrowly defined domains of environmental transactions’ (Besthorn, 2008). As Saleebey and Day (2008) notes, the realities of power, conflict and oppression, and violence, are central to the survival of many groups including prostitutes, and are given a curious and unreal patina by the adaptation perspective. The environment is a socially constructed entity, therefore the ecological model solely, escapes a place where an individual, before adaptation, is an entity in their own right. Ecofeminism, further draws on the works of Foucault (1992) ‘Margins of Philosophy’. According to him, ‘the body is the inscribed surface of events (traced by language and dissolved by ideas), the locus of a dissociated self (adopting the illusion of a substantial unity), and a volume in perpetual disintegration’. Foucault requires us to understand a deconstructionist approach, to deconstruct the body in the context of its life course and current location. This supports the proposed argument of ‘other’ within the environmental process. As summed up by Simone De Beauvoir’s existential philosophy ‘One is not born, but rather becomes a woman’ (De Beauvoir, 1949, p.1.). Such ideas are inherent to understanding prostitution in society today. It is not acceptable to simply understand the profession or industry, without connecting with a theoretical framework which can explain, locate and address the circumstances of prostitution in Ireland today.
Chapter Two: Literature Review

The literature will first discuss prostitution within a traditional ecological framework, while throughout drawing from an ecofeminist perspective to maintain respect of the individual as the starting point of the discussion. To create a service delivery as needs-led, as opposed to a predominant emphasise of the macro; cultural and policy led agendas’ which are patriarchal and oppressive to certain groups, such as women and most certainly prostitution.

2.3 The micro system

The micro system refers to the settings in which the individual has direct face-to-face contacts, usually the family, school and local community and so on. The development of the individual will be influenced by the roles, relationships and activities played out in these contexts. As the micro system expands, the nature of the activities become more complex. For Bronfenbrenner (1986), the expanding capacity for greater levels of complex interaction was the essence of human development. The focus at the micro level is whether the relationships are positive or negative and whether the individual is valued and respected. Such relationships can act as determinants to someone’s life course in respect to resilience, opportunity and self-efficacy (Jack, 2010). For this section, the focus will be the family. This will be assessed in respect to the changing nature of family in Irish society, inclusive of stressors. Further to this, the literature will evaluate the micro system considering services and supports available to the family as a preventative intervention of family breakdown, teen homelessness, the care system and its link to prostitution.

There is no one agreed or unified definition of family, but many of the different definitions have certain things in common (Santrock, Minnett and Campbell 1994). Macionis (2005) describes a family unit as ‘a social group of two or more people, related by blood, marriage or adoption and usually live together’ (p.462). Gough defines family as: ‘a married couple or other group of adult kinship who cooperate economically and in the upbringing of children, all of whom share a common dwelling’ (Gough, 1959, p. 23). Nevertheless, there have been radical shifts in patterns of family formation and dissolution in recent years. There has been a large increase in one parent families, step-families and a greater trend to cohabitation and births outside marriage. In recent times there has also been an increase in migration,
therefore an increase of families of different ethnic backgrounds, cultural beliefs, religions and practices. International migration ensures that no major society consists entirely of people who follow just one cultural tradition (Hayek, 2012). The Irish constitution defines family as: Article 41.1; The State recognises the family as the natural primary and fundamental unit group of society, and as a moral institution possessing inalienable and imprescriptibly rights, antecedent and superior to all positive law. 2; the state therefore, guarantees to protect the family in its constitution and authority, as the necessary basis of social order and as indispensable to the welfare of the nation and the state. Other conditions clearly recognise the woman’s place within the home and in the context of the sanctity of marriage (Article; 41.2.1 and 41.3.3). As families and its individuals do their jobs to support each other within this unit, subject to their external environments, this is said to shape or hinder ones experiences and life choices (Bronfenbrenner, 1986).

In the 1990’s and up to the present time, feminist writing emerged to challenge common perceptions about family (Ferree, 2010). Some of the basic assumptions of feminist thought were: women are oppressed and the ‘personal is political’ (Hanisch, 2006). In other words the social structure influences and is influenced by personal experiences. In effect, this thinking is quite progressive in understanding oppression and women in the context of their environment. As Bronfenbrenner suggests; ‘what happens to an individual in his or her family, can only be understood by the relationship of the family to society at large’ (Bronfenbrenner, 1986 cited in Muuss, 1996, p. 338). Ferree (2010) argued that, contrary to popular perception, the family is not a private sphere which is immune to the inequality that exists in wider society. She believed that family cannot be understood separately from the economic, political and other systems of male power. Furthermore, she questioned the assumption that families are singular units where men and women share a standard of living, class, position and set of interests. As Eshleman (1997) concludes, family will never be an egalitarian institution while women remain dependant on men for resources and status. Considering the above theories it is necessary to place prostitution within the debate. Evidence suggested that family breakdown of severe dysfunction can lead to prostitution for women. When dysfunction is discussed it is important to consider what this term means in its specific context. This will be explained using Hardiker’s (1991) scale for level of need; Level 4 primarily focuses
on the dysfunction level of a family of severe nature. For example, in crisis situations when a child or young person has been placed in alternative care due to physical neglect or sexual abuse (Hardiker, 1991, p. 43). The literature will discuss family breakdown and the link between alternative care (as a substitute for the family unit) and prostitution.

2.3.1 Family breakdown and the care system

Studies have provided figures to link alternative care and entry into prostitution. Across the UK, surveys of women involved in the sex industry have identified a disproportionate number of girls and young women with backgrounds of local authority care (residential and hostel accommodation). In Stoke-on-Trent, a 2001 survey by the Women’s Project found that 39 per cent of women working on the street had care backgrounds (Moss and King, 2001). City councils in both Glasgow and Leeds have undertaken enquiries into reports of girls in children’s homes selling sex on the streets and using drugs (Valios, 1996; Nicoll, 2002). In the Midlands, a study found that 51 per cent of women selling sex on the streets had care histories (O’Neill and Campbell, 2001) and, in the South West of England, research identified that 38 per cent of women had spent time in local authority care (Sanders, 2001). Pearce et al.’s (2003) study with sexually exploited young women was conducted in a London borough and a Northern city found that 71 per cent had had episodes in care. A recent mapping exercise in Newcastle-upon-Tyne found that 21 per cent of young people known to be selling sex had been in local authority care (Thompson, 2005). These studies were followed up again 2004, showing similar results (Jeal and Salisbury, 2004). Research of this kind has not occurred to date in Ireland.

International research evidence also demonstrated a similar pattern between local authority care and commercial sex. In Norway, research found that 58 per cent of women had experiences of the care system prior to their first commercial sex encounter (Hoigard and Finstad, 1992). Studies in Canada have also identified disproportionate percentages of care backgrounds (approximately 50 per cent) among women who sell sex (Nixon et al., 2002). A comparative study of outcomes for young people leaving care in both the UK and Australia revealed that entry into the sex industry was a risk for female care leavers in both countries (Mendes and Moslehuuddin, 2004). The poor material outcomes for young people leaving care are
well documented in terms of homelessness, low educational achievement, substance misuse, over-representation in the prison population and teenage motherhood (Broad, 1999; Stein, 2006). However, as Coy (2008) suggested, there is a lack of theoretically informed empirical evidence on the lives of young women in local authority care. Therefore, little information on how vulnerability to involvement in the commercial sex industry is cultivated within the care system. The available research study with young women in residential care, suggests that institutional reinforcement of gendered roles and feminine norms, and inadequate responses to sexual activity, are significant features of children’s homes (Green’s et al 2000; Stein, 2006; Coy, 2008). O’Neill et al. (1999), in an Irish context, identified that emotional insecurity characterises young women’s’ experience of being in care and precipitates entry into the sex industry: some were young women who drifted into prostitution on leaving care because of financial problems and their association with the street culture. Others were clearly pimped and coerced into prostitution, whilst in care, through developing ‘romantic’ relationships with local pimps. All of these young women had profoundly sad backgrounds of child sexual abuse, physical and emotional abuse, family breakdowns, and multiple placements in care. These results indicated extreme vulnerability and emotional neediness, as their needs had not been met within the organisation of residential care despite some very committed staff (O’Neill et al., 1999).

More generally, literature on routes into the sex industry among adolescents have identified a kaleidoscope of ‘push factors’, including family disruption and/or breakdown; previous experiences of abuse; poor educational achievement and disenfranchisement from school; running away and homelessness; substance misuse, including alcohol and solvents as well as class A street drugs such as heroin and crack cocaine (Melrose, Barrett and Brodie, 1999; M. O’Neill and Campbell, 2001; Pearce Williams and Galvin, 2003). Young people living in and leaving local authority care were recognised to be particularly susceptible to all of these risk factors (O’Neill, 1999; Melrose et al., 1999; Friedberg, 2000; M. O’Neill et al, 2001). Cutbacks in social and economic benefits that have affected young people’s benefits entitlements are especially significant for young care leavers, leading them to find selling sex a practical means of income generation (Melrose, 1999). In addition, research identified aspects of the care system as presenting risks, primarily
peer introduction to exploitative men and lifestyles and the lack of support networks available to care leavers (Melrose et al., 1999; Home Office, 2006). Therefore, there is direct link between prostitution and family breakdown. Such studies were followed up to provide similar findings (Jason, Davis and Ferrari, 2007).

The care system cannot exist in isolation but is rather an extension of family breakdown. Coy (2008) attempts to outline these factors within her article; *Young Women, Local Authority Care and Selling Sex: Findings from Research*, whereby she evaluated her participants inclusive of their psychosocial vulnerabilities.

2.3.2 Psychosocial experiences in response to family breakdown

The narratives of the women who participated in Coy’s (2008) study, show that the psycho-social vulnerability of young women in care was the result of a combination of their personal histories and experiences of care settings. Listening to young women’s life stories revealed their own constructions of sense of self. The key themes that emerged were women’s identity development and embodiment whilst in care and prostitution, and experiences of stigma and ‘othering’ (Coy, 2008). The study design focused on the narrative and life history of the participants. According to Coy (2008), the psycho-social dimension of young women’s lived experience in the care system was central to the multiple ways by which young women enter prostitution, including by coercion, drift by peer association, or an equation of selling sex as an option that fits with their self-perception. The narratives showed that the young women’s identity development was based on a failed development of the relational self, a social construction of gendered/feminine selfhood that is embedded in successful relationships with others (Gilligan, 2001). The multiple placements that characterised experiences of local authority care as based on principles of disruption and instability, instilled a feeling of ontological insecurity, in which the young women’s sense of being was uncertain. Young women without a web of relationships in their lives felt that they were invisible, and described how this was reinforced with each move and placement breakdown (Laing, 1961, 2002).

Coy (2008) added that the women’s relationships with their bodies during adolescence and their lived experiences of family breakdown were central to their entry into prostitution. Similarly, women’s relationship with their body is also
crucial to understanding the ontology of commercial sex, depending on selling access to parts of the body and enabling clients to assume a degree of command over the body (O’Connell Davidson, 1998, 2006). In their narratives, the women described a troubled sense of ownership of their bodies that reflected what they had learned through how others had reacted and regarded their bodies. This culminated in a habitual knowing of their bodies (Merleau- Ponty, 1962) that was based on others’ use for violence or sexual release. This afforded them little sense of clear ownership or a feeling of bodily integrity. The women also expressed feelings of hostility towards their bodies as a result of physical and sexual abuse, and described developing a range of dissociative mechanisms (Coy, 2008). These experiences contrasted with trust, reciprocity, routine and ritual, as Gilligan (2001) maps out as the core functions of a family. This also refrained from the notion of resilience and social capital discussed by Jack (2011) as key determinants gained from a supportive family unit to establish coping mechanisms for life’s unpredictable crises. Furthermore this study raised the issue of stigma. Stigma is defined by Goffman (1963) as ‘the situation of the individual that is disqualified from full social acceptance’ (P.9), and the women’s narratives revealed multiple ways in which they were aware of their ‘difference’ and perceived deviancy linked with their location outside of the social mainstream, family. Coy (2008) found that the women’s experiences of marginalisation from society were crucial to understanding how they felt disenfranchised and drifted towards street sub-cultures that revolved around commercial sex and drugs. Their narratives highlighted that identification and adaptation to the norms of family breakdown were based on becoming the ‘deviant other’. Finally, identification with other young women who were selling sex was significant (Coy, 2008). Goffman (1963) identified this process as identification with ‘sympathetic others’ or as individuals that also share the stigma of homelessness. This created identification and affinity with women who sell sex. Young women absorbed experiences and events through the physical proximity in street soliciting areas and involvement in street subcultures (Coy, 2008).

Family breakdown is not the only reason why family as a micro unit can fail to meet the needs of the individual in their early stages of development. Conflict migration and forced separation added stress to the family unit according to ‘Strong Bonds:
Working Cross Culturally’ (2009). The issues that can impact on migrant families and refugees include:

- Grief and loss.
- Post-traumatic stress.
- Isolation and lack of social connectedness.
- Language barriers.
- Heightened intergenerational conflict due to a clash of values and customs.
- Settlement problems - including access to welfare and financial support, employment, affordable housing, education and training.
- Difficulties adjusting to the education system.
- Racism.

These factors created family and individual stressors, assuming, in this case, that the whole family has migrated together. Another factor to consider was the gendered nature of migration, 'the feminisation of migration' (Sasson, 2013; Berry, 2009). Here the main care giver (usually the mother), leaves the family home to migrate to another country to find work to support her family. This deconstruction of the family unit, can impact on all its members.

While the family continues to exist as the most important unit in society, according to the Irish constitution, how its members exist within this unit can impact on their development and future. Ecological theory can support the family by further outlining how the family is intrinsically linked and acts in accordance with the wider society, social norms and values. To include an ecofeminist dimension, the family unit itself must be supported by family policies and interventions which require the environment to adapt to the family’s needs of crisis, breakdown and migration (Besthorn and McMillen, 2002).

2.4 The meso system

The meso system refers to the interrelations among the various settings in which the individual is involved. These can be family, schools, peer groups and church. The meso system is described as the interactions between the micro systems. More importantly, in respect to women involved in prostitution, the individual is not simply observing events happening to them, but are playing an active role in helping
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create the experiences they have. According to the literature, women involved in prostitution today in Ireland are of 51 different nationalities and indoor prostitution is where the women are; mostly working in apartments and/or out of hotels. Between three and thirteen per cent of the women in indoor prostitution are Irish, which means that up to 97 per cent are migrant women (Immigrant Council of Ireland, 2009, p.23). The women advertise on the internet, for example, www.escortireland.com. We also know from the literature that the women are engaging in prostitution outside of the law and women are reluctant to access health care or become known to services as involved in prostitution (The Women’s Health Project, 2007). The women themselves do not alone create the current phenomenon of prostitution in Ireland; they participate alongside clients, organisers of prostitution (pimps, drug dealers) and the Gardai and health services. Their interactions therefore determine their experiences.

2.4.1 Clients

There is little written in Irish literature on clients who use prostitution. We can assume there is a demand as the evidence suggests that prostitution exists in every pocket of Irish society (Ruhama, 2007). In 2011 Limerick police, as part of an operation to tackle prostitution, arrested 21 men in the act of soliciting women involved in street prostitution for sex. The age profile of the men was between 20 to mid-60s. All men pleaded guilty and were charged (Irish central, 8th December, 2011). In an Information/Discussion Papers - Ruhamas Perspective 2007, Ruhama outlined details on clients based on research from O’Connell Davidson (1998). More than 350 western men were interviewed about their prostitute use in the course of research into prostitution and sex tourism over seven years. Her central conclusion was that the use of women in prostitution represented a means of sidestepping certain aspects of social regulation of sexual life, a way of attaining power and control over other people as sexual beings without incurring dependencies or obligations (Ruhama, 2007). Mansson and Heddin (1999) looked at both situational buyers and habitual buyers. Situational clients are those who find themselves in a situation where they buy sex although this was not their premeditated intention. Habitual clients make conscious decisions to buy sex. The clients may be split into 70% occasional (single or rare incident) and 30% habitual (more than twenty
contacts). Habitual clients are not numerous but regularly use a large number of women. These users project their emotional problems onto women, using violence in varying degrees to humiliate and degrade them. According to Mansson et al., these men are not very receptive to legal measures and present a major challenge in terms of prevention (Mansson et al., 1999; Ruhama, 2007). The usual profile for habitual users appeared to be men in their 30s, employed, married and have no previous convictions for prostitution or otherwise. In a British Home Office study on street prostitution in 2004, figures, supplied by police, for men soliciting women, showed a median age of 35 years. Most (67%) were in fulltime employment; most white European; nearly half were married; nearly half were home owner occupiers and most had no previous charges (O’Connell Davidson 1998; Mansson et al, 1999). A study by the Swedish National Institute of Public Health found that one man in eight in Sweden bought sex at least once in his life. They came from a cross section of social classes; had money, stability, education and power – in contrast to the women they bought.

In an age where the internet plays an active role in choosing and booking sex, a study in the US by Gannon (2013) looked at the profile of men who buy sex online. She called them ‘Hobbyists’, these were the men that posted comments and ratings up on a site for other buyers to view. According to the findings, the men were most likely to be white, educated, married and employed in well-paid jobs. The men mostly thought that prostitution should be legal and that the women enjoyed their work. In Ireland clients also access escort sites to buy sex and they too have access to a comment board (Ruhama, 2007).

2.4.2 Organisers of prostitution

The organising of prostitution in Ireland is considered here in two strands, the pimp or brothel keeper and/or the drug dealer. There is evidence to suggest that brothel keeping has occurred. For example, Thomas Carroll, 48, an Irishman, and Shamiela Clark, 32, his South African wife, ran 35 brothels mainly active throughout the Republic of Ireland. Among the prostitutes were six trafficked girls and young women, aged from 15 to 21. They were arrested in 2010, in 2012, eight people were arrested in a cross-border operation targeting organised prostitution, criminality and money-laundering (breakingnews.ie) and in 2012 as part of Operation Quest the
Gardai raided 14 brothels in Limerick which was a European prostitution ring (Limerick Post, 31st May, 2012). The evidence suggested that the main cohort of women working in the brothels were foreign nationals where their visas and legal status to remain in the country were compromised. The literature outlines a direct link between migrant women working in prostitution and organised crime in particular for women who do not hold an appropriate visa to travel or live in Ireland freely.

For the purpose of this section, drug dealers will be discussed specifically relating to drug dealers who present as pimps and/or boyfriends to the women. There is substantial literature indicating relationship between street prostitution, drug addiction and relationships with their drug dealers (Melrose, 1999; Coy, 2008). Women, particularly adolescent women, appeared to be enticed by pimps into a life on the streets by five powerful forces: love, debt, addiction, physical might and authority (Kennedy et al, 2007). According to their study, drug dealers zoned in on drug using women who were homeless or at risk of homelessness, by housing them for a few weeks while introducing them to drugs. Prostitution began with the dealers encouraging the women to sleep with friends of the men to pay for the drugs, thus grooming them into the world of prostitution. The women who were recruited by this method would acknowledge that they were addicts before they turned to prostitution (Kennedy et al, 2007). According to Erikson (2005), the financial stress of maintaining a drug habit left the women feeling trapped. Evidence also suggested that the women first perceived their dealers to have been their boyfriends, they were ‘in love’ and had formed emotional attachments to their pimps or drug dealers which opened them up to a manipulative, abusive relationship with detrimental consequences (Dalla, 2001, O’Neill 1997).

2.4.3 The Gardai

Women involved in prostitution are effectively engaging outside of the law under the Criminal Law (Sexual Offences) Act, 1993, Public Order offences. For this reason the Gardai have a precarious relationship with the women involved in prostitution. A Report prepared for EUROPAP and the Eastern Health Board and in conjunction with the Women's Health Project (1996), suggested that all of the members of the Garda Siochana who were interviewed accepted that the current law had created
difficulties for women working in prostitution, particularly those working on the street.

The Gardai also suggested that they, as frontline workers in prostitution, required training specific to prostitution and the health and wellbeing of the women. "The women we are dealing with are just ordinary women; they are human beings, not criminals" (p.12). Another Garda suggested the need for training in relation to the development of social skills. In this report, it was evident that the views of the Gardai from the city (Dublin) differed to their colleagues in more rural settings. This was mainly due to limited knowledge or whereabouts of prostitution activity outside of the Capital at this time. The women themselves who partook in this study talked about harassment from the Gardai and the majority of the women stated that they would not go to the Gardai if they were attacked by a client. Overall, the report in 1996 showed a gap in support and communication between the women involved in prostitution and the Garda Siochana. This gap primarily centred on current legislation and training.

In 2013 the gap appears to be narrowing as the Gardai have shifted their focus to the organisers of prostitution and those who seek to gain the greatest capital and benefits from the sex trade such as brothel owners and traffickers. For example, the O’Carroll case mentioned earlier, where Mr O’Carroll and his wife were jailed for brothel keeping, following an international investigation by the Gardaí, the PSNI and the UK’s Serious Organised Crime Organisation in 2011. In 2012, Gardaí conducted 110 searches under a joint operation with the PSNI, which carried out 20 raids in the North. A number of suspected brothel organisers were arrested in the Republic, including two Hungarian women, and a Chinese woman in Dublin. There were 14 searches in Cork and more than 15 in Limerick. Nineteen searches were also conducted in the South-East, across counties Tipperary, Kilkenny, Carlow, Waterford, and Wexford (Irish examiner, May 31st, 2012). In 2013, Gardaí raided a building in Limerick as part of their crackdown on prostitution. They found 18 Romanian women and a number of men inside the house. The house was being used as a brothel. The women were aged between 18 and 36, and came from Romania just outside Bucharest (Limerick post, 30th August, 2013).
Adding to this shift of focus is the new legislation on trafficking for the purpose of sexual exploitation Criminal Law (Human trafficking) Act, 2008. An anti-trafficking unit (AHTU) has been established in the Department of Justice and Equality in February 2008, working to ensure an Irish response to human trafficking. A key element of this strategy is the National Action Plan to Prevent and Combat Trafficking in Human Beings in Ireland 2009 – 2012, which was published by the Minister for Justice and Equality in June 2009 and is available at www.blueblindfold.gov.ie. A second National Action Plan is currently being developed. In addition to the AHTU there are three other dedicated units in state agencies dealing with this issue, the Human Trafficking Investigation and Coordination Unit in the Garda National Immigration Bureau (GNIB), the Anti-Human Trafficking Team in the Health Service Executive (HSE) and a specialised Human Trafficking legal team in the Legal Aid Board (LAB) (Department of Justice and equality, 2013).

The Discussion Document on the Future Direction of Prostitution Legislation by the Department of Justice and equality (2012), provides information which seeks to identify the buyers of sex as the perpetrators of crime and not the women involved in prostitution (This is based on the Swedish model to criminalise the buyer to curb demand). In response to this the Gardai have become more sympathetic to the women selling sex and have attempted to bypass them when considering the law and have solely focused on criminalising the buyer. Evidence if this is ‘Operation Kerb’ (2011), where Gardai targeted men soliciting sex in both Dublin and Limerick. Gardai took the approach of making it illegal to buy sex but not to sell it, acting on the Government Report on the discussion of decriminalising the seller of sex.

2.4.4 Health services

There is one HSE designated health centre for women involved in prostitution in Ireland. The Women’s Health Project was established in 1991, as part of the HIV/AIDS prevention strategy. The project provides an accessible drop-in service, open each Wednesday between 2.30pm and 5pm and again on Thursday evening between 8pm and 10pm. A full sexual health screening and counselling service is available including HIV and Hepatitis A, B and C testing, vaccinations, smears, counselling, contraception, pregnancy testing and advice, support, referral and
education. Additional services include a methadone and needle exchange programme. All services, including drugs and condoms, are free. The HSE house two support workers specifically to work with trafficked women, however they are located in a separate building and location in Dublin, and come under different legislation (Human Trafficking Act, 2008) and within a different sector of crime (AHTU).

Services specifically for women in prostitution are delivered ad hoc throughout the country. The primary setting would be sexual health clinics with an emphasis on sexual health screening. The current efforts focus on one main centre in the country provided by the HSE (Women’s Health Project), emphasising sexual health and a drug user approach to practice which meets the needs of drug using street women, yet the literature suggests that women in prostitution are more diverse with more diverse needs (Immigrant Council of Ireland, 2009). Street prostitution still remains strongly linked to drug abuse and addiction but this visible cohort does not represent prostitution in Ireland and the indoor group situated throughout the country (Immigrant Council of Ireland, 2009).

2.5 The exo system

The exo system has a direct impact on the individual although they are not directly involved with this system per se. For example, as Bronfenbrenner (1986) originally looked at its impact on the child, if a parent’s work environment was not conducive to familial care such as longer working hours for the mother, or minimum wage, this directly affected the child. Childcare may be compromised or there could be limited time together for child and mother. For the purpose of this framework the child will be replaced by prostitution as the individual involved in the exo system. The external forces which are being examined are poverty and migration and environmental contexts are significant within this debate. In prostitution, issues of sexual politics become entwined with economic and political issues such as housing, social welfare, health, childcare, and the feminisation of poverty. All these factors are combined to create a situation (Dalla, 2000), where prostitution is viewed by some women as the best option available to them (McLeod, 1982; Dalla; 2000; Ekberg, 2004; Outshoom, 2005).
2.5.1 Poverty

Women involved in prostitution are ‘doing it for the money’ according to Dalla (2002). The discussion is gendered as it is primarily a female selling market and a male buying market. This research is interested primarily in the psychosocial experiences of women involved in prostitution; therefore, the discourse is gendered. According to the literature poverty plays an important role in prostitution. International research has found that women can become involved in prostitution because of their restricted access to financial and material resources (Harding, 1987). For example, as Harding outlined (1987), homelessness is a recognised entry route into prostitution. Limited opportunities can make prostitution attractive (Brock, 1998) or provide the veneer of choice and control (Pearse, et al, 2003). In an Irish context there is evidence to suggest a link between homelessness, drug addiction and street prostitution (O’Neill, 1997). Although Ireland maintains a robust social welfare system, without a fixed abode one cannot access social welfare support. Young women, who fall between the cracks of the care system and street culture, are open to poverty and prostitution (Coy, 2008). The women have little involvement in the organisation of poverty variables yet these variables directly impact on them. Women and children have a higher risk of poverty than men do in Ireland (Murphy, 2003). However, poverty can be reduced by redistributing income across the life cycle, particularly to people at key stages of care provision, through state transfers such as child welfare payments (Murphy, 2003). This debate needs to extend to simplifying the route from welfare to work. An expanded ecofeminism model encompasses and addresses a broad range of environmental and social issues rather than dissecting interrelated issues such as poverty into disconnected pieces.

Poverty factors include migration and why women in particular leave their impoverished countries to travel to Ireland to work to send money home to their families. Women come to Ireland to work in the service industry and/or find themselves in prostitution or they come here specifically to work in prostitution (Immigrant Council of Ireland, 2009). The policies and socio economic concerns within their countries have a direct impact on their choices to leave. This can be extended to include women seeking asylum in Ireland to flee conflict from their country of origin. The greater concern here is how Irish policy and legislation have
the capacity to create poverty for this group. Therefore, the exo system of Irish economic and migration legislation structures can influence the decisions and experiences of women currently involved in prostitution today.

2.5.2 Migration

Agustin (2007), in her book *Sex at the margins*, explained how wealthy westerners cast immigrants as `The Other’, similarly to how Simone De Beauvoir (1997) referred to women as the specific other. This is relevant as it is women who are on the move globally now more than ever (Ehrenreich, and Hochschild, 2004). Although Agustin (2007) makes the distinction between the very vulnerable traveller with nothing and the traveller who comes to another country with goals and expectations and a social network, we cannot conclude this debate without acknowledging the structural barriers women face when they arrive in their country of destination, i.e. Ireland. Structural racism, classism, and sexism are institutionalised forms of oppression through institutions in a society that subordinate individuals based on their race, class and sex classifications, respectively (Mooney, Knox & Schacht, 2001). Structural racism is always being classed and gendered (Ntiri, 2001), and thus structural aspects of migration can facilitate a woman’s entry into prostitution. For example, in Ireland, all non EEA nationals, whether visas are required or not, are subject to immigration controls upon arrival into the State. Such environments seek an ecofeminist analyses to locate migration and migration policies as maintaining an expectation that the migrant will conform to these policies as opposed to policies adapting to meet the needs of the individual migrant. Non EEA members can remain for 90 days provided they meet the criteria of the Immigration officer. These criteria exist in the form of ´Stamps´.

Stamp 1: Non EEU nationals issued with a work permit

Stamp 2: A person can only work 20 hours per week

Stamp 2: A person is allowed to remain only as registered in education

Stamp 2A: A person is permitted to study but may not take up any employment

Stamp 3: This is a visitor’s permit only
Stamp 4: The person is granted leave to remain and can access social welfare (Refugee Act, 1996).

These stamps determine one's outcome in the country. They are clear guidelines set down by the Department of Justice and Equality, Irish naturalisation and Immigration service.

Those seeking asylum in this country are not permitted to work or engage in a course or education. Asylum seekers are housed in Direct Provision hostels throughout the country where they benefit from food and shelter with a weekly allowance of €19.20. Although those seeking asylum in Ireland have access to a general practitioner, medical card and other health services where needed, RIA (Reception and Integration agency), who are the agency responsible for housing asylum seekers, are not directly responsible for health concerns and social services for their residents. This appears to highlight a direct gap in the psychosocial health needs of the population, as reinforced poverty and no involvement within the community through education, training or employment. This is consistent with structural racism and not an eco-feminism paradigm. Ecofeminism argues for a vision of community that is not continually subject to the debilitating economic cycles and social inequities associated with the modern, consumer-oriented culture of western societies and migration (Besthorn and McMillen, 2002). These factors can impact on Asylum seekers mental health and imply only a biomedical model as a solution. Such structures, it could be argued, leave the women vulnerable to prostitution and grooming/targets for prostitution.

Women involved in prostitution are influenced by their exo systems although not directly. They act in accordance with determinants set out by poverty and migration. If we accept that these structures are flawed insofar as protecting its vulnerable citizens, then such structures play a part in creating prostitution. While ecological theory focuses on personal or adaptive processes, ecofeminism argues that within this model alone, the responsibility appears to remain with the individual to adapt to a changing environment. ‘Such environments are inherently conservative socio-political orientations which focus on narrowly defined domains of environmental transactions’ (Besthorn and McMillen, 2002, p. 221). This supports the proposed argument of ‘other’ within the environmental process. As summed up by Simone De
Beauvoir’s existential philosophy ‘One is not born, but rather becomes a woman’ (De Beauvoir, 1949, p.1.).

2.6 The macro system

The macro systems are concerned with policy and cultural norm and beliefs (Bronfenbrenner, 1986). To understand the macro system one must identify dominant discourses which shape the environment. Healy (2005) proposed three key discourses which shape service delivery in health. These discourses were: biomedicine; neo-classic (neoliberal) economics; and the law. ‘Dominant discourses are strongly aligned to linear notions of progress. In many health institutions, these discourses profoundly influence what counts as true, right and rational ways of proceeding’ (Healy, 2005, p.18). The ecological model guides assessment and offers general direction for intervention, but it does not propose specific intervention methods (Healy, 2005, p.137). Ecofeminism allows the researcher to locate the individual within given systems; however, it calls on such systems to make necessary changes to support the individual. For example, policies at a macro level which filter through to the other systems such as services and so on. Eco feminist writers suggest that humans have lost their integrated wholeness through a gradual shortfall of perceptual awareness initiated and sustained by modern institutions, such as health, economics, the law and educational systems (Besthorn and McMillen, 2002). This is discussed below.

2.6.1 Biomedicine

Healy (2005) acknowledged that ‘the biomedical discourse is one of the most powerful discourses shaping practice contexts, particularly in health services such as hospitals, rehabilitation services and mental health services’ (p.20). This discourse therefore becomes dominant in the wider social services context. In respect to prostitution, we are placing prostitutes within a vacuum of biomedical ideology which offers one way of looking at things, culturally, historically and institutionally. Therefore, Healy (2005) pointed out that health and social practitioners are also victims of the biomedical model which sets practice rules and expectations for practitioners to ‘fix’ service users within its framework of biomedicine. Rather than challenge what is ‘normal’ as healthcare practitioners, are we not just trying to help
others become what is the perceived ‘normal’? A holistic approach seeks to understand the person in their social context and to promote an optimal state of physical, mental and social well-being, not merely the absence of disease’ (Daly, Hill and Guillemin, 2001, p.xiii). A core purpose of the ecosystems intervention is to improve transactions and adaptation of person and their environment. According to Germain and Gitterman (1996) ‘the ecological metaphor helps the profession enact its social purpose of helping people and promoting responsive environments that support human growth, health, and satisfaction in human functioning’, but as Healy proceeded to point out: life transitions such as relocating or environmental stressors such as poverty and so on must also incorporate the recognition of power and structural injustices which often do not allow for social location and diversity of lifestyles’ (Germain and Gitterman, 1996). Such macro environmental discourses need to be identified when proposing to locate and understand the psychosocial needs and experiences of prostitution.

2.6.1.1 Irish health policy

With regard to healthcare services for people in marginal situations, the Council of Europe recommended the governments of their member states to develop a coherent and comprehensive policy framework that secures and promotes the health of persons living in insecure conditions; protects human dignity and prevents social exclusion and discrimination; and ensures supportive environments for the social integration of persons living in marginal situations or in insecure conditions (2001). Member states were also urged to strengthen and implement their legislation in order to ensure human rights protection, social solidarity and equity (Council of Europe, 2001).

Unlike other European countries, Ireland does not have a unified health service. Instead there is a fragmented system of healthcare services made up of public, private and voluntary providers (Burke, 2009). Entitlements of health depend on level of income. At best, it is fair to assume that economic policy fuels health planning which is enforced by government and policy makers alike. According to Burke (2009), Irish health policy focuses on a privatisation model, subject to the market and therefore the significant consumer. Service delivery centres on ‘what you pay for’, and how quickly you can be ‘fixed’. Biological conditions continue to
escape the psychosocial factors of ill health which often dictate outcome and experiences of those on the periphery of society and health policy per se (Burke, 2009).

Stegeman and Costongs (2003) highlighted the multi-dimensional nature of social exclusion and health: deprivation in one area may lead to deprivation in many areas. It is therefore important to find ways to break through these cycles of deprivation, which affect individuals as well as society as a whole. Stegeman and Costongs (2003) concluded that the public health and health promotion sectors can play a significant, ‘upstream’ role in this respect. Although the evidence provided by Stegeman and Costongs (2003) is reflective of a good model for practice, it is imperative that public health and health promotion sectors work in conjunction with practitioners to provide acute care in assessing psychosocial health requirements, but more importantly to actually achieve this requires addressing current health policy and seeking change within a biomedical culture of assessing and determining need. The literature provides an overview of Ireland’s current health policy, which exists within conflicting ideologies regarding the delivery of health care, i.e. the liberal, conservative/corporatist or social democratic models. However, it appears that a liberal conservative view is the dominant ideological position (Burke, 2009). The debate primarily centres around three main Issues:

1. Equity - who will receive the services and how their cost will be shared?
2. Comprehensiveness - what services will be provided and to what extent? And,
3. Cost-effectiveness - how will the services be delivered so as to derive the greatest benefit from the available resources?

The issue of equity is analysed here with respect to women in prostitution in Ireland and the range of issues that exists for these women as on the periphery of health care and health policy.

*Equity*

Equity relates to the distribution of costs and benefits of health services among a population (Marmot *et al*, 2008). A definition of equity in relation to the distribution of health care is difficult to achieve, for two main reasons. First, measuring the outcomes of health care is extremely difficult as health care inputs can affect individuals differently, and second, there are many factors that influence the health
of individuals, for example, the environment, healthy lifestyles or chronic illness and abuse (Braveman, 2006). Therefore, different people require access to different types of health care at different times, depending on their health status over a lifetime. For these reasons, it is more useful to focus on equality of necessary health care that is, ensuring that provision is available in relation to the needs or demands of the population nationally or locally. In Ireland, for example, the majority of centres for the women involved in prostitution are centred in Dublin. To date findings remain that prostitution existed solely in the capital excluding the wider counties (EUROPAP, 1996). This is in keeping with the notion of ‘who will receive services and how their cost will be shared’. However, evidence indicates change in patterns of prostitution around the country (ICI, 2009). Government distribute services accordingly, and access to health service depends on level of income. Therefore, the debate should extend to equality of access and equality of utilisation to consider socio-economic circumstances and an ecological interpretation of need (Braveman and Guskin, 2003).

**Distance**

As times have progressed, the sex industry has shifted from brothels and streetwalkers to include a more recent phenomenon of more underground activity which creates a more isolated and hidden group throughout the country (Ruhama, 2006). The use of mobile phones and Internet has been identified as tools which support the underground and changing nature of prostitution today (Nussbaum, 1999). In 1996, a report provided by EUROPAP and the Eastern Health Board (Women’s Health Project), named *Women working in sex work: Toward a Healthier Future*, was a national objective plan to consider the needs of women in prostitution. The report on the health needs of this group, estimated that the number of sex workers in Galway ranged from 0-5 (O’Connor, 1997). Furthermore, it was viewed that prostitution was of a transient nature, travelling for events seemed more likely. The outcome of this study did not justify national development of this service. Now in 2013, no further research has happened and the city has grown extensively to a population of 57241, which is a vast increase of 15% (Central Statistics Office, Ireland). The general population is now inclusive of Direct Provision accommodation, foreign national communities, undocumented populations, which present much diversity in respect to the 1996 research (CSO, 2013). According to the
Chapter Two: Literature Review

Women’s Health Project (2007), levels of confidence in availing of health services varied among prostitutes, there is reluctance on the part of most women to access health care professionals and to tell them of the work they are involved in. Alongside the stigma attached to prostitution, many women cannot access services in Dublin for various reasons; financial, access to transport, chaotic lifestyles, and social support networks and so on. Services are not unique to their needs locally, which are consistent with inequality of access and service utility (Dixon-Woods, et al, 2003).

Voice
According to Dixon-Woods et al (2003), it is likely that difference in the ability of social groups to express their opinion (or ‘voice’) is a major factor affecting access to health services. Patients from lower socio-economic groups may have lower levels of health literacy skills, which may prevent them from understanding and interpreting information. They may have lower levels of self-efficacy, which means they are more reluctant to take part in shared decision making. Furthermore, as a direct effect of prostitution policy in this country, this double edge sword only inhibits engagement between practitioner and patient further.

An expanded ecological model- ecofeminism, would fully recognise that just as humanity and nature need to be understood, so too must modern social, political, and economic realities (Mack, 1995). Healthcare providers need to identify barriers that prevent access and utility of service to those engaged in prostitution, to examine their experiences, and in addition to explore the attitudes of professionals and the policies of agencies providing these services. The social-political reasons for entering prostitution such as poverty, drug use, sexual abuse, pre-care (Coy, 2008) and grooming by partners or friends must be understood by professionals to establish best practice, and to consider the implications for and inform the development of a holistic, multidisciplinary health care service for women.

Health seeking behaviours
Analysis by Dixon-Woods et al, (2003) suggested there are systematic differences in the health beliefs and consequent health seeking behaviours of lower socio-economic groups compared with higher socio-economic groups. Social difference may also
affect delay of seeking care and denial of symptoms, and opting to self-managed symptoms.

A holistic approach seeks to ‘understand the person in their social context and to promote an optimal state of physical, mental and social well-being, not merely the absence of disease’ (Daly et al, 2001, p.xiii). A core purpose of the ecosystems intervention is to improve transactions and adaptation of person and their environment. According to Germain and Gitterman (1996) ‘the ecological metaphor helps the profession enact its social purpose of helping people and promoting responsive environments that support human growth, health, and satisfaction in human functioning’. But as Healy (2005) proceeds to point out, life transitions such as relocating or environmental stressors such as poverty, must also incorporate the recognition of power and structural injustices which often do not allow for social location and diversity of lifestyles (Germain and Gitterman, 1996). Such macro environmental discourses needed to be identified when proposing to locate and understand the psychosocial needs and experiences of prostitution inclusive of an ecofeminist approach

Lower social-economic groups also tend to have more misconceptions of acute problems or treatment possibilities (Dixon-Woods et al, 2003). If lower socio-economic groups systematically underestimate their health state or the likelihood that they will benefit from health care, this could also have implications for self-reported health as indicators for their health needs which will impact on their quality of life and indeed the wider community (clients). Again, it is necessary to understand the key determinants that could influence prostitutes to underestimate their health needs and decline from self-reporting symptoms. Contributing social factors were mental health issues, addiction, poverty and access and more inclusive of all the factors is the current law on prostitution (Farley, 2003). In turn, these all represent barriers to accessing services and therefore contribute to the minimising the impact or occurrences of symptoms and self-diagnosing and treating where necessary.

Dixon-Woods et al (2003) identified two types of disadvantage that lower socio-economic groups experience when using the health service: those that relate to the problems of making first contact with the services, and those that concern the problems they experience once contact has been established. Most of the factors
associated with disadvantage affect both types, but health beliefs and behaviour are more likely to affect first contact while difficulties around ‘speaking up’ are more likely to impact on second stage. Considering these problems proposed by Dixon-Woods et al., prostitution in Ireland can also be addressed here. A report by The National Women’s Council (2008) on drug misuse placed prostitutes at risk of minimum contact with services and drug misuse and sexually transmitted diseases continue to dominate Irish literature on prostitution and health to date (WHP, 1997, 2007).

At this point, it is also important to note Ireland’s participation in the global sex industry which includes migrant sex workers and women being trafficked for the purpose of sexual exploitation (Immigrant Council of Ireland, 2009). In this regard, making contact with health providers is often hindered by control of person, language barriers, monitory means and familiarity of location. This group is particularly vulnerable and where they may access health support for specific conditions, the problems they experience once contact is made, often impacts on their experiences (Immigrant Council of Ireland, 2009).

To establish equity in health care, it is vital to incorporate a gendered health care system and policies alike. Equity needs to be based on diversity - the need to develop flexible and accessible services which respond equitably to the diverse needs and situations of women, quality in the provision and delivery of health services to all women throughout their lives, and relevance to women’s health needs. In carrying out its statutory functions, health policy could adopt the WHO definition of health (1948), a measure reiterated in the Department of Health’s ‘Quality and Fairness’ document (2001). This definition states that: ‘Health is a state of complete physical, mental and social wellbeing’. The most recent document on Gender and Health published by the Women’s Health Council; National Women’s Strategy (NWS) identified the need to incorporate a gender perspective into mainstream health policy, as well as implementing positive action measures to ensure that the health of women in this country is promoted and protected (Government of Ireland, 2007). The strategy also refers to the importance of gender as a health determinant and the recognition by the Health Service Executive of the need to work in partnership with the Women’s Health Council (WHC) to develop gender mainstreaming in the
planning and delivery of its services (HSE, 2005). In light of these commitments, objective 8A of the strategy reads: To improve the health status of women in Ireland through gender focused policies and identifies indicators, actions, targets and responsible agents.

2.6.2 Economics

Neo classic economics is the driving force of western society today (Heywood, 1998). In respect to globalisation, it is the dominant discourse throughout. The recurring themes of neo classic economics is ‘free market’ and ‘individual responsibility’ (Heywood, 1998). Through the free market, the interests of buyers and sellers are coordinated to ensure the production of goods and services that are valued most by the consumer at the best price. In addition free markets encourage competition between sellers, which according to this discourse; also contribute to the efficient allocation of resources. Neo classic economists argue that free market competition provides a vital mechanism for driving down costs and weeding out ineffective and inappropriate uses of scarce resources (Hussen, 2004; Skidelsky, 2010). When one incorporates this ideological framework into health policy and service provisions, it becomes apparent how psychosocial needs are not at the forefront of service objectives. As minimal state involvement is a dominant request of neo classic economics, Healy (2005) argued that social and health service expenditure is represented as a drain on the economy, rather than as a public responsibility and investment in society, in this way the discourse allows governments to distance themselves from their responsibilities to the most disadvantaged and vulnerable in society. According to the Women’s Health Project (Nelson and McGrath, 2007), levels of confidence in availing of health services varied among prostitutes. Western economic theory tends to appreciate only those entities and practices that have market value; material things and the flow of goods and services to satisfy consumer need. One potential application of a new ecofeminism practice might include the profession’s active participation in critiquing modern economic theory and the way it works to sustain oppression of both humanity and nature (Agger, 1979, 1992)

Individual responsibility is another key theme of neo classic economics. As Heywood (1998) pointed out, this notion has led liberal thinkers to view society as
simply a collection of individuals, each seeking to satisfy their own needs and interests. Such views do not align with ecological theoretical interpretation, in that the individual is part of a wider system including family, community and society. Healy (2005) discussed self-determination, a core theme of social and health promotion values: ‘by returning all responsibility to the individual, this discourse obscures the systematic and structural influences on peoples ’free choice’ as well as the broader impediments to people living a life of their choosing’. It is unfair for women engaging in prostitution due to factors of poverty, abuse, victimisation, or social and economic exclusion to achieve self-determination without the proper support of key public and private institutions.

2.6.3 The law

Irish social policy and legislation is designed on the assumption that the ‘person’ is at the core of its objective and that it is needs led (Byrne and McCutcheon, 1996). The law does not exist in isolation of political and social values of its day. According to Byrne and McCutcheon (1996), law-making draws on social values. This symbiotic relationship reflects current ideals and values of a society. The legal system subsequently enforces the perceived status quo. Therefore it is fair to assume that prostitution in Ireland is viewed by society as reflected by the laws that surrounds it. The law is instrumental in shaping social policies and public services and is therefore worth considering as a contributing barrier to accessing health services nationally. Considering this, a review of the Irish legal literature on prostitution was required. The Irish legislation on prostitution selects a strong emphasis on loitering and public nuisance, thus prostitution has found its place within public order offences. This was the original discourse prior to the Criminal Law (sexual offences) Act, 1993 and continues to reflect this discourse today. The 1993 Act represented a limited attempt to modernise the law, perhaps most notably, it did so through dropping the term ‘common prostitute,’ and creating gender-neutral offences of loitering and soliciting for the first time, thus extending the criminal law to cover men as well as women engaged in prostitution; and to cover clients and touts, not just prostitutes themselves. Greatly increased penalties were also introduced for all the prostitution-related offences. It appeared that no attempt was made to examine other ways in which prostitution could be regulated, or to examine
the potential effect of the new law on the lives of those engaged in prostitution (IHRC, 2007). As a result, the provisions of the Act dealing with prostitution `do not display any fundamental reassessment of what the law’s role should be in the area of prostitution’, but retain the basic policy that prostitution is not illegal per se, but `must be subject to various kinds of restraints in order to prevent it becoming a nuisance or an affront to public decency’ (O’Malley, 1996, p. 20).

Table 2.1: Recorded prostitution offence.

<table>
<thead>
<tr>
<th>Year</th>
<th>Brothel Keeping Recorded</th>
<th>Brothel Keeping Detected</th>
<th>Organisation of prostitution Recorded</th>
<th>Organisation of prostitution Detected</th>
<th>Prostitution, including soliciting Recorded</th>
<th>Prostitution, including soliciting Detected</th>
<th>Total Recorded</th>
<th>Total Detected</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>57</td>
<td>50</td>
<td>16</td>
<td>10</td>
<td>174</td>
<td>170</td>
<td>247</td>
<td>230</td>
</tr>
<tr>
<td>2010</td>
<td>67</td>
<td>61</td>
<td>3</td>
<td>3</td>
<td>135</td>
<td>127</td>
<td>205</td>
<td>191</td>
</tr>
<tr>
<td>2009</td>
<td>26</td>
<td>25</td>
<td>7</td>
<td>7</td>
<td>60</td>
<td>59</td>
<td>93</td>
<td>91</td>
</tr>
<tr>
<td>2008</td>
<td>29</td>
<td>24</td>
<td>11</td>
<td>10</td>
<td>96</td>
<td>93</td>
<td>136</td>
<td>127</td>
</tr>
<tr>
<td>2007</td>
<td>13</td>
<td>10</td>
<td>34</td>
<td>29</td>
<td>62</td>
<td>60</td>
<td>109</td>
<td>99</td>
</tr>
<tr>
<td>2006</td>
<td>13</td>
<td>12</td>
<td>17</td>
<td>17</td>
<td>77</td>
<td>74</td>
<td>107</td>
<td>103</td>
</tr>
<tr>
<td>2005</td>
<td>8</td>
<td>4</td>
<td>19</td>
<td>19</td>
<td>57</td>
<td>52</td>
<td>84</td>
<td>75</td>
</tr>
<tr>
<td>2004</td>
<td>5</td>
<td>4</td>
<td>25</td>
<td>24</td>
<td>189</td>
<td>181</td>
<td>219</td>
<td>209</td>
</tr>
</tbody>
</table>

(The Central Statistics Office- based on Garda PULSE data, 2004 to 2011)

2.6.3.1 Other criminal offences related to prostitution

Although most prostitution-related offences are now contained in the 1993 Act, other relevant offences may be found in separate legislation. Section 2 of the Criminal Law Amendment Act, 1885 penalises the procuring or attempted procuring of a woman or girl to become a common prostitute in Ireland or elsewhere, or to have her live in or frequent a brothel in Ireland or elsewhere. Under section 3 of the same Act, it is an offence to procure or attempt to procure a woman by threats, intimidation or false pretences to have unlawful sexual intercourse. Section 8 of the 1885 Act makes it an offence to detain any woman or girl against her will in a brothel (IHRC, 2007).

Section 23 of the Criminal Justice (Public Order) Act, 1994 prohibits any person from publishing, distributing or causing to be published or distributed any advertisements for brothels or prostitutes in Ireland. The provision is wide enough to
cover advertisements that do not include the words ‘brothel’ or ‘prostitute’, but instead use words such as ‘massage parlours’. The prohibition also covers advertisements posted on the internet, but does not cover advertisements for brothels located outside the State. Section 23(3) provides a defence for those whose business it is to publish, distribute or arrange for the publication or distribution of advertisements. Where they can show that the advertisement was received by them in the ordinary course of their business, they will have a defence if they did not know nor had reason to suspect that the advertisement related to a brothel or prostitute (IHRC, 2007).

In view of the above laws, it could be considered that those engaged in prostitution are unprotected by virtue of being prosecuted within a system of patriarchal insensitive guidelines. Once the law decides to punish women involved in prostitution, it therefore claims to place them outside of the system. Ecofeminism would argue that systemic oppressions such as the law, maintain human alienation, uninterested in placing a demand on the legal system to adapt to the social environmental realities and circumstances of prostitution. Should a woman seek refuge from services such as the Gardai or indeed healthcare professionals, it is apparent that she is demonised by society’s perceptions but more importantly at risk of prosecution (IHRC, 2007). The 1993 Act is indeed a benchmark as to whether women involved in prostitution present themselves to services or how services are developed to meet their needs. On a needs basis, prostitution, by virtue of the law, is an isolated group. Therefore an approach to healthcare specific to their needs of support and protection falls short. As O'Malley argued (1996), it therefore proceeds from the assumption that prostitution must be contained within certain limits and hidden from public view.

Furthermore, it is important to observe through the legal literature, that because the act of selling sex itself is not illegal, the double standard is apparent (this is the case in most legal systems). The law targets only the most visible manifestations of prostitution, not the private exploitation of women. As discussed in the section Demographic profile of Prostitution in Ireland, the changing nature and trends of the industry are moving ‘indoors’.
Law, just like biomedicine and economics, is a contested domain; there are many strands of legal thought’ (Healy, 2005, p.36) A common legal thought is legal positivism, which often dictates legal practitioners delivery. Positivism requests distancing oneself from the emotional and moral aspects of legal decision making (Coleman and Leiter, 1999, p. 242). The objective is to remain detached from the clients experience in order to interpret the law effectively. This form of practice excludes individual experiences and life course.

The law on prostitution still remains the same today in 2013; nevertheless, it is worth mentioning at this point that the legislation is under current review by the Department of Justice and Equality. It is in the preliminary stages, debates have occurred and a document named: Discussion document on the future legislation on prostitution in Ireland has been written by the department of Justice and Equality; following on from this, the findings from this research were accepted and included in a final document ‘submission for review of current legislation on prostitution’ (Sweeney, 2013).

This review of the legislation identified two key concerns: Firstly, assuming that prostitution does and will continue to exist; does the current legislation cover the complex issue surrounding prostitution? And; secondly, the law does not criminalise the exchange of sex for money per se but it does criminalise most prostitution-related activities. Street prostitution is indirectly and effectively illegal, however, providing sexual services indoors is not illegal and this has raised concerns for advocacy groups acting on behalf of indoor women and the risks involved. This, along with the changing nature of prostitution, migration, use of technology (mobile phones, internet) and criminality and human trafficking, led to the formation of the discussion document. At the centre of the discussion and amidst lobbying forces, the request is to change legislation by removing prostitution from within the public order offences and placing it within its own law enforcement unit. The aim is to criminalise the buyer of sex and decriminalise the seller. This advocated framework follows on from the Swedish model for prostitution. In 1999, Sweden changed its prostitution laws to punish only purchasers or consumers and not sellers of sex, an approach that has been followed by Norway and Iceland (This will be discussed later
in the literature under the heading *A comparative model of prostitution, a review of the Swedish model*).

2.6.3.2 Trafficking for the purpose of sexual exploitation

The UN Protocol, as stated in the Convention against Transnational Organised Crime since November 2000, defined ‘trafficking’ as the process that takes place over time (recruitment, transportation, and control) and organised for purposes of exploitation. Human trafficking and trafficking for the purpose of sexual exploitation is located under The Criminal Law (Human Trafficking) Act 2008. Women who may become known as trafficked are dealt with within the Anti-Human Trafficking Unit (AHTU) of the Department of Justice and Equality, a separate jurisdiction than women identified as prostitutes. In order to be identified as trafficked, the person must identify themselves to the Gardai before receiving care and support from the Health Service (HSE). The women can then access organised accommodation and legal representation on her behalf.

Although this law offers a safe haven for trafficked women, it cannot be assumed that the person will come forward and identify themselves as trafficked for many reasons. O’Connell Davidson (2013) outlined a clear distinction between trafficking and smuggling as forced and voluntary illegal migration. Certain groups or individuals can agree to be smuggled illegally with the prospect of a better life or financial security elsewhere. Poverty has led women to be on the move globally now more than ever (Ehrenreich and Hochschild, 2004). In this respect, the smuggled individual has given consent but may remain indebted financially to the smuggler and may enter prostitution as a means of paying back the debt. This group may be less likely to identify themselves to the Gardai as they in some way consented to their illegal entry into the country. They may also fear their criminal smugglers/traffickers or fear for their families’ safety back home. So even with current Irish legislation on trafficking it seems that, insofar as accumulating numbers, acting on and providing adequate care to all those who effectively come under the remit of forced or coerced migration proves difficult. In a study conducted by Ward and Wylie (2007) *the nature and extent of trafficking in women for sexual exploitation into Ireland*, the probable minimum number of women trafficked into Ireland for the purposes of sexual exploitation between 2000 and 2006 were 76. This
remains a complex issue and it seems the law only provides protection for few; more typically true enslaved women trafficked for the purpose of sexual exploitation. Like prostitution itself, these women continue to predominantly remain hidden.

Conclusion
Bronfenbrenner’s (1986) ecological model places the individual within their environment. At best we must not assume the macro remits to be in support of all individuals but rather understand its function as of restricting some of its members in society. It assumes that individuals will adapt, but often due to its limitations, it is in fact the macro environments which need to adapt. In respect to eco-logism and the ecological framework model, this is not consistent with a neo-classic economic macro agenda. As Heywood (1998) points out, `eco-logism does not merely demand the transformation of the economic system or the reordering of power relations within the political system, it also seeks to establish nothing less than a new mode of being, a different way of experiencing and understanding existence` (Heywood, 1998, p. 290), explored through ecofeminism.

2.7 Demographic profile of prostitution in Ireland

In Ireland today women are engaging in prostitution in an ever changing sex industry. How we address this issue is reflected by our current socio-political climate. To understand where prostitution lies today it is necessary to take a comprehensive review of the literature which traces this industry through time, observing characteristics of change and indeed similarities which have shaped current behaviours, both societal and activity based.

History of prostitution in Ireland

Nineteenth century Ireland portrayed a ‘paradigm ` of visibility, morality, and venereal diseases which placed prostitution on the `medical map` of its day (Luddy, 1997). Interestingly, their medical requirements (subject to women only), were responded to by locking them up to protect decent citizens from their clutches, a “nursery of human turpitude and hotbed of depravity [where prostitutes] in a state of nudity openly and wantonly assailed the most respectable persons” (Luddy, 1997, p. 496). Streetwalkers and brothels flourished throughout Ireland, with evidence suggesting their extent from Dublin, Cork, Athlone, Roscommon and anywhere else
where a community existed (Luddy, 1997; Hallgrimsdottir, Philips, Benoit and Walby, 2008)).

In response to the Contagious Disease Act, 1964, the police and medical professions joined forces in a combined attempt to monitor the behaviour of prostitutes and, ultimately, keep the general population at large safe from their diseases. Prostitutes were subjected to arbitrary and compulsory examinations. In Luddys’ article (1993), evidence suggested that if the women were found to have contracted a sexually transmitted disease, they were locked up and registered as prostitutes. They were permitted to remain in these ‘Lock up hospitals’ for up to nine months. Such hospitals existed in Dublin, Cork and the Curragh (county Kildare) by 1869. Should an assumed prostitute resist examination, a penalty of one month imprisonment followed (Luddy and Murphy 1989). The medical supporters of the Contagious Disease Acts opted to take these precautionary measures a step further. An article was thus published in the Dublin Journal of Medical Science; wishing to extend the Acts to the ‘civil’ population, ‘amongst whom they would prove as beneficial as they have in the case of soldiers’ and sailors’ (1869). In short, this appeared to be an acknowledgement from the medical profession of the widespread use of prostitutes at this time. However, this reflection of medical/health intervention at this time, predominantly centred on a moral judgement of prostitution and the need to protect its citizens. The holistic health needs of the prostitute were of little consideration. This complies with the medical and health models of its day, that were neither gender or ecologically sensitive. ‘The rapid growth in specialised knowledge over the 19th century resulted in the implementation of ‘preventative’ and ‘interventionist’ philosophies and approaches in medicine, law, child care, social work and so on’ (Skehill, 2010). As Cooter (1992) as cited in Skehill (2010) points out such dominant intellectual discourses contributed to the construction of motherhood and women’s roles. Such professionals operated in the space referred to by Donzelot (1980) as the ‘social’, the discursive space between the ‘private’ family and the ‘public’ state. Women engaging in prostitution stood on the periphery of social norms, expectations and roles. This new designed approach simply isolated them further, extending on into the 20th century which influences existing paradigms today.
Developments within the 20th Century

Twentieth century Ireland was about ‘institution’ in the form of the state and Catholic church. All social matters were conformed within a discourse of patriarchy, a rising capitalism and a merging middle class. Such ideology had two key influences on prostitution; how it was regulated and how these groups’ personal circumstances reflected their patterns of prostitution. Foucault (1977 and 1991) described how particular power discourses legitimate, institutionalise and normalise certain practices, constructing common sense and/or dominant ways of understanding the social world. In Ireland, prostitution was subject to a double edge sword, women’s identities were recognised within ‘the family unit’, neither as employee nor for the purpose of ‘transactional sex’ (Beaumont, 2006).

Within the context of health, Health Boards and Health legislation were introduced i.e. The Health Act of 1965. State funding now played a leading role in service development and The Health Act of 1970 led to the restructuring of health services nationwide. Nevertheless they simply mirrored the direct link between women and their relationship with the private domain, a reflection of Ireland’s socio-political and cultural ideology of this time. Children and women who were unmarried or prostitutes were being placed in institutions as part of the Healthcare Acts, 1965, 1970, as they were deemed unfit to participate in normal society. These institutions were more often run by charity and church with minimal state regulation. Therefore, their health needs were not the focus of the active state funded health services coming into existence throughout the country. Religious orders attempted to provide shelter in the disguise of redemption and moral guidance. The lay population saw these refuges run by nuns as hiding places for ‘shame filled’ daughters. As the nuns had acquired authority over Catholic children through education, the Catholic community gave them the authority to mould and influence their wayward daughters and to keep them, in an age which was becoming increasingly concerned with the concept of ‘respectability’, from public shame (Luddy, 1994).

The late 20th Century phenomenon of a Drug using culture

Over time the sex work remit had also shifted, from brothels and streetwalkers to include a more recent phenomenon of more underground activity which created a
more isolated and hidden group. The use of mobile phones and the internet have been identified as tools which support the underground and changing nature of the industry today (Nussbaum, 1999, in Spector, 2006). However, the impact of a 1996 report provided by EUROPAP and the Eastern Health Board (Women’s Health Project), named; *Women working in sex work: Toward a Healthier Future*, was a national objective plan to consider the needs of women in prostitution. The report on the Health needs of this group, estimated the number of prostitutes in Ireland at this time (0’Connor, 1996).

Table 2.2: Demographic profile of women involved in prostitution in 1995

<table>
<thead>
<tr>
<th>Area/Region</th>
<th>Estimated number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Minimum</td>
</tr>
<tr>
<td>Dublin/Eastern</td>
<td>100</td>
</tr>
<tr>
<td>Cork/Southern</td>
<td>20</td>
</tr>
<tr>
<td>Galway/Western</td>
<td>0</td>
</tr>
<tr>
<td>Limerick/Mid-Western</td>
<td>25</td>
</tr>
<tr>
<td>Sligo/North-Western</td>
<td>Not given*</td>
</tr>
<tr>
<td>Waterford/South-Eastern</td>
<td>Not given*</td>
</tr>
<tr>
<td>Totals</td>
<td>145</td>
</tr>
</tbody>
</table>

(EUROPAP, 1996)

The Women’s Health Project’s report *Drug Using Women Working in Prostitution* (1996) stated that at that time the Garda Síochána estimated that there were 400 female intravenous drug users involved in prostitution and the Women’s Health Project had had contact with 260 of these women up to that date. The report focused on the Eastern Health Board area (Dublin and county), and details the results of interviews conducted with 77 drug using women working as prostitutes. A total of 64 women (or 85%) had injected drugs in the month before the interview. Ruhama (2006) stated that drug-using women involved in street prostitution are predominantly Irish nationals. Health services in the capital prioritised health needs such as addiction and sexual health.

The summary of the table above identified that five prostitutes worked in the Galway area. Furthermore, it was viewed that sex work was of a transient nature, travelling to Galway, for example, for ‘social events’. In turn this study did not justify service development in the west of Ireland. Now in 2013, no further research has happened.
and the city has grown extensively to a population of 57241, which is a vast increase of 15% (Central Statistics Office, Ireland).

The prostitution population is now inclusive of direct provision accommodation, non–Irish national communities, undocumented populations, which presents much diversity in respect to the 1995-1999 research and recognition of a changing nature of prostitution in Ireland. The west of Ireland has been identified by the researcher to reflect the need for service provision throughout the country. In the Irish sex industry today:

- There is a minimum of 1,000 women in indoor prostitution in Ireland at any one time
- There are 51 different nationalities of women available to men in indoor prostitution
- Nearly 40 per cent of migrant women in prostitution attending the WHP (HSE) have children and, for a minority of women, their children reside with them
- Between 3 and 13 per cent of the women in indoor prostitution are Irish, which means that up to 97 per cent are migrant women
- Of women advertised on the internet, 41 per cent were described as ‘touring escorts’. These women move around Ireland and some travel internationally
- The women’s ages range from 18 (with some evidence that girls as young as 16 years are involved) to 58 years. The average age is estimated at 25

*(Immigrant Council of Ireland, 2009, p.23)*

In 2013 a strong emphasis is placed on the globalisation of the sex industry, which incorporates diversity in Ireland of women of many nationalities, recognition of human trafficking for the purpose of sexual exploitation and, indeed, a lucrative criminal underground racket (2009).

**2.8 Globalisation; modern Ireland’s sex industry**

The term globalisation has been in increasing use since the mid-1980s and especially since the mid-1990s. In 2000, the International Monetary Fund (IMF) identified four basic aspects of globalisation: trade and transactions, capital and investment
movements, migration and movement of people and the dissemination of knowledge (Beck, Kunt and Levine, 2000). Human migration is movement by humans from one place to another, sometimes over long distances or in large groups. Migration continues in the form of both voluntary migration within one's region, country, or beyond and involuntary migration (which includes the slave trade, trafficking in human beings).

Since the 1990s’, Ireland’s economy changed due largely to a successful policy of peaceful industrial relations and joint wage bargaining through a mechanism involving all of the social partners, based in part on the German model (Beck et al, 2000). This increased foreign investors and Ireland became a global player on the economic stage. This brought new migration flows, in the period 1995-2000, approximately a quarter of a million persons migrated to Ireland, The CSO office, Population and Migration Estimates up to April 2000, published in September 2000; indicate that 12% or 29,400 over the five years, came from outside the EU and the USA. These categories included:

- Asylum-seekers
- Programme refugees
- High-skills in-migration from non-EEA countries
- Other in-migration from non-EEA countries

The 1951 Common Travel Area Agreement (and later the Treaty of Rome) and other legal instruments in the case of British citizens, and citizens of other EU and/or EEA member States also meant that certain European neighbours could continue to enter Ireland freely. There emerged diversity amongst its population.

There is a significant link between globalisation and women’s migration (Sassen, 2013); therefore this becomes a gendered discourse discussion. As Brennan and colleagues outlined, women involved in prostitution through migration are independent and dependant, resourceful and exploited. They are local agents caught up in a web of global economics, primarily leaving third world countries to migrate to the first world (Brennan, 2004).
According to a study: *Globalisation, Sex Trafficking and Prostitution: The Experiences of Migrant Women in Ireland* (Immigrant Council of Ireland, 2009), between January 2007 and September 2008, 102 women were identified by ten services as being trafficked into or through Ireland. The Immigrant council of Ireland added that the women identified a further 64 women ‘may’ also have been trafficked into Ireland, thus bringing their estimated figure to 166. It is claimed that the vast majority of this group are from African countries. According to the report (2009), this may partly be explained by the expansion of the European Union (EU) in 2004 and 2007, which has meant increased freedom of movement for some Eastern Europeans (p.21).

There is another perspective on the trafficking debate. Not all migrant workers who have experienced trafficking are victims and should not be treated so. Agustin (2007) argues that ‘what we say about any given subject is always constructed, and there are only partial truths’. Based on her empirical findings, human trafficking does not always describe migrant women’s lives as victims who need to be ‘rescued’ (Agustin, 2007).

Ecofeminism supports this argument by recognising the flaws within macro systems. The individual expectation to adapt is recreated to not only acknowledge the systems function to adapt to individual needs and experiences, its core feminist values seek to locate female individual experiences as on the periphery of patriarchal institution macro systems in existence within neo-classic economic concepts. ‘Traditional female values are reciprocity and cooperation’ (Heywood, 1998, p. 288), this is inconsistent with that of individualism and self-preservation. ‘The macro systems perspective is intended to enable us and practitioners to recognise the complexities, and to avoid reductionism in assessment and intervention, by understanding the above discourses, we enhance our capacities to use them, and, where necessary, to challenge their influence on health promotion and social service practices’ (Healy, 2005, p. 43). To locate prostitution in society it is evident their location is organised and designed by the macro systems, it is not simply enough to understand the prostitute within their environment, but rather to assess this environment in a theoretical framework which is respectful and conducive to a person’s needs and experiences.
2.9 Psychosocial experiences of prostitution

Women involved in prostitution must be understood according to the experiences they currently encounter and have previously encountered during their lifetime. If we endeavour to draw from an ecological model of interpretation it is then essential to evaluate life experiences in accordance with the environmental systems that this group have come from and continue to live in. The section on ecological theory outlined the systems which manipulate life values, policies and experiences, this section will endeavour to provide and discuss the literature on the psychosocial experiences which engulf those who have lived and are living in environments of prostitution. Farley (2006) points out that in respect to our broader social and political systems, harm and the experience of harm are often invisible, as prostitution holds significantly less value in our current societies.

Mental health issues factored for a high proportion of the women involved in prostitution (Farley, 2000; Farley, Lynne and Cotton, 2005). The long term affects of ‘Dissociation’ supported chronic patterns of mental health behaviours. Dissociation occurs during extreme stress amongst prisoners of war who are tortured, among children who are/have been sexually assaulted and among women being battered, raped or prostituted (Herman, 1997). When one is prostituted for any length of time, a state of intense, unbearable fear develops (Herman, 1997). Dissociating disorders, depression and other mood disorders were common among prostituted women in street, escort, and strip club prostitution (Beltan 1998: Ross, Anderson, Heber and Norton 1990; Vanwesenbeeck 1994). Dissociation in prostitution resulted from both childhood sexual violence and sexual violence in adult prostitution. The dissociation that is necessary to survive rape in prostitution is the same as that used to endure familial sexual assault (Giobbe, 1991; Millar, 1986). Most women, according to Vanwesenbeeck (1994), reported that they could not prostitute unless they dissociated. Chemical dissociation aids psychological dissociation and also functions as analgesic for injuries from violence. When women in prostitution do not dissociate, they are at risk of being overwhelmed with pain, shame and rage. Dissociative patterns supported by chemicals such as drugs and alcohol inherently facilitates the possibilities for addiction. Addiction and dissociative patterns were documented as common factors of Irish women engaging in prostitution as stated by The Womens Health Project (2007).
On this principle of addiction, The Eastern Health Board provided health services for Ireland in Dublin and initiated a Women’s Health Project as part of its HIV prevention strategy. It was and still is to date, run from a community hospital in south Dublin and aimed at women working in prostitution, offering a wide range of health-care services. These include screening for STI, HIV testing and counselling, cervical cytology, hepatitis B screening and vaccination, and family planning. The Women’s Health Project is a member of EUROPAP, a European network for HIV and STI prevention among prostitutes. The EUROPAP study (1996) described the health profile of prostitutes attending in relation to risk factors for the spread of STI and HIV only. A total of 150 prostitutes attended the clinic during the study period. The age of women ranged from 16-59 years. Eight per cent (12/150) of the women reported that they were current intravenous drug users. Their mean age was 25.8 years compared with 32.2 years among non-intravenous drug using prostitutes. They were less likely than non-intravenous drug using women to undergo testing for HIV, hepatitis B or hepatitis C and had higher seropositivity rates for these infections than prostitutes who were not intravenous drug users. Seventy nine per cent (119/150) of the prostitutes were tested for HIV, of whom 2.5% (3/119) were positive. 83% (124/150) of women were tested for all hepatitis B markers of whom 4.8% (6/124) showed evidence of current or previous infection.

The EUROPAP study in Ireland also reported that almost all the women reported using condoms on all occasions with clients as a means of protection against STIs’, but the majority also reported burst condoms on at least one occasions (EUROPAP, 1996). Almost 16% (20/128) used no contraception. Data on cervical cytology were available for 65% (97/150) of women. Of these, 45% (44/97) had a normal smear result, 35% (34/97) had an inflammatory smear and 19% (18/97) had evidence of dysplasia, which was moderate or severe in eight women. The most frequently encountered infections were genital warts (8/21), chlamydia trachomatis (4/21) and trichomonas vaginalis (3/21). Women with STIs’ were significantly more likely to have an inflammatory or dysplastic smear than those with a normal STI screening result and the relationship was strongest for genital warts. This has been the largest study of prostitutes in Ireland to date. Although we do not know how representative the women are of all prostitutes working in Dublin, or indeed throughout Ireland it nevertheless represents a sizeable sample of the estimated 600 prostitutes in the city.
Chapter Two: Literature Review

(EUROPAP, 1996). No health survey has been carried out to date. The women in this study were mostly ‘street workers’. This is not therefore representative of the new phenomenon of brothels, internet and mobile organised activities of 2013. Furthermore, this study eliminates foreign-nationals working in Ireland and around the country, the global sex trade industry and trafficking for the purpose of sexual exploitation.

More recently the discussion document by the Joint Oireachtas Committee on Justice, Equality and Defence: on the Review of Legislation on Prostitution (2013) makes reference to the health risks of women involved in prostitution. However, the health risks identified centred on HIV prevention with little concern for the psychological impacts of prostitution for women in Ireland.

Although sexually transmitted diseases are an important risk factor, services should not just be founded on this factor alone. The Women’s Health Project in Dublin was originally founded with the HIV situation in mind; however, the literature outlines other key determinants which impact on their psychosocial health and wellbeing. This document does recognise the physical safety risks for the women involved in prostitution and where the law needs to be adapted to consider such issues. Sanders (2004) argued that, although sexual health and violence are real concerns to many women involved in prostitution, the emotional risks of selling sex, in particular the chance of ‘being discovered’, is prioritised in the hierarchy of harms (p.558). This is not included in the document on the review of legislation on prostitution (2012).

2.10 A comparative model of prostitution, a review of the Swedish model.

For this study it was necessary to explore models of prostitution which were already in place and could be used for Ireland to learn and develop from. In effect, most other European and global neighbours address the issue of prostitution differently from Ireland. It must be noted that Ireland’s historical road to independence, and subsequently, the development of a relatively new phenomena of social policy and legislation is unique to others in respect to its independence in 1922 alongside a strong catholic heritage and more notably its journey from a catholic corporatist state to a hybrid neoliberal platform.
The literature will critically assess the Swedish model of prostitution as Ireland is currently exploring the Swedish model as its way forward in addressing prostitution. The Seanad Éireann debate proposed a move to criminalise the purchase of sex in Ireland in order to curb prostitution and trafficking (Vol, 210, no 13, 2011). Again, the Government consultation process on prostitution legislation (2012), included within the debate that current legislation requires reviewing as it currently may not meet the nature of prostitution today and has added the Swedish model into the discussion under the heading ‘Legislative approaches in other jurisdictions’. Agencies working with women in prostitution in Ireland are lobbying for this model to be introduced: The Women’s Health Project, Ruhama, Immigrant Council of Ireland and the campaign, ’Turn off the Red Light’. Academics such as Ward and Wylie (2007, 2012) advocate further discussion on the subject.

In 1999 the Swedish State introduced an innovative law that prohibited the purchasing of sexual services (Law That Prohibits, 1998, p. 408). The significant difference here is that the law in Sweden regarding prostitution falls within the category of ‘violence against a person’. This approach was women centred and gender equality motivated. Within parliament, the bill was assessed and written into law accordingly. Already one can identify the legal interpretation between Sweden and Ireland. The Irish legislation on prostitution selects a strong emphasis on loitering and public nuisance, thus prostitution has found its place within public order offences, the Criminal Law (sexual offences) Act 1993. In this case the prostitute is causing the sexual offence as opposed to the Swedish law which believes the prostitutes requires protection from the law as opposed to being prosecuted. This (Irish) legal approach is oppressive to the complexities that exist for women in prostitution in modern Ireland today. This significant difference in approach is potentially crucial to redesigning a gender sensitive model for Irish society. Public/ health policy is a direct consequence of the laws that design and govern a society.

In essence the Swedish law claims to be women centred and determines that only the buyers of sexual services and not the woman involved in prostitution can be criminalised. The principles behind the Swedish model are recognition that prostitution is an act of violence towards women and children. This violence extends
to encompass, violence in the form of physical, social, and emotional violence both to those engaging in prostitution and their life events which have brought them here (an ecological approach to assessing need). Sweden seeks to maintain full gender equality and regards a zero tolerance of the purchaser as a means to end intrinsically harmful behaviour in society.

The Swedish approach to prostitution is unique in that it attempts to address the root causes of prostitution by encompassing the reality of what is experienced in the course of a prostituted woman’s life. From research and analyses, it found that, unlike the men that exploited them, prostituted women had led severely marginalised lives and experienced severe violence within prostitution. Hence the Swedish model recognised the incongruity of penalising ‘the weaker partner who is exploited by those who only want to satisfy their sexual desires’ (Ruhama, 2007, p 3). The Swedish model recognised that the responsibility for generating and sustaining prostitution had to lie with the people who sought the services of women involved in prostitution.

The Swedish model acknowledged that legislation repressing the demand would not alone solve this complex issue (Monasky, et al, 2011). A fundamental part of the Swedish model was to implement initiatives and empowerment strategies that aim to support the women concerned and to provide them with genuine opportunities and alternatives to the industry. In respect to their Quasi-public or social insurance model for health, a form of compulsory taxation or ring-fenced resources for social services, Swedish employees and employers share the responsibility proportionate to their level of income and then paid into a specific fund. The state pays into funds for the unemployed and other low income groups. As a direct result of this system, the Swedish government have provided a secure budget annually to the support and health services of women in prostitution. This is not something that has been considered here in Ireland, as a result of our public or general taxation/private insurance model, more familiarly known as a two tier health care system. This restricts available resources for less fortunate group investment. However, health services in the capital have attempted to prioritise health needs as addiction and sexual health. Ruhama (2006) stated that drug-using women involved in street
prostitution were predominantly Irish nationals not inclusive of foreign nationals working in prostitution.

This method of healthcare support, although relative, has left the door open to a gap in research to explore current phenomenon and practices of prostitution inclusive of a more modern global sex industry and address service development accordingly. Services meet the needs of women in Dublin, but are not accessible to women throughout the country. Now in 2013, the population is inclusive of direct provision accommodation, foreign national communities, undocumented populations, and a global sex industry accessible via internet and mobile phones. This new phenomenon has a direct impact on the women’s health, both mentally and physically. This calls for healthcare professionals not only to become informed of this population but also to adapt a holistic approach to assessing and providing appropriate healthcare to this group around the country.

Furthermore, the Swedish government provided additional funding to educate society to provide greater awareness and understanding about prostitution practice (Quasi-public or social insurance model). As a result in Sweden today, over 80% of the population support the law and the principles behind its development (Ekberg, 2004). In contrast to other countries that seek to regulate or legalise prostitution, the Swedish State claim to have adeptly managed this complex and controversial issue and have had successful results. In the years that the law has been in effect, it has dramatically reduced the number of women working in prostitution (Farley, 2004). Furthermore it claims to have had a significantly positive effect on women involved in prostitution as ‘60% of the prostitutes in Sweden took advantage of the well-funded programmes and succeeded in exiting prostitution’ (peacework.org). The results appear to have achieved the aspirations and goal of any comprehensive prostitution strategy of prostitution support and option reduction.

Where the Swedish law on prostitution fails to meet the demands of prostitution is on the issue of migration. In 2010 the most common reason for migrating to Sweden was (21%), family reunification (20%), refugees (12%) and 32,000 people applied for asylum (Eurostat, 2011). If a person was deemed undocumented in Sweden or an application for asylum has been refused, then they had to leave the country. This applied to women even if they had been located or identified through prostitution. If
this was the case then it becomes clear that the Swedish model only accepts its legislation to support women in prostitution for Swedish nationals or those who have status to remain. Therefore, this model cannot solely seek to respond to Ireland’s needs as a growing migrant sex industry. Could it also be that the Swedish State claim that the prostitution statistics have lowered significantly (Hubbard, Mathews and Scouler, 2008) is in fact, like Ireland simply a reflection of the changing nature of prostitution from street based to indoors, hidden?

The core argument against the Swedish model centres on driving prostitution underground, in particular for migrant women. Therefore, it does not wholly attempt to break down the stigma of prostitution in society (Eriksson, 2005). Academics such as Kulick (2005) concluded that the model has meant that the street women have come to frequent illegal brothels, indoors and subject to pimps and violence. It is not sufficient to claim that to criminalise the buyer will mean that the women will automatically leave prostitution and avail of exiting strategies, but it does mean with fewer clients buying sex, the women can become more desperate and open to practicing unsafe sex to secure a client (Ericksson, 2004). Ward et al (2012), proposed that Ireland is drawn to the ‘symbolism’ of the Swedish model, but law and policy cannot be driven by ‘symbolism’, rather we need a more investigative understanding of the issues that are existing in Ireland today. Is Ireland advocating for changes or simply to abolish prostitution in the hope that it will go away? Prostitution itself cannot be abolished when it isn’t clear what we are seeking to abolish. Irish agencies working with women involved in prostitution are calling for legislative change, but there is not so much a call for expanding services, providing training and information to healthcare providers or broadening the debate to include other perspectives.

In conclusion, the Swedish model on prostitution provides a perspective which is gender-appropriate and seeks to advocate for equality for women. The government have followed up on this by including prostitution on the public agenda, creating healthcare provisions throughout the country and providing clear guidelines for practice both for government and voluntary agencies which work together on this issue.
This legislation however does exclude non Swedish nationals and does also give limited attention to the women who are forced to go underground and decide to stay in the (sex) industry. In brief Ireland can learn a lot from this model, but in support of the argument proposed by Ward et al (2012), it can only play a symbolic role as Ireland still has a long way to go in respect to policy, debate and the realisation that prostitution is less likely to be abolished so therefore where can we go? This does not support health service development, migration prostitution and the notion of collaboration between research and practice. Historically Ireland has evolved quite uniquely to other European countries; this has shaped policies, social norms and service development. It is not enough to draw on other ‘aspects’ of comparative models but rather identify local paradigms and their impact in relation to the true nature of prostitution in Ireland.

2.11 Conclusion

This chapter concludes by providing a review of the literature on prostitution and until the legislation changes, it is vital to provide women in prostitution with services, and the need to gain a better understanding of their needs. The challenges within the literature review were locating peer reviewed literature from Ireland on prostitution. The literature is limited with only a handful of academic writing on Irish prostitution specifically (Ward and Wylie, 2007; Ward and Wylie, 2012, Ward, 2010) and the particular studies on health are outdated, such as the EUROPAP report on the health needs of drug using women involved in prostitution (1996). Furthermore, due to only three agencies specifically focused on prostitution, reports and outcomes, too, are limited and mostly guided by the philosophies of the particular agencies.

Ecological theory remained central to the literature and will be used to develop a model for practice to identify the psychosocial experiences of women involved in prostitution. Bronfenbrenner (1986) was the starting point in terms of the discourse explored followed by a feminist alignment of ecofeminism which interprets this model to address the needs of women and gender oppressive macro structures which influence the other subsystems, micro, meso and exo systems. This framework will be discussed alongside the findings later in the thesis (Chapter five).
The next chapter outlines the philosophical underpinning of the research by maintaining a feminist epistemological standpoint using biographical narrative interviews (BNI) with women involved in prostitution and analysing the findings in a consistent manner using a voice centred relational model (VCRM) of interpretation.
Chapter Three: Methodology

3.1 Introduction- phase one

This chapter outlined the research method used in this study, how the research was conducted and what this involved. This included the research design, the recruitment of the study population employed, and method of data analyses, ethical considerations and the scope and limitations of the method used. ‘Research methods can be, and are associated with different kinds of research design’ (Bryman, 2001, p.28). The methods are presented in two phases. Phase one is centred on the lived experiences of women in prostitution and phase two, of the research centred on the practices and ideologies of support agencies in the field of prostitution. This section was decided upon as it added the macro environments within which the women in prostitution exist. Although the women interacted with their environments, they had little control of policy implications and legislation, yet these impacted on their lives. Phase two provided support to phase one.

The methodology described here was predominantly led by the emancipatory research question. Emancipatory research arose from researching people with disability and the need to locate their experiences illustrating the complexity of the process of disablement with reference to environmental and social factors’ (Barnes, 2002, p.4). This has, thus, influenced the choice of a wholly qualitative approach to gathering information. An emancipatory stance which is ‘open’, ‘dialogically reciprocal’ and ‘grounded in human capacity’ (Lather, 2004) and requires a ‘biographic narrative’ format of interviewing in order for the participant to tell their experiences, attitudes and feelings to the researcher is favoured. This is fundamental and consistent with feminist/ecological principles and practice.

3.2 Qualitative inquiry and health promotion research

The approach provided a holistic understanding of women’s health by locating their experiences at a grassroots level and to understand this location within the structural environments of macro level policies. This is understood through the biographical accounts of women involved in prostitution. The researcher also explored social, economic and political forces which shape lives and impact on human rights and
social justice. This was understood through semi-structured interviews with agencies in the field of prostitution, locally, nationally and in Sweden. The overall perspectives on health recognised the complexities and differences in women’s life circumstances and became even more apparent (Ruzek, Clarke and Oleson, 1997), through the decided research methods approach.

The literature identified that women who engaged in prostitution often had personal experiences of child sexual abuse, poverty, addiction and global trends (Farley, 2003; Farley et al, 2004; Herman, 1992; Giobbe, 1991; Chambers Millar, 1986; O’Neill et al., 1999). Such variables needed to be understood in order to wholly understand prostitution. It is worth providing a lengthy quote here from Holloway as it nicely sums up what precisely qualitative research offers:

"Qualitative research is a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live. A number of different approaches exist within the wider framework of this type of research, but most of these have the same aim: to understand the social reality of individuals, groups and cultures. Researchers use qualitative approaches to explore the behaviour, perspectives and experiences of the people they study; the basis of qualitative research lies in the interpretive approach to social reality"

(Holloway, 1997, p. 2)

To:

- Locate the psychosocial experiences of prostitution
- To understand their health and well being
- To know the key determinants which impact on their psychosocial health, and;
- To identify barriers to accessing health

In order to solve the problem, the researcher sought to develop theories which would empower the participants’. Creswell (2013) argued that to achieve such problem solving, the researcher must; hear the participant’s stories and must hear their voices. Hence, a qualitative inquiry was decided upon and the below section, named ‘research design’ frames this inquiry within an interpretive framework. This
remained consistent with a health promoting and ecological perspective as discussed in the literature.

3.3 The research design

The research design chosen was a biographical narrative interview approach led by a feminist standpoint epistemological framework. Both designs combined sought a design which promoted the `voice` of women involved in prostitution.

3.3.1 Biographical narrative research

Biographical narrative research is person centred; `an approach which seeks to understand the link between individual agency and wider social structures and processes, having relevance for professional practice, highlighting as it does the lived experiences of empowering policies or of poverty and social exclusion`(Chamberlayne, Bornat and Wengraf, 2000, p. 22). Biography based research is a methodology for exploring lived experiences through the use of biographical narrative interviews (BNI). This approach originated from the workings of Rosenthal and Wolfram Fischer-Rosenthal where they combined and enhanced the practical skills of narrative style interviewing (Wengraf, 2001). Not to be confused with Biographical Narrative Inquiry Method (BNIM), BNI was chosen due to the difficulty in recruiting women involved in prostitution and their potential fear of opening up. BNI also allows for a more engaged approach verbally, using phrases such as, `you are doing great`, `I appreciate this may be difficult for you`, or encouraging phrases such as `that was really interesting, your experiences are so important`, and `I am learning so much from you`, would be more supportive to the women (Olney, 1998; Carroll, 2007; Hunt, 2006). Considering also the researchers skills in social work assessment, it allowed the researcher to know when to intervene to extract greater information and richer data appropriately.

The purpose of this research was to gain insight into the stories the women involved in prostitution told and how they view their own lives. How they interpret their experiences of their health needs became important to deciding upon a style of interview which allowed the participant to take time to tell their life story without inflicting constraints. Often, within qualitative interviewing, set questions are posed which can direct the interview. This assumes certain responses to certain questions,
which, in a sense, guide the participant to answer in response to specific questions and sought answers on behalf of the interviewer. However, if we maintain a person centred approach as discussed by Chamberlayne, Bornat and Wengraf (2000) we can collect material which is entirely true to their experiences. By allowing a more flexible space, the participant was invited to take ownership of their interview experience and tell their life story as they saw it.

The interviewer’s role was to listen and prompt where appropriate. In essence, the role of the interviewer was to attempt to interpret these stories only through the eyes of the story teller. The writing must, as far as possible, be free from personal agenda, political conviction or emotion on the part of the researcher. It is their stories and experiences that are located and told and they have ownership of the research outcome. We cannot ignore the power discourse between interviewer and interviewee, but we can acknowledge it and attempt to address this through giving true merit to interpreting their truths and realities.

The OCAP model of research originated amongst First Nations communities in the United States in the 1990s (International Workshop on Ethical Issues in Health Among Circumpolar Indigenous Populations 1995) and has been defined as “a political response to colonialism and the role of knowledge production in reproducing colonial relations” (Espey 2002) thus is has particular resonance for the Irish experience. It specifically looks to ownership, control, access and possession of knowledge and the relationship between researchers and research participants challenging the dominant status quo. It is of particular interest to this study as it was in the health promotion domain that it gathered momentum (Kwanlin Dün Health Centre 2001).

If services and practitioners alike are concerned with the empowerment of individuals and a psychosocial interpretation of health, a biographical interpretation seeks to achieve this. Williams (2004) argued that to understand the health inequalities in society, then health promotion and practitioners’ need to reinterpret the determinants of health. He emphasised the need to use a narrative approach, this he framed as listening for the ‘hidden injuries of class’ rooted in history and social conditions. The key components featured in biographic narrative interviewing are the ‘history’ and the ‘social’ environments of the storytellers. To understand the barriers
which exist for women involved in prostitution we need to understand their history against the backdrop of their social environments, as they experience their lives in addition to placing this story within the political and social ideology of today. The relevance of highlighting resource inequality, social positioning and political heritage are paramount to understanding the importance of sensitive inner words, emotional blockages and the interaction of those with complex cultures and contexts (of families and services), in order for professional intervention to be effective. This method supported a framework for analyses which placed ‘the voice’ (of women involved in prostitution or patients of any accord) at the centre of an already exhaustive biomedical model of measuring care. We cannot measure people’s life stories and we cannot compare them as similar or equal. Events can, no doubt, equate similar outcomes, but how each person understands and experiences these events are not the same.

3.3.2 Locating qualitative Inquiry within an interpretative framework

The literature often begins by telling us that storytelling is a phenomenon that has been around for centuries (Denzin and Lincoln, 1994; Strauss and Corbin, 1998; Byrne and Lentin, 2000 Chamberlayne, Bornat and Wengraf, 2000; Riemann, 2003). The key authors attempted to refine the purpose of these stories by allowing them their place within a qualitative definition or field. The objective is to listen to the story which is being told and to place this centrally within the research, to understand people’s histories and experiences through the participants’ lenses. Life stories have an interesting parallel to the history of sociology; as Riemann (2003) outlined the significant account of early Chicago sociology in the 1920’s whereby ‘unorthodox use of autobiographies, letters, diaries and other personal documents created an awareness of the complexities of modern life, histories, milieus and social worlds’ (p.1).

Since then, social scientists have ‘latched’ onto this strategy and over time refined this qualitative methodology. Although history presents the ‘ethnographer’ as the data collector of studied tribes or communities; as time has moved forward, researchers have a commitment to ethics of practice but also a commitment to be true to the participants and their accounts of their circumstances and events. This inquiry required the researcher to become a ‘reflective practitioner’; sociological skills
which are required within disciplines such as health promotion, social work, community development and more recently within the curriculum of medicine and healthcare (Naidoo and Wills, 2009; Limberly and Butler, 2004; Healy, 2005). The term biography simply means ‘life writing’. Olney (1998) presented it as a critical and historical overview of biographic narrative inquiry. The idea that story telling has existed has now the opportunity to be recorded with the ‘teller’ in mind, using a tool which reflects this through the absence of measurement and restriction.

More recently, life writing has been adopted by feminist sociologists (Carroll, 2007; Hunt, 2006). The renowned phrase ‘personal is political’ resonated the ideas behind biographic narrative inquiry. Feminist ideology aims to place the person at the centre of her environment. Feminist researchers want to know how this person ‘feels’ oppression, poverty, patriarchy and so on. Biographic narrative inquiry, too, attempts to understand the person (micro) within her larger social environment (macro). As we can see, there is a correlation of these two disciplines which share a history and pattern of research.

The qualitative researcher aims to gather an in-depth understanding of human behaviour and the reasons that govern such behaviour. The qualitative process investigates the why and how of decision making, not just what, where, when. Denzin and Lincoln (1994) outlined the conflict that exists within this field. Much as qualitative methods are far less rigorous than quantitative measurement, often the proposed arguments, in-camp conflict can be contentious in itself. Disciplines such as sociology, psychology, education and history more often disagree or discredit other disciplines use of qualitative process. This is because each discipline views the world from a different starting point. Denzin and Lincoln propose to overcome this and decide on what method works best for the researcher, suggesting the researcher must locate oneself within these tensions and contradictions. This is the first lesson a researcher must learn, a lesson that is indispensable to one’s choice of research tactic.

Denzin and Lincoln’s ‘interpretative paradigms’ help to locate our individual position in the research process. There are six paradigms within this framework, a basic set of beliefs that guide action. The research question; psychosocial experiences of women involved in prostitution aims to identify barriers that can
impede or prevent women involved in prostitution availing of the health services. It seeks to examine the experiences of women engaged in prostitution and the socio-political reasons for entering prostitution. The interpretative paradigms provided by Denzin and Lincoln (1994) located the research within the paradigms of feminist, ethnic, Marxist and culture models, material-realist ontology (the real world makes a material difference in terms of race, class and gender) and subjectivist epistemologies and naturalistic methodologies are also employed (Denzin and Lincoln, 1995).

To refine this further within the research question, Oleson et al (1994) take a refined view respective of gender and the qualitative alignment process. They argued that the professionalisation of medicine and, indeed, healthcare have created a collective discontent amongst women patients. So, to understand the construction of health through the lens of women involved in prostitution it is important to view participants as ‘subject’ and, thus, focus on the naturalistic methodologies in order to report their experiences. This is best achieved through biographic narrative interviewing, or a ‘feminist standpoint epistemology interviewing’ an ‘interviewee-guided’ investigation of a lived experience (Sandelowski and Pollack, 1986, p.140). A feminist standpoint epistemology approach to this research was used in an effort to inductively develop a theory based on the participant’s views of the situation under investigation. Embedded within this approach was the recognition of the impact of the researcher’s own background and experiences; which highlighted the need for a system of reflexivity where the importance of self-awareness, cultural awareness and ownership of one’s own perspective is emphasised (Patton, 2002).

3.3.3 A feminist approach

When choosing a theoretical framework, it became apparent through the literature that the study design required a feminist location of the lives of women involved in prostitution. In order to achieve this, this theme needed to extend throughout the process. If so, then a feminist recurring theme must also extend to the type of methodology chosen, how this was carried out and in keeping, how the data was analysed. Such reasons have guided and supported the researcher in choosing a biographical narrative inquiry process in order to achieve this. Individual experiences cannot be recounted within a set of categorisations that simply quantify
outcomes. If feminist theoretical frameworks seek to locate women’s experience and life events which reflect social behaviours within a current society of oppression and patriarchy, then it is suggested quantifiable means will devalue their voices. Feminists seek a biographical narrative inquiry research method to make that voice vocal (through the researcher) to sustain experience and personal truth.

Feminism draws on different theoretical and pragmatic orientations, different national contexts, and dynamic developments (Oleson, 2004). When considering a feminist framework, research topics can include: policy issues related to realising social injustice for women, such as women involved in prostitution and their access to appropriate healthcare, and according to Oleson (2004), specific contexts and knowledge about oppressive situations for women. Considering this, the literature provided a strong correlation between a legal and political system as steeped in patriarchal structures which have impacted on the protections available and the pathologising of individuals involved in prostitution in Irish society (Byrne and McCutcheon 1996; IHRC, 2007). This greater system impacted on policies of health (care) which under a neo-classic economic roof excludes the minority and the poor (McDonnell, McDonnell, O’Neill and Mulcahy 1997; Farley, 2000). Feminist theory indicates a strong parallel between women’s lived experiences and gendered structural inequalities embedded in society. These are the most important elements of biographical narrative interview research, inclusive of the delivery of the participant’s life story; how do they (participants) participate, experience and interpret their lives within these structures. In feminist research approaches, the goals are to establish collaborative, non-exploitative relationships, to place the researcher within the study so as to avoid objectification, and to conduct research which is transformative. These are consistent features of biographical narrative inquiry and the use of a ‘voice centred relational model’ of analyses. VCRM (See VCRM explained below) is consistent with the OCAP research framework discussed earlier in this chapter. It is a complex area of inquiry, with numerous frameworks (Oleson, 2004).

The questions feminist pose relate to the centrality of gender in the shaping of our consciousness. The aim of this ideological research is to ‘correct both the invisibility and distortion of female experience in ways relevant in ending women’s unequal
social position’ (Lather, 2004, p. 71). Another writer, Stewart (1994), translated feminist critiques and methodologies into procedural guides. She suggested that researchers need to look for what has been left out of social science writing to provide a broader understanding of identities, sex roles, domestic violence, health, comparable worth, affirmative action and the ways which women struggle with their social devaluation (Stewart, 1994).

3.3.4 Feminist standpoint epistemology

The methodology used is a feminist standpoint epistemology in keeping with an interpretivist/feminist qualitative framework. Simone De Beauvoir (1997) wrote `one is not born a woman, but rather becomes...’, this statement urges us to understand women’s location within societal (already shaped) structures. Feminist standpoint epistemology borrows from the ideology of Marx and Hegel suggesting that individual’s daily activities or material lived experience, structures their understanding of the social world (Hesse- Biber et al, 2006). Thus, feminists argue that it is women’s position in society that explains their oppression. Berman (1994) argues that ecofeminism “is a theory and movement for social change that combines ecological principles with feminist theory” (p. 173). This connection between feminism and ecology is also suggested by Sandilands (1991), who defines ecofeminism as “a theory and movement for social change that combines ecological principles between feminism and ecology. It is also suggested by Sandilands (1991), who defines ecofeminism as “a theory and movement which bridges the gap between feminism and ecology, but which transforms both to create a unified praxis to end all forms of domination” (p. 90). The worker/slave dichotomy (Marx and Engles, 1883) could be used here in the context of women involved in prostitution on two counts. Firstly, society’s/uneven distribution of resources, and secondly, the client/prostitute power dichotomy. In accordance with the literature it is necessary to extend this debate to include class, race and global trends which impact on women’s lives and lived experiences. Essentially, the core principle of feminist standpoint epistemology is the calling for attention to women’s diverse lived experiences. This philosophical position is consistent with the object of the research question and an ecofeminism perspective.
3.4 Data collection

The study population consisted of 15 women involved in prostitution in the west of Ireland and its environs. The sample was purposive and was recruited through gatekeepers, an agency specifically working with women in prostitution (Women’s Health Project, Dublin, HSE). A snowball sample was introduced. Each participant was asked to invite a friend or acquaintance also involved in prostitution that they thought may be interested in attending for interview. This process helped to avoid bias within the research. The recruitment criteria were as follows:

1. All participants must be or have been actively engaged in prostitution in the west of Ireland. This group may be based full-time in County Galway, or of a transient nature
2. All participants were over 18 years
3. Informed consent was sought and signed off
4. All participants held a good command of the English language

The age group ranged from 18 years and above (19-50 years were represented). No age limit was administered.

3.5 Recruitment

The agency was approached and invited to partake in this process by letters of participation. This was followed up with a phone call and opportunity to meet to discuss the study. Consent was given from the Women’s Health Project Coordinator and her superiors within the HSE, and then the process of recruitment began. Interviews were held in the Women’s Health Project premises. This was decided as a familiar, safe environment for the women and they also had access to supports post interview should they need to avail of them.

The Women's Health Project was established in 1991, as part of the HIV/AIDS prevention strategy. The Women’s Health Project is a sexual health and support service for women working in prostitution. They provide sexual health screening, addiction services, outreach to streets and parlours, training and education workshops. A full sexual health screening and counselling service is available including HIV and Hepatitis A, B and C testing, vaccinations, smears, counselling,
contraception, pregnancy testing and advice, support, referral and education. Additional services include a methadone and needle exchange programme. All services, including drugs and condoms, are free. Clinical services are based at 19 Haddington Road, Dublin 4 (beside Baggot St Hospital).

3.6 Risks and benefit to the gatekeeper

Risks: there were no anticipated or articulated risks for the gatekeeper agency in participating in the study.

Benefits: the benefits consisted of recognition for the work the agency does for women involved in prostitution, also it was felt the research should potentially highlight greater needs and resources that may be useful to the agency.

3.6.1 Risks and benefit to the participants

Risks: By discussing emotional experiences which may arise for the participants, support workers were on standby in the Women’s Health Project to provide counselling if required. The interviews were scheduled during clinic hours where a full workforce of support workers was active. Further to this, a doctor and nurse were on site also to provide information support or examinations.

3.7 Interview format using a biographic narrative interview approach

The interview technique was ‘biographic narrative inquiry’. A semi-(un)structured interview style format applied. The interview style was imperative to achieving the necessary information. The interviewer guided the interview on the participant’s terms without seeking to test any preconceived hypotheses of the researcher (Belensky, 1997). The key factors considered were: the participants experience or story, a female participant group, and the consideration of use of (simple) language and social circumstances that the participant may bring. To design appropriate questions accordingly and in keeping with achieving an interviewee-guided, woman to woman egalitarian interview, the following format was chosen:
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3.7.1 Part one: Life story and experiences

1. To begin, can you let me know how you first came to be involved in prostitution? If you are comfortable talking about this, then I will listen and not interrupt. I would like to understand more about your life and experiences.

The purpose of this opening question was to try to understand why the participant has become involved in prostitution? What life events or experiences have led to this? To comprehend the women’s backgrounds helps to advocate for their psychosocial supports which attempts to take into account their holistic needs and not just their sexual health.

2. If we can, I’d like to go back to a point you mentioned earlier?

Here, I would pick up on something the participant had said or focused on and ask a little more about this. This would develop into another area the participant wished to discuss and I would engage with questions where appropriate. This happened several times in the context of engaging in dialogue throughout the duration of the interview.

3.7.2 Part two: The practice story

3. Can you tell me a story about a time when your physical health was affected through prostitution?

Here, I may pick up on something the participant has said and ask more about this where appropriate.

4. Can you tell me a story about how your emotional health was affected through prostitution? For example; you were feeling sad, low or worried?

Here, I may pick up on something the participant has said and ask more about this where appropriate.
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During the course of the interview, I attempted to address key themes:

- What were the key sources of support or resistance you encountered?
- Tell me about some of the memorable people in your life. The ones that give you support or worry?
- What was most difficult or challenging? How do you deal with these challenges?

3.7.3 Part Three: Reflections

1. What do you feel I need to understand about prostitution for the women involved?
2. What would you like to see change for women involved in prostitution?
3. What supports do you feel are most important for women involved in prostitution?

These questions may have already been addressed above through prompting, exploring etc., so there was not always a need to individually ask them. However, if these issues had not been addressed then it was important to provide the space for the participant to end the interview on an empowering note.

4. Thank you so much for meeting with me, I’ve enjoyed spending time with you and learning from you. Before we end our meeting, is there anything else you feel I should know or learn?

Final closure happened with taking time at the end of the interview to debrief where necessary or simply to chat about how the participant was feeling after the interview, what their plans were for the rest of the day for example. Essentially, the interviewer aimed to end the interview on a positive note for the participant.

On closure of the interview, the participant was given the space to add anything further or simply reflect on the experiences they had spoken of. It was expected that each interview would last between 30-40 minutes and this was achieved in most
cases. However due to other time commitments on the part of the women, a couple of interviews ended under 30 minutes.

All interviews were tape-recorded and transcribed verbatim after the interview took place.

3.8 Data analysis

The data were analysed using the ‘voice centred relational model’ (VCRM).

*Voice centred relational model* is primarily concerned with capturing and amplifying the ‘voice’ of the research participant. This method of analysis was introduced and developed through the research of Brown and Gilligan (1995) within the Psychology disciplines and was later adapted into Sociology by Mauthner and Doucet (1998). If the research embraces an ecological understanding of human condition, then it needed to acquire a different understanding of behaviour and circumstances of social interaction and positioning; a ‘relational ontological’, understanding of the participants within research. According to Mauthner and Doucet (1998), there is space for a ‘duality’ of social structures and human agency, and they argued that a ‘relational ontology’ is not dissimilar to that of symbolic interactionism used within traditional social science research. They believed that the ‘voice centred relational model’, with its strong attachment to feminist theory, captures the essence of interdependence, dependence and independence of the private sphere subject to the interrelated and theoretical issues presented, which can build on a traditional symbolic interactionist approach used within traditional sociological research (Mauthner and Doucet, 1998). It became apparent that this model was a fit for the research perspective held by this researcher.

3.8.1 Analyses using VCRM

1. *Reading for the plot and for our responses to the narrative*

In the first reading the researcher identified and located the main events of the story which were told by the (narrator) participants. For example: what was the plot? Subplots? Main events? Recurrent images, events, metaphors and contradictions (Mauthner and Doucet, 1998, p. 126). On accumulating these events, an understanding was gained by the reader of what issues came to the fore for the teller.
Therefore, as part of reading one, the reader was required to read the transcripts again to recognise their own personal interpretations, values, bias and so on which may compromise the telling of the participants stories, `voice’ and accounts. According to the literature, power discourse exists between the prostitute and society at large. This has been noted through the historical developments of prostitution to date, the legal and political frameworks they participate within and a patriarchal resonance which filters through biomedical models of practice. This power discourse must therefore extend to the relationship between the researcher and the researched. To achieve or at least to attempt to understand this process, Brown and Gilligan (1992) suggested that the researcher consider how their thoughts and feelings may affect their understanding, interpretation, and the way they write about that person. They suggested highlighting the issue of `reflexivity’ in terms of the researcher’s social location and emotional responses to the respondent (Brown, 1994, Gilligan, 1992). This is central to achieving a biographical narrative account. In Byrne, Canavan and Millar’s (2007) discussion; participatory research and the voice centred relational method of data analyses: is it worth it? They addressed the issue of power by highlighting the middle class interpretation of events from the researchers point of view, acknowledging that the researcher must share that power and by doing so, may democratise the process but only through addressing one’s own set of values as different from the participant, but not better or accurate. It is the lived experience of the teller which must resonate through.

Subject to this second reading, the researcher formed a more in-depth account of the narrative, plot and overall experience of the interviewee. This was achieved by using a highlighter marker and trudging slowly through the material, highlighting important phrases, comments and reactions. The information was then given its own title: `The Plot’, and then stored for recoding. The breaking down of the plot consisted of sub-themes. This was achieved through thematic coding, advancing the VCRM into a hybrid analyses project. Themes continued to emerge (sub themes of subthemes) until the researcher was satisfied that saturation had occurred.

2. Reading for the voice of the ‘I’; the reading of `I’

Reading two concerned itself with locating how the participants spoke directly about themselves. For example, what exactly was the person talking about and what
journey or experiences were they locating with the use of ‘I’, ‘we’, ‘you’ and so on. This process helped the researcher to understand how the participant saw their life events and distinctions. The researcher identified the ‘psyche’ (psycho) of the participant and also the social positioning of the participant as they saw it (social). This use was consistent in recognising the psychosocial experiences of the participant as the research title asked. By focusing on the ‘I’, researchers are clearly stepping away from the multi-layered interpretations both them and the literature can often draw. The ‘voice’ must stand precedent within the literature and the research process.

The research was seeking the private experiences within an ecological framework, rather than just a public goal of interpretation. For that reason the interviewer read for the use of ‘I’ within the text. For example, Mauthner and Doucet, in Edwards, Ribben and McCarthy (1998) stated that ‘in researching areas of private life where process-oriented values and ways of being are more emphasised rather than the more public goal oriented values and ways of being’, we can locate processes, meanings, relationships and contradictions which are central to a person's life. This study sought to understand the stories of women involved in prostitution from their personal accounts and experiences. We can understand prostitution through public goals and values through the medium of laws and policy, but are these policies and legislation acting in accordance with the women’s perceived needs or societies perceived needs for them? To use grounded theory could mean trapping the very nature of the research into a public neoliberal analyses and interpretation which would be inconsistent with the research question and the theoretical framework it required.

Again, the researcher chose another colour marker to read through each transcript, locating interpretations of how the participant spoke of themselves and their experiences. The words, ‘I’, ‘we’ and ‘you’ were also internally highlighted within NVivo software tools. This was decided upon for the purpose of recognising when and how these words were used. For example, when a participant spoke of family/children, were they more likely to use the term ‘I’? But when referring to an experience of rape or theft; were they more likely to use the word ‘we’ or ‘they’? This could be construed as a form of disassociation, a liking to removing one’s self
emotionally from a particularly negative situation or experience. This process confirmed the strength of using the ‘voice centred relational model’ as it explored the voice and its multi-layered meanings. This remains true to the philosophical and theoretical framework of the research. Each event cannot exist in isolation, but rather they existed in an intertwined state.

Again, as themes emerged from this section, a hybrid approach of thematic analyses was used or added to (sub) theme until saturation was reached.

3. **Reading for relationships**

Here, the researcher identified the relationship experiences of the participants, for example, their families, partners, and children and so on. Within the literature, the issue of family breakdown and links with the care system (Sanders, 2001; Coy, 2008; Moss and King, 2001; O’Neill and Campbell, 2001) were discussed in relation to women becoming involved in prostitution. However, this reading gave the researcher the opportunity to see these events through the eyes of the teller.

4. **Placing people within cultural contexts and social structures**

In the fourth reading, the researcher placed the respondents’ accounts and experiences within broader social, political and cultural structural contexts. This reading created the opportunity to understand the participant’s experiences through an ecological understanding which was consistent with the object of this research. To understand the experiences and needs of women in prostitution and to seek a more holistic method of intervention as opposed to the static biomedical model most dominant in Irish healthcare today. This reading allowed the researcher to identify the need for a macro analyses which led to the development of phase two of the study: Interviewing agencies working directly with women involved in prostitution.

3.8.2 Critical overview

Byrne, Canavan and Millar (2007) noted that dominant research interests can still emerge. For example, which sections of the transcript were selected to be left out or dismissed from the analysis? However, while considering this, it was decided nevertheless that this model still attempted to address the issues of power discourse which emerged on behalf of the participant sufficiently.
It was also considered that completing four readings of each participant’s transcript was time consuming (Mauthner and Doucet, 1998). However, it had been made clear by the authors (Brown and Gilligan, 1993; Mauthner and Doucet, 1998; Byrne, Canavan and Millar, 2007) that the researcher could adapt this approach to suit the researcher’s disciplinary approach and indeed time frame. To achieve this within the PhD timeframe, the researcher chose to transcribe the interviews verbatim and then provide an analysis of four readings, per transcript only. No focus group or interaction with the participants would occur after the interview occurred. This adaptation instead, included a hybrid analyses approach, using thematic coding of each heading.

3.9 Data storage

In accordance with O’Leary (2004), confidentiality was maintained through secure storage of data. This required restricting access to the data and keeping it locked in a filing cabinet (my personal filing cabinet in my PhD room). This was filed using abbreviated codes known only to myself. As no real names existed in the storage, and the use of pseudonyms was used, a listing of abbreviated terms and pseudonyms were stored in a separate file. No true names were recorded throughout the research process; therefore, the identification of the real identity of participants is most unlikely. This was a crucial step in managing and storing data in relation to doing research on sensitive topics (Lee, 1999).

Data records were stored on computer for the purpose of entry into the ethnography software programme as data was coded using the constant comparative method, and refined to establish theoretical relevant categories within NVivo. This was stored on the researcher’s personal computer (password protected) whereby access was only determined by the researcher.

3.10 Consent

Information sheets were provided to all the participants. Verbal and written consent was obtained prior to the interview. Assent was discussed and assured throughout this process. ‘Process consent’ was used rather than a once off initial consent agreement as an alternative approach (Boorman, Behrens, Woolrich and Rushworth, 2009). Informed consent cannot eliminate all the potential risks but it does give the
potential participants a degree of control over both their participation and the perceived risks (Herrera, 1999). This is consistent with an empowerment approach and maintaining the principles of social justice.

Full verbal and written explanations of the study were given to all participants and their questions answered. It was explained that consent can be withdrawn at any stage. The information sheet provided to the participants was phrased clearly and easy to understand. This is considerate of a basic level of literacy in respect to poor educational attainment and where English was not a participants first language. The objective of the process was not to alienate the participants.

3.11 Ethical considerations

The study was reviewed and approved by NUI Galway Research Ethics Committee.

As outlined earlier in this chapter, the OCAP model of research has been used for consideration of ethics as it specifically looks to ownership, control, access and possession of knowledge and the relationship between researchers and research participants challenging the dominant status quo (Kwanlin Dün Health Centre 2001).

This research focused on a minority population of women involved in prostitution. The women may have experienced sexual violence, family separation or breakdown, addiction and migration. Cwikel and Hoban (2005) discussed in their research, how women were often grateful for the opportunity to tell their stories to an interested neutral listener. Therefore ethically, it became the researcher’s responsibility to set the researcher considerations sensitively to uphold this and in keeping with the principles of health promotion, to empower the women in sharing their experiences.

It is important to note here, that the researcher is a qualified social worker and has practiced in the area of domestic violence, child sexual abuse, undocumented populations and asylum seekers. This experience was invaluable and necessary to conduct the interviews with sensitivity with potentially vulnerable women.

Ethical challenges in the research:

*The major ethical challenges in research arise primarily from inequality, difference, risk and uncertainty* (Bond, 2004, p.4).
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The ethical challenges included practical considerations with respect to the research location, where the interviews would occur. Other challenges anticipated in interviewing women in prostitution were power discourse, and the participant’s experiences of secondary trauma while speaking of events in her life, confidentiality, trust and finally closure of the interview process for the participant. The following steps were adapted to address these challenges:

Research location and developing trust: To address this it was decided that The Women’s Health Project (HSE), would be used as the site location to host the interviews. Furthermore it would provide a safe, non-threatening environment for the women as they would be familiar with the location site and would have already built trust with the support workers.

Through sharing our experiences with projects focused on (prostitution) services and supports we provide insights into our attempts at establishing reciprocal relationships with community members (Knot, 2014). In the capacity of social work practitioner, the researcher had already established links with this agency which provided the foundation for trust and reciprocity. This trust was transferrable to the participants. If the health unit where the women attended trusted the researcher, it was more likely that the women would trust the researcher. This was an important starting point as the women were hard to reach as a population and, of course, were engaged in prostitution which is outside of the law.

Power: *Understanding the power dynamic in a participant-interviewer relationship and how both manage that relationship is key, not only to carrying out the study, but also to understanding the data it generates* (Van den Hoonnaard, 2005, p.2). If the ‘voice’ of the women was to remain central to the research consistent with a feminist standpoint epistemological underpinning - then power needed to be addressed. The researcher endeavoured to achieve this by reminding the participant that they could withdraw consent at any time during the interview process. An attempt was made to enable the participants to feel valued. For example, throughout the interview process, the researcher reminded the participants of how their experiences made them and them alone, the experts and that the researcher was in a position of learning.
Trauma for the participants: Using a biographical narrative open approach interview format, it was difficult to know what issues might arise including any distress or disclosures while discussing difficult or upsetting issues. To address this, the researcher liaised with WHP, to put safeguards in place. Counselling services were offered to all the women who participated in the study or appropriate referrals would be made on their behalf (At the time each interview took place, trained support workers from the Women’s Health Project were on site). These services were supplied on site when interviews were completed where necessary. All services were free of charge as (the Women’s Health Project is funded by the HSE to provide health support such as sexual screening and counselling where required).

Trauma for the researcher: Successful research inevitably involves some emotional investment on the part of the researcher (Hobbs 1988, cited in Sanders, 2005, p.36). Despite the professional background of the researcher, the researcher is a person not removed from human empathy and emotion; Liebling and Stanko (2001) describe the moral turmoil experienced by researchers who are witness to the violence and harm in other people’s lives. For this reason and considering the researcher’s emotional investment within the research, the WHP team and coordinator would take on the proactive role of debriefing with the researcher following interviews of an upsetting nature if needed. This commitment was made by the coordinator before the interviews began.

Confidentiality: sharing experiences and lifestyle choices could be sensitive subjects for the women and this should not be under-estimated. Anonymity was guaranteed to all participants. Any information that may identify a participant was omitted from this study. The women did not have to provide their real names to the consent forms and if they felt threatened by doing so, by virtue of their involvement in prostitution, they would be reassured the conditions of confidentiality and would be reminded that they can withdraw consent at any time during the interview process.

A necessary exception to this condition would be where in rare circumstances when information was disclosed by a participant that may identify or lead to harm of themselves or another person. This was in keeping with the social work guidelines of practice and duty of care (Department of health and children, 1999). This was brought to the attention of the women prior to interviews commencing.
Closure of Interview: it was important for the interviewer to ‘informally debrief the interviewee’ in order to ensure that any difficult questions or emotions that may arise were not left unaddressed which could leave the interviewee alone upset or vulnerable. It was necessary to create an ‘informal space for post interview debriefing of the interviewee’ (Wengraf, 2006, p. 95). Each participant would be asked to reflect on how they felt the interview was for them; they were also reminded that support was available on site for them to access.

3.12 The pragmatics of the research process

It was decided that an adapted or hybrid version of VCRM would be used. VCRM in its original form can require a second or even third visit with the participant following the first interview. Due to the nature of the population group this was not an option. This was a ‘hard to reach’ population and it took over a year to secure 15 interviews for the study. It must be acknowledged that the women can live chaotic lifestyles and are typically moving around the country. For this reason, the women often found it difficult to keep appointments. Furthermore, the Women’s Health Project has just two clinics a week to meet with the women. For the scope of the research and the time frame allocated to the PhD, revisiting the participants was not an option.

It is also important to note that a study which is wholly qualitative is time consuming and requires total attention to detail. With this, each interview was to be analysed four times to meet the criteria of VCRM and its four readings. Although this was a lengthy process, the research with its use remains loyal to a feminist method which effectively locates the voice of the women as central to the research.

3.13 Introduction- phase two

Stage two of the data collection proceeded to gather information from healthcare professionals engaging with women in prostitution within their professional capacity. This posed a challenge as this cohort of agencies was small within Ireland. It was necessary to also consider local agencies in Galway city within the sample as the research seeks to understand women’s experiences of engaging in prostitution throughout Ireland. The services chosen locally were primary services which work predominantly with women in the west of Ireland in a supportive capacity (They
were not specifically for women in prostitution, as such services do not exist). On a national level the services chosen worked specifically with or in the area of prostitution face-to-face and in a research capacity. As Ireland progresses forward to amend the current legislation on prostitution, it has been decided by the specific agencies and lobbying groups that Ireland should adapt the Swedish model on prostitution and trafficking for the purpose of sexual exploitation. A proposed document has been formulated and accepted by (then) Minister for Justice Mr. Alan Shatter, on their behalf. For this reason, it became clear that an investigation into the Swedish legislation on prostitution needed to be included in this research to wholly address and propose an answer to the research question ‘the psychosocial experiences of women involved in prostitution’.

3.14 Agencies in the field of prostitution

![Diagram showing local agencies, national agencies, and representative agent of the Nordic states]

**Figure 3.1: Agencies in the field of prostitution.**

Local agencies: Galway Rape Crises Centre, Galway Refugee Support Group, Cope Homeless Services Galway (Osterley Lodge)

National agencies: Ruhama, the Dignity Project, Immigrant Council of Ireland

Representative agent of the Nordic States: Patric Cederlof, National Coordinator of prostitution and trafficking, Sweden (National Support Organisations Team).
3.15 Research design

The feminist epistemological base of the previous phase of enquiry provided the scope to understand prostitution through the experiences of those involved and how they see or perceive their world as a tool to guide the researcher. Here, the focus was not interested in the voices *per se* of the participants but rather the agency/institutional discourse which attempts to act on behalf of the women involved in prostitution. This design supported the researcher in comparing and contrasting sites within the backdrop of agency structures which work in response to and directed by macro policies and agendas, held within dominant discourses as identified in the literature (Biomedicine, economics and the law).

The research used a structured interview process born out of the idea proposed by Karl Popper (1968), of the *theory before research model* in order to refute or disprove or support the idea that women involved in prostitution are being supported by current health services and practitioners alike throughout the country.

Idea- Design- Data collection- Analyses- Findings- Dissemination

The *idea* was the *research question* itself, considering the experiences and identified needs of the women engaging in prostitution and if these needs were being met by current services? Data are collected to support or refute this and therefore the information collated from phase two of the study was addressed only against the voices of the women’s stories to seek a match or identify gaps within services. Thus, the *theory before* the research model pertained.

The structured interview required a set of questions to be formulated and then put to each interviewee. Bryman (2008) wrote of how each question must be put to the participant in the same fashion and in the same order. This occurred, however, it was necessary to formulate three sets of questions for each category to extract the most appropriate responses. For example, each category (Local, national and the Sweden perspective), held different positions and came from different backgrounds and health care agendas. Each category followed the structured interview style otherwise.
3.16 Data collection

The data reflected purposeful sampling where each participant was chosen based on the merit of experience relating to the research question. The participants partook in the study and they were divided into three categories based on location. The participants were all known to the researcher through her previous work as a medical social worker in Galway city or by introduction through stage 1 of the data collection. Recruitment was, thus, straightforward by email or telephone. Information relevant to each category was sent to the participants, consent was given and the interviews commenced. Only the local representatives were interviewed in person, the others were interviewed by telephone for the convenience of the participants in respect to their busy schedules.

For each participant within their given categories a structured interview took place (See 3 sets of questions in Appendix III). See inclusion criteria below:

Category 1: Local agencies

Category 2: National agencies

Category 3: Agent of the Swedish model on prostitution

3.17 Data analysis

The data were analysed using NVivo. The concern here was only to locate the women’s voices within the broader social- economic realms of their environment. The researcher was not interested in analysing the data, creating themes and subthemes, but rather to document an account of agencies locally, nationally and in Sweden to support and identify possible barriers to health. The data was simply coded under the questions asked.

3.18 Conclusion

This chapter has provided the methodology for the study. The next chapter presents the findings which emerged from the data.
Chapter Four: Findings

4.1 Introduction - stage one

This chapter outlines the findings which emerged from the data collected. The previous chapter on research methodology outlined a hybrid voice centred relational model/thematic analyses tool to locate the women’s lived experiences within prostitution and also their lives and experiences located behind prostitution by using the voice centred relational model of analyses. Four key themes were used:

1. The main events or plot - The cultural context of prostitution
2. Reading for the voice of ‘I’, ‘we’ and ‘you’
3. Reading for relationships
4. Placing the women within cultural/social structures

By using these themes, the findings remain in keeping with a feminist framework as outlined both within the literature review and the methodology chapters. The feminist framework perspective has also been placed within the context of ecological theory within the literature review which recognised the space to locate the women’s experiences within the micro, meso, exo and macro subsystems which exist within society and as citizens we all engage in (Bronfenbrenner, 1986). For this reason, the findings are also set out using this framework. The voices and experiences which were located in reading one ‘reading for the main events/plot’ are used to place reading two, three and four in context. Reading one therefore sets out the scene. Reading one provided the experiences of the women before, on entering, within and post prostitution which provides evidence of how the systems or environments have impacted on their lives and facilitated their paths into prostitution.

As the findings emerged it became clear how reading two, three and four became significant. For example, when reading for relationships in reading two, there appeared a pattern of family breakdown or migration before entering prostitution followed by their journey into prostitution and relationships thereafter which impacted on their psychosocial experiences. Thus, reading one (The main events/plot) became the sign post for the three remaining readings within the findings and was used here to set the scene to draw out the other themes which emerged thereafter.
Chapter Four: Findings

The second section of this chapter outlined the findings of the agencies which were interviewed in this study. Set questions were put to the agencies and the data were analysed using thematically analyses. This section was decided upon as although the women themselves interact with their environment, at a macro level the women do not have direct role. As stated in the literature from an ecofeminist perspective, ‘Such environments such as policies and laws relating to prostitution are shaped by cultural values and norms which are inherently conservative socio-political orientations which focus on narrowly defined domains of environmental transactions’ (Besthorn and McMillen, 2002, p.221). Therefore, section two places the findings from section one in context and locates cultural norms and values alongside policies and legislative practices which impact on the psychosocial experiences of women involved in prostitution.

4.2 Using quotes within the findings

The interviews were transcribed verbatim to ensure the women’s voices and experiences were identified. It was decided that because the interviews were biographic narrative accounts of their lived experiences then their quotes would be presented within the text below. In conversation and narrative analysis, the spoken words and discourse are themselves the matter of enquiry (Cordon and Sainsbury, 2006). Furthermore, commitment to giving research participants a voice was a priority for the researcher. The researcher also concludes that the use of quotes from the interviews is in keeping with the women’s voices as the forefront of the findings. This is in harmony with the voice centred relational model of analyses outlined in the methodology of the research, as it can be useful to show how something affected a person’s life by using their own words (Corden and Sainsbury, 2006).

According to Corden and Sainsbury (2006), decisions sometimes have to be made about how far to break up long sections of transcript into chunks. The process of blending quotes into the findings was critical. It was decided that due to the length of the chapter as the data is wholly qualitative and also due to the expectations set down by the PhD requirements, that quotes would be included but one voice (or one quote) would be used as representative of all voices.
This chapter outlines the findings which have emerged from the strategy addressed above and will set the scene for the issues which require discussion in the next chapter of the thesis.

4.3 Participant profile

Table 4.1: Participant profile

<table>
<thead>
<tr>
<th>Participants</th>
<th>Addiction</th>
<th>Age Range</th>
<th>Children</th>
<th>Immig -ration Status</th>
<th>Nationality</th>
<th>Sex</th>
<th>Type of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anna</td>
<td>Not Disclosed</td>
<td>40-45</td>
<td>Yes</td>
<td>Undocumented</td>
<td>Brazilian</td>
<td>Female</td>
<td>Escort</td>
</tr>
<tr>
<td>Bridget</td>
<td>Not Disclosed</td>
<td>31-35</td>
<td>Yes</td>
<td>Non Irish EU</td>
<td>Portuguese/ Originally Brazil</td>
<td>Female</td>
<td>Escort</td>
</tr>
<tr>
<td>Cathy</td>
<td>Not Disclosed</td>
<td>20-25</td>
<td>No</td>
<td>Non Irish EU</td>
<td>Spanish</td>
<td>Female</td>
<td>Escort</td>
</tr>
<tr>
<td>Emma</td>
<td>Yes</td>
<td>31-35</td>
<td>Yes</td>
<td>Asylum Seeker</td>
<td>South African</td>
<td>Female</td>
<td>Street</td>
</tr>
<tr>
<td>Fiona</td>
<td>Not Disclosed</td>
<td>20-25</td>
<td>No</td>
<td>Asylum Seeker</td>
<td>Nigerian</td>
<td>Female</td>
<td>Escort</td>
</tr>
<tr>
<td>Gene</td>
<td>Not Disclosed</td>
<td>20-25</td>
<td>No</td>
<td>Student Visa</td>
<td>Brazilian</td>
<td>Female</td>
<td>Escort</td>
</tr>
<tr>
<td>Helen</td>
<td>Not Disclosed</td>
<td>46-50</td>
<td>Yes</td>
<td>Student Visa</td>
<td>South African</td>
<td>Female</td>
<td>Escort</td>
</tr>
<tr>
<td>Irene</td>
<td>Not Disclosed</td>
<td>40-45</td>
<td>Yes</td>
<td>Non Irish EU</td>
<td>Spanish/ Originally The Dominican Republic</td>
<td>Female</td>
<td>Escort</td>
</tr>
<tr>
<td>Jenny</td>
<td>Not Disclosed</td>
<td>20-25</td>
<td>Yes</td>
<td>Student Visa</td>
<td>Brazilian</td>
<td>Female</td>
<td>Escort</td>
</tr>
<tr>
<td>Kate</td>
<td>Observation</td>
<td>20-25</td>
<td>No</td>
<td>Irish Citizen</td>
<td>Irish</td>
<td>Female</td>
<td>Escort</td>
</tr>
<tr>
<td>Lynne</td>
<td>Yes</td>
<td>20-25</td>
<td>Un-known</td>
<td>Non Irish EU</td>
<td>Romanian</td>
<td>Female</td>
<td>Escort</td>
</tr>
<tr>
<td>Mary</td>
<td>No</td>
<td>20-25</td>
<td>No</td>
<td>Irish Citizen</td>
<td>Irish</td>
<td>Female</td>
<td>Street</td>
</tr>
<tr>
<td>Niamh</td>
<td>Not Disclosed</td>
<td>20-25</td>
<td>No</td>
<td>Temporary Visa</td>
<td>Brazilian</td>
<td>Transsexual</td>
<td>Escort</td>
</tr>
</tbody>
</table>
The above diagram provides important categories such as foreign national women working in prostitution, migration, family separation, indoor/street prostitution and addiction which emerged from the data. These categories led the researcher to theme particular subject matters which facilitated the emerging subthemes.

This purposive/snowball sample identified the population of women engaging in prostitution today around the country. The researcher originally set out to interview women engaged in prostitution in the west of Ireland. However, it became apparent that the women were moving around the country working also in other cities, towns and countryside throughout Ireland. This supports the literature which identifies a changing shift in prostitution in Ireland today (Immigrant Council of Ireland, 2009). The population is primarily made up of non-Irish citizens, working as **Escorts** indoors/apartments. The women mainly come to Ireland with children remaining with other family members back in their country of origin.

The women identified as street prostitutes had a history of family breakdown which, again, was consistent with the literature on family breakdown.

### 4.4 Reading one - the plot or main events of their stories

This section located the essence of ‘narrative’ or the main events of the stories. Each story told did not tell wholly of one event but rather a sequence of events which required an ecological interpretation and context. Recurrent images, events, metaphors and contradictions (Mauthner and Doucet, 1998, p. 126) were recorded.

*Stories show how human actors do things in the world and also reveal the way events and other actors act upon someone, shaping her possibilities, the way she views herself and her world, stories explore the complex motives that drive individuals to act in some ways rather than others and they also reveal the*
Chapter Four: Findings

*constraints of environment, of body, of social contexts that delimit a person's possibilities for action* (Mattingly and Lawlor, 2000, p.4-14).

Throughout the interview sessions with each of the women, it became clear that their stories had a beginning, middle and an end, so while they unfold in time, the order is more than mere sequence but revealed a ‘sense of the whole’ (Ricoeur, 1984). So in keeping with the ‘story telling process’, the sequence of events clearly unfolded to explore the participants individual and shared cultural paradigm of lived experiences of prostitution. These stories unfold ‘within’ the headings below. Reading one sets the scene for the other readings.

4.4.1 Before becoming involved in prostitution

Like all stories, we begin at the start and thus the transcripts introduce the reader to events which occurred before entering prostitution, the important key factors which shaped the events to follow. The participants identify financial indicators which existed in their lives prior to prostitution. This existed within the backdrop of current situations or situational which located the events. For this reason, the following headings under ‘before’ were necessary - financial and situational, which were then sub themed marking the landscape of family breakdown, poverty and migration.

Financial reasons for entering prostitution

All the women who partook in the study discussed their financial circumstances before entering prostitution and noted poor earnings in their country of origin, poor earnings here in Ireland and also the financial benefits of moving into prostitution. Financial concerns were dominant but this is clearly also a reflection of the participants situations or circumstances. Globalisation and the movement of women across borders and existing socio economic factors in their country of origin were key factors and will be highlighted throughout the findings and discussed in greater detail in the discussion chapter.

Situational reasons for entering prostitution

The researcher identified reasons for entering prostitution from the data and that the financial circumstances of the women were embedded in these situational reasons which are presented below.
Chapter Four: Findings

Family breakdown

The women frequently spoke of family breakdown or family displacement. There was no difference between street prostitution and indoor prostitution. However, family displacement was more apparent where women crossed borders to seek an income for their families back home. One story tells of how Fiona came to Ireland alone to access the asylum process here in Ireland.

...yeah, I went through the asylum seeker process... not yet, not yet (her application has not been processed yet), that is why I say, I'm working on it, but I have to pay my rent, I have to pay my bills, I have to take care of myself, I've no receiving social (welfare payment). It is kind of difficult, if I don’t work, what should I do? I have no documents so I work (In prostitution) always... Yeah, 19 euro in a week (laughs), 19 euro in a week, you don’t pay rent, nothing, but you don’t have???(Word unclear) you have to make your way for yourself, you know, (Fiona)

She spoke with such sadness of leaving her family behind and the deep pain of missing her mother every day. She spoke about how lonely she is here in Ireland with no one to care for her and support her. Although she has a boyfriend who has refugee status he does not work and the money she gets in prostitution supports both of them financially.

You know some people they have family, they have friends, they have brothers who can take care of themselves (you), I don’t have nobody.

Family breakdown, where the women found it necessary to leave the home because of conflict or abuse existed for younger women. Although all the participants were over 18 years at the time of the interview, some women stated that they had left home prior to turning 18 and had engaged in juvenile prostitution. Not all the women termed it as this but rather spoke of family breakdown at a young age. This cohort had experienced the care system and homeless services.

...and then one day I said; I’ve no money, oh my God, and I’ve no one to help me, Oh my God, what will I do? So I literally saw this number like that was literally stuck to a lamppost, you know so I rang it and he said; come on down to the social welfare place, and I said; I’ve no money, I’ve nowhere to stay? So I never even knew what the dole was at this stage and he said; are you homeless? And I said
(defiantly), I’m not homeless, and he said; your homeless, and I was like, oh my God I am, Yeah I am homeless, so he sent me to an emergency hostel. Then I met a girl, and I was told not to hang around with her, we went shopping, we went robbing, (Mary)

Not all women left home for the same reasons as one story tells: Niamh is a transsexual working in prostitution as an escort for straight men. She has had surgery to support these changes however she has kept her genitals, and has no immediate desire to engage in further reconstruction surgery. In Brazil, life was difficult both within her community and within her home. Transsexual people in Brazil are the country's single most marginalized group (GLBTQ, 2006).

...yes, I want to be like woman, a want to, I am a lady but this is not good in Brazil to be a boy and to want to do the changes to be the girl. It is very difficult, you always are getting abuse both by shouting names at you or they want to beat you. But it is ok for me, it is what I want so I need to get the money for this, so I begin prostitution in Brazil but it is hard there, you get very little money for this and lots of times beaten?(Niamh)

Fear, ignorance, and hypocrisy lead to discrimination and lack of education on the subject of transsexual and transgender people, which in turn render transgender/sexual people subject to violence, social exclusion, drug abuse, crime, prostitution, exploitation, and severe health risks, each of which results in further discrimination (GLBTQ, 2006).

Irish Nationals

Women in the study were Irish nationals also. They were involved in indoor prostitution and in street prostitution. The women who worked indoors held third level qualifications, and stated they made a conscious choice to become involved in prostitution. They owned their own properties and were more likely to maintain a secure client base where they were familiar with their clients and their sexual expectations.

Well I did have another option, I had a degree and I had a Masters and I did have another option, but I just didn’t do it...
Foreign Nationals

The majority of the women in the study were foreign nationals. The breakdown was as follows:

1. Undocumented: here in the country illegally
2. Touring escorts: spends time in Ireland but resides in another country
3. On student visas: International study visas for the purpose of studying in Ireland
4. EU citizens: Members of the European Union
5. Asylum seekers: Living within the asylum process in direct provision accommodation
6. Holiday visa: can travel into the country on a holiday visa permit (Example: Brazil)

Regardless of the individual reasons for the women to be in Ireland, the shared themes were poverty and socio economic limitations within their own country of origin. Each woman saw Ireland as an opportunity to work and create better opportunities.

*Well my sister had a friend, yes who had a friend and she heard from another friend that things (prostitution) are better here in Ireland because she was working like in prostitution in Spain and she said she would like to come here, so she did. And my sister and me we talk and between us and we said `ok let's go and try` and my sister with her friend came here and they stayed like 4 days and after they call me too and I stayed 2 days the first time, that was 2 years ago. (Cathy)*

Women said they decided to come to Ireland to get employment as they believed a thriving economy would secure them work.

*No because it is speaking English, and it is a small country, it is small and I think it is better, I think not a lot of people will come to Ireland*

Not all the women anticipated engaging in prostitution on arrival to Ireland. For example, they envisaged factory or cleaning work. The student visa participants did engage in study but could not maintain the cost of living alongside their student fees
Chapter Four: Findings

and the touring escorts who originally came from third world countries had either married a European citizen or sought asylum within that European country. The participants who had originally came to seek asylum found their conditions to be unsustainable within the Direct Provision scheme.

Locating foreign nationals within prostitution in Ireland has been an interesting and important finding and requires understanding global trends, migration, social and economic policies and infrastructures within their countries of origin and indeed Immigration laws and policies within Ireland itself. As this research is specifically exploring women involved in prostitution, it is necessary to locate these issues through a gendered lens. Often, men were absent from their stories, the women were the main care givers and often their children remained with other female caregivers such as grandmothers or sisters. Women are on the move globally now more than ever (Ehrenreich and Hochschild, 2004), as one participant tells:

Yes, but I don’t come here, I don’t thinking about prostitution. I start thinking about it when I live here and you don’t find work. My children need money, they live still in Brazil with their father, he is sick and he cannot work so I make money for my children. (Anna)

The headings which emerged support these issues as requiring further discussion and analyses which will be addressed in the next chapter. The particular headings: financial, choice, Irish and foreign nationals and family breakdown have provided evidence of the participants lives pre prostitution which has brought them to the place of entry into prostitution.

4.4.2 Entering prostitution

The women involved in prostitution discussed their entry into prostitution. Through their stories, particular themes emerged that where significant to their circumstances for entering prostitution. The headings were themed and further sub themed where more depth was required. The main themes emerged were choice, independent escorts and street prostitution.
Chapter Four: Findings

Choice

The researcher deemed it necessary to locate this term within the stories of the women themselves. In reading the manuscripts, it became clear that the terms `my choice`, or `I had no choice`, or the stories that didn’t include the word `choice` at all, were used. The researcher decided to identify the context in which it was used within the stories as a framework for locating the women’s experiences and use of the term. Although in the minority, some women stated that entering prostitution was an informed choice unlinked to financial necessity or limited options. Of this group the three women held a third level qualification and or were in full time third level education studying for a degree. For this reason, a direct link between choice and education became apparent. Therefore, the subtheme of choice was education.

*Well I did have another option, I had a degree and I had a Masters and I did have another option, but I just didn’t do it...* (Kate)

Kate’s entering into prostitution was different from other women’s experiences. Kate was introduced to prostitution by her boyfriend and she saw it as an opportunity to travel and maintain a good income.

*...em, well I had a sugar daddy, as they say, and so he was Indian and I travelled to India as well...*

It is important to note that the women who said they entered prostitution by `choice`, all work indoors as escorts. They have never worked on the streets and own their own homes and are Irish citizens. Another woman who was interviewed and from South Africa who stated `my choice` had put her son through University.

Independent Escorts

The heading independent escort became an obvious theme because most of the women worked as independent escorts. Independent escort is where the women work indoors and advertise their services via the internet on an escort site. The women claim to be acting independently without a third party. To understand what being an independent escort means for the women in the study, it was necessary to breakdown their stories into themes which best reflected their experiences. In reading through the data, themes and subthemes emerged before reaching saturation. Here their
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stories were located under three main headings: Introduced to prostitution by friends or peers, lap dancing and gentlemen’s clubs, and migration.

_introduced by friends or peers_

All the women said that they were introduced to prostitution by a friend or peer. The below examples provide a synopses of entering prostitution in this way.

_Well my sister had a friend, yes who had a friend and she heard from another friend that things (prostitution) are better here in Ireland because she was working like in prostitution in Spain and she said she would like to come here, so she did._ (Cathy)

The women shared a common theme, they all had a support network or in the case of the women involved in street prostitution they met peers who were experiencing homelessness who introduced them to clients and the industry, which either directly or indirectly led them to contacts already in the area of prostitution.

_Lap dancing and Gentlemen’s clubs_

Some of the women told how they first worked in lap dancing clubs or gentlemen’s clubs before entering prostitution. This is a relatively new phenomenon in Ireland. Women worked abroad in this industry in South Africa and Belgium, and also in Ireland. Their stories tell of poor working conditions, poor pay and the common link between working in lap dancing environments and the progression into prostitution. It is necessary to locate this as a theme because it provides evidence to support the link between the sex industry as a whole and prostitution. Further subthemes which emerged from this theme were advertising and websites and security (men that provide security to the women for a fee). These subheadings were decided upon because they were discussed by the women as the tools that introduced them into prostitution but also highlighting the multifaceted area of prostitution in Ireland.

_First I do lap dancing... yes because I didn’t want to do like ‘sex’, because for me it was; agh! Yes something that was very like hard and strange for me, I never thought about doing it in my life..._ (Jenny)

_Advertising and websites_

Independent escorts advertise on escort websites. In these cases the women who identified themselves as escorts had advertised at some point on the internet.
I don’t think every week you have 700 hundred women here? Like you will find on the website...

Cathy talks about the particular website she uses and how there are 700 women using it at any one time. To put their profiles up on a site, the women must provide a picture and a list of the acts they will perform and their contact details. These sites fall through the loop hole as 'Soliciting in a public place or running/advertising a brothel', (Sexual Offences) Act, 1993, as the Irish law does not include advertising as an 'escort’. The definition for escort is ambiguous; a person escorting another for protection or as a mark of rank (Oxford dictionary), and this is not addressed under Irish law in relation to prostitution. The women pay a weekly fee of around 100 euro depending on the site.

No not really, sometimes they call; they see the site (Independent escort.ie). Not the same men, different men. I work 'independent’. I advertise on site for 100 euro per week. I pay them (escort.ie) and they keep my details so men see, they like, they call me. (Anna)

yeah, so, and then one time I said, I said to my friend, I’m going to call that girl, and then I called her, and she explained to me about the website, and everything, and then I just went to the place, yeah, I put my stuff up for, I called one girl from the website for renting the room, and then I started. It was very strange. (Jenny)

Security is a prominent feature for new women entering into prostitution. Security are provided by particular men who make themselves available to the women and offer them security and protection against theft or abuse from clients for a fee.

No its not, it is completely different. Security for us was a guy who I paid for a week and they paid for the rent and everything, but he was there only to look after me (stresses this point), not to get money from me or anything. I would pay him, but only, you know, because he needed to get a job as well. I had a man there to look after me, but he never needed to inter, intervene, yeah. He never needed, because I never told anybody that he was there, just in case, you know, someone would break into the apartment, you know. (Gene)

These men do not consider themselves as pimps but rather a support option for a fee. This particular cohort in turn may also organise clients for the women and
apartments for them to rent, again, for a fee. The women themselves see these men as providing a service unrelated to that of a pimp.

Migration

A large number of the women have migrated to Ireland from their countries of origin. Their reasons for migrating vary; education, work, seeking asylum and all of these factors require the participant to actively leave their families and culture to live in Ireland. The root of their decision is the situation in their country; poverty, lack of opportunities, conflict or poor infrastructure, such as adequate social and public policies and, indeed, health policies and practices, alongside weak gender ideology. We cannot disregard the global context of women’s lives when looking at prostitution here in Ireland in order to provide a more holistic, ecological understanding of the determinants of their psychosocial experiences and their overall health needs. Thus, migration remains a theme throughout the findings. The two main themes which emerged from exploring migration were financial reasons (further sub themed to capture poverty), and education in Ireland. One woman tells of the economic downturn globally; as the economic climate has changed dramatically in Spain and her parents are unemployed, they cannot afford healthcare for her mother who has been diagnosed with cancer.

But me, I had a problem with my mom, she had the surgery, because it is expensive and my dad lost his job, like many of us and to work in my country (Spain) is to work for 600 euro’s a month and pay, and my school during this time and helping my family, that was too hard... (Cathy)

It is clear from this story that financial necessity motivated her path to enter prostitution, driven by the financial crisis in Spain. This and other stories tell of similar patterns.

The women also discussed education as a primary reason for coming to Ireland. It is important to note that some women are on study visas which demand high fees. One woman from Brazil tells how she could not meet the expense of her college alongside meeting deadlines and classes as she entered prostitution to pay for her study visa and college expenses.
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Well I first came to Ireland to study, so I was here for about (pauses to think and calculate) 9 months before I started in this job and I had a work in a pub and the pub closed down. (Gene)

At the time of interview, only a few of the women had remained in education here in Ireland. The sole remaining student did not envisage completing her course. They found the demands of prostitution interfered with their studies. Also, they stated that the demands of meeting the high costs of student visas and course costs to be unachievable.

...so em, if I can continue to make the money and fund the studies, em, and if they’ll allow me to stay the due course of the studies em...they, they, they keep on changing the student laws, so you know, it’s kind of difficult, it’s really unfair on me, you know I whinge about it all the time, I just had the misfortune to be born in the wrong place and now I’m denied so many opportunities. (Helen)

Street prostitution

Entry into street prostitution appeared to show different dynamics than apartment or indoors prostitution. Women on the street led chaotic lifestyles and were more difficult to access for interview. Nevertheless, the women who were interviewed certainly gave an insight into life on the street as a prostitute and their entry into prostitution. The outstanding issues were: drug use, family breakdown, grooming and homelessness. The women interviewed entered prostitution either to pay for a drug addiction where one woman openly discussed a habit of 500-900 euro per day cocaine addiction. Whereas other women became homeless due to family breakdown, accessing emergency hostels and were groomed on the street by other women. They also provided secondary information when they spoke of other women working in the street sharing similar backgrounds to them.

...from home, after a fall out with my family, and I moved in January, would it have been 2005, 2006, anyway I was 17, and turned 18 in May and I hadn’t a great job... I ended up living in a hostel, yeah...

The findings for entering prostitution created a picture of the women’s lives as they tell of their experiences of penetrating the world of prostitution. Core themes which emerged were stories surrounding indoor prostitution and migration, and also street
prostitution and experiences of addiction and homelessness. There is a clear divide between street and indoors in terms of the women’s life events which have brought them here. This divide is indoor-foreign nationals (Migration) vs. Street-Irish nationals of addiction and homelessness.

4.4.3 within prostitution

As outlined earlier, each story told of a beginning, middle and an end. The previous section provided the findings on ‘entering’ prostitution and the ‘before’ entering prostitution. These events do not exist in isolation but rather outline a series of events which are intrinsically linked. The core findings however, focused on the psychosocial experiences of women engaging in prostitution. For this reason, this section required depth and detail and focus on the events within prostitution.

The nature of prostitution

Prostitution in Ireland exists within the parameters of indoor and street. The industry is intrinsically linked to the global market, and is not exclusive in its behaviours to other countries which shared similar legislation and culture. The next section outlines this industry to show the nature of prostitution in Ireland is today.

Indoor prostitution

Indoor prostitution occurs in apartments which are mostly rented on short term leases by the women. Some of the women owned their own apartments or rented them on a long term basis and sub-let to other women who needed space for their clients. The women themselves were not always in control of their environment, as there are particular male individuals who take on the role of organising apartments for the women for a fee. Women who are new to the country, have language barriers or are unfamiliar with the landscape of prostitution tend to avail of this support. There is also evidence to suggest that criminal gangs are involved in housing women in apartments and moving/rotating them throughout the country at various intervals.

coughs (sorry), yes, the cold weather and you have to get your luggage and go in a new place, I heard that there are many girls who were (going to) renting an apartment from persons, they were given a key and when they go there to the apartment the keys not good (works in the lock), they just take the money, give a normal key and that’s it... Yes, they don’t give their real name or anything, they say
'oh, I will call you’, or, ‘I have an apartment that you want, do you want?’, You say, ‘yes I want’, then you go meet the guy, you give him the money, 350 (euro) per week, and he gives you a key and he says that, ‘oh the apartment is there’, you go there with the luggage, you wake up and your nowhere because (pauses, angry, upset)... well (pause), they (women) go to other cities, were they find a place, if not, I don’t know, (agitated now, pauses), It is hard. It is very hard this life. (Cathy)

Cathy travels to Ireland during holiday times from college where she attends in Spain. She originally travelled here with her sister who has subsequently married an Irish man and lives in Ireland permanently. She does not know too many of the other women as she is not here for long periods, so she contacts particular people who can organise her apartment for her around the country, depending where her specific client base is located.

Kate talked about her experiences indoors; she owned her own apartment which she sometimes worked from herself. As she also travels around the country, she sub-lets from other women involved in prostitution or would organise short term leases in different counties. She informed the researcher of how you can simply rent a holiday apartment for a week or two, as advertised on websites which advertise rented accommodation.

...yeah you can look on (Names a well-known property website), in terms of holiday lettings and stuff...

The practical side of organising apartments for the purpose of prostitution also created situations of hidden dangers. Theft and abuse had occurred and women who talked about their experiences of apartments when discussing indoor prostitution expressed living in constant fear of theft and violence. This was addressed against the backdrop of client theft and violence and in terms of the ‘middle’ man who gained a fee or stole from the women. This includes acknowledging the existing legal framework (which creates the environment for women to work alone), forcing them to remain hidden and unprotected.

At the beginning of this research it was decided that the participant profile would only be of women engaging in prostitution outside of Dublin, in particular Galway and environ. This was based on the knowledge that Dublin alone had some
provisions for meeting the health needs of women involved in prostitution in Ireland. However, a significant finding emerged that most women engaging in prostitution, in particular indoor prostitution, were not based in any particular region. The women interviewed who worked indoors talked about being in constant movement around the country. Thus, the nature of prostitution has shifted to indoor activity and exists in every pocket of the country. This is an important finding when considering access to health.

*Only em, like a, em, a week in here, a week there, so it is always travelling, I never stop...* (Anna)

...I’m going to stay here until Sunday morning (today is Thursday). Then I’m going to Kildare. I’m going to stay there for another week and then I have to look for another place to go. So, that’s the way... I might then go to Galway, I want to go back to Galway, and I love Galway. (Bridget)

Fiona talked about the situation of ‘call outs’, this is where she visits the client in a hotel room or at the clients own place of residence.

...yes, call outs, like if I’m in Dublin or in Cork I can go to the clients house, but if I’m in other places I can’t do this, I wouldn’t take the risk I don’t do call outs in smaller places, so (long pause), I think, I never experienced anything bad, but I heard some girls, but I never experienced anything to happen to me...

Moving around the country the women meet their clients. This option of constant mobility makes it difficult to track the women, identify them and, therefore, their existence is subsequently hidden. This, in turn, impacted on their protection and access to services. It did, however, fit into the prostitution ideology of a community with limited rights as they are more difficult to locate.

*Street prostitution culture*

The make-up of street prostitution remained predominantly Irish women of addiction or family breakdown (As presented in the findings above). Of the women interviewed, two fell into these brackets. Although the women may be more visible than the indoor women, they were still likely to experience rape, theft, violence and poor pay according to the women’s stories. As Emma tells:
Chapter Four: Findings

No, God no, if you are a prostitute, you’re, you’re the, you’re the scum of the earth, nobody wants to do, nobody wants anything to do with you, nobody would help you they would rather see you suffer. They are exposed in the street. But you get the guys that likes, that does that for, and that does that for the thrill of it…

Support from the other women on the street appeared compromised by competition and haphazard lifestyles. Women on the streets were less likely to access healthcare for addiction, rape etc. which put this cohort at risk and vulnerable. As Emma adds:

So if you get the Irish women on drugs; they may fall out of the housing system and then they become targets?

Emma, in particular, spoke of addiction and abuse whereas Mary, who also worked on the street, focused more on the issues of homelessness and family breakdown. However, she did report the high rates of women in street prostitution living with addiction.

... What I would worry about is like getting stabbed or getting hurt, what I hear is that girls are getting stabbed, they are robbing people and then they come back the next night and get them or something, but then, drug wise, one girl showed me her abscess up here (Points to her neck) one night, like burst or something; oh look at, I injected coke into me last night or some weeks ago and look what’s happened now...

Health

The purpose of the thesis is to locate the psychosocial experiences of women involved in prostitution. From the findings the researcher has located the determinants of health which impact on the women’s lives. The two categories that emerged were: physical health and psychological health and although one may impact on the other, for the purpose of the findings it was necessary to address them separately to allow for a more in depth report. The stories bring these issues to the fore as they impact on the overall psychosocial experiences of the women involved in prostitution and the Irish healthcare service.

Physical health

The practical impacts on the women’s physical health are presented. These emerged as the stories tell of the physical day to day aspects of engaging in prostitution.
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Cathy shared her story of her general wellbeing while involved in prostitution.

*I was working 6 nights a week, it’s weird like health wise, I was working 6 nights a week, I had a urinary tract infection, things, I would be eating, toasties morning through night, that’s all I ate, I hadn’t time for, I was sleeping early, sleeping, going to bed late. Waking up at 9 early, looking after her baby while she slept. I was really like a little maid or something so, and I, I was going to ‘A & E’, saying listen I’ve got urinary tract infections*

The women also talked about the impact of moving around the country. These women did not have any fixed address, but rather constantly moved around to facilitate clients. Again, this is the nature of indoor prostitution in Ireland today. The women talked of how moving around impacts on their general wellbeing explained here by Cathy:

*Only em, like a, em, a week in here, a week there, so it is always travelling, I never stop. Sometimes I stay here in Dublin and for one or two weeks, just to rest, because it is very hard to travel around with this weather...*

Although some women enjoyed travelling around as they felt safer and less identifiable this way, or indeed taking in the sites the country has to offer, women talked about their physical safety. This included the street women that participated in the study. The women, in general, spoke of actual experiences and/or the fear of something happening which would impose on their physical safety. Niamh, who is a transsexual, talked about masculine stereotypes and constant beatings back in Brazil. She found it safer in Ireland, as the male clients she met with wished to be discreet and anonymous about meeting with her and so she felt her physical safety was better here.

*...yes and also by just the people around this; anyway I hear from a friend, go to Ireland or Europe, you will get better money, I like Ireland, they don’t beat you too much here.*

Although she did add that she ‘keeps herself to herself’ as she feared violence from the male public in general.
Psychological health

The psychological determinants of health are multifaceted and complex. Rather than refer to the literature alone to understand this, the women’s own experiences clarified their particular needs or issues from engaging in prostitution. The main themes which emerged from the data were fear, financial and emotional responsibilities and misconceptions.

Sometimes I feel bad. I have a problem, like everything that happens to me, I keep here with me (upset and gestures to her heart, chest), so sometimes I want to like, blow up and scream some words (laughs to indicate use of not so nice or appropriate words) `why do you get with me`? (Bridget)

And

Yes it is kind of a problem, because sometimes people look at you with different eyes and you are imagining things, maybe you are hallucinating and it’s just in your mind but with this work it is very stressing and we don’t know what to think and you are scared... (Pause), you are scared all the time. (Cathy)

These key themes impacted on the women’s psychological health and wellbeing.

Fear

All the data indicated conversations relating specifically to fear. Fear was discussed in relation to fear of abuse, fear of the demands from clients and fear of violence.

Most women interviewed told stories of abuse, either situations which directly happened to them or to someone they knew. There was always the anticipation of something bad occurring or could occur which instilled fear in the women. As Cathy explains:

... I feel like I live on Mars (laughs) Yes really, everybody, like seems like aliens and they want to hurt me and I want to kill them...yes,

Throughout the stories, there were often strong references to theft by clients or men posing as clients. Most of the women make specific references to robberies in their interviews.
… Because I have experienced it, the boy, he come into my apartment and he say ‘give me 3000 euro or I kill, I kill your friend’ he take the computer from my friend and my 2 phones (Irene).

Theft of property of the women, or where the women have sex with the client and he refuses to pay was discussed by Lynne:

yes of course, I told you someone I stayed with, he took back the money, you know in that case, if they tell you they want the money back and you don’t give the money back, then there is a problem, for you to say; give him the money, let him go, let him go...

Women involved in prostitution meet with clients who are usually men they do not know. In meeting with the clients they are entering the client’s expectations, demands and fantasies.

Some would come up to you that actually want you to hurt them, you know, some guys, they take the mask off that they wear in the daytime, they take it off with you and they can actually be the one that they have inside, they can actually expose it to prostitutes, I dunno know, the closet that they get into, they can actually get out, with a prostitute. (Emma)

The women talked about the demands from clients that made them experience stress or anxiety. The issues raised were demands to perform sex without a condom, rape, intoxicated clients unable ‘to get an erection’ and became aggressive and demanding, and again clients who had sex without paying the women.

… Yes, to my apartment, sometimes, sometimes too, every time you fear that they will rape you. Like I say, there are three risks, the Gardai, sickness or someone that will just after they take back the money, or they beat you or, rape you... (Fiona)

In considering the psychological health needs of the women it was important to locate the client in the findings. Women who had regular clients often found the experience much better as they knew them and their backgrounds as Patricia explores:
...Yeah, yes, and I never felt threatened, I never had a bad experience, I had one I suppose, one customer got fixated with me...

Also within the findings it became clear that if the client requested the 'boyfriend experience', which was sexual intercourse without anal sex or particular fetish requests then usually the meeting would go off without any consequences. But in reality, the majority of the women interviewed moved around the country and their clients were unfamiliar to them. Women who talked about the sexual demands from clients spoke negatively about this.

Most women discussed violence from clients, boyfriends/pimps and those disguised as client but were thieves. This topic was spoken of in relation to the fear of violence and the actual events of violence occurring to them directly or to other women they knew. Violence is something the women appear to live with which had a direct impact on their psychological health. Women, who talked about violence, discussed this in relation to rape. This was a significant finding to include while looking at the psychological factors of the women involved. The reasons for failing to report incidents of rape were due to legal status in the country, language barriers, and fear of disclosing prostitution. Emma tells:

Where I’m from yeah, you’re a prostitute you can’t be raped. (Long pause) It doesn’t work that way. You’re a human being, you are a woman, and you can be raped. If you say no, it’s no, it’s rape then, if you say no and the guy does it, its rape

The repercussions of remaining silent impact on the psychological wellbeing as Fiona explains,

…they can’t say they are raped; they only say the condom got broke... Just to take care of their head, maybe they will drink some alcohol or take some tablets.

The findings confirm the link between rape and prostitution and its impact on the women involved in prostitution and their psychological health.

Users and clients of prostitution

Users of prostitution, as explained by the women included pimps, traffickers, boyfriends, drug dealers and clients, had a direct impact on the psychological wellbeing of the women involved in prostitution according to the women’s stories.
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The users of prostitution play a pivotal role in the women’s experiences and intruded on the focus of ‘choice’ for the women. Elements of control and power suggest that the discourse shifted for the women depending on these factors. Lynne tells the story of a violent sexual assault which occurred when her client became enraged when she did not act in accordance with his expectations,

…and I say, it’s not drugs, but look what the pills it is? And he gets out of control, he says; ah you take drugs, and beat me, and em...

This particular incident resulted in the sexual assault of a minor and Lynne still talks of the trauma and memories that this experience has had on her life.

All the women talked about these factors in their interviews. The women that advocated ‘choice’ in their involvement in prostitution and who also spoke of liking their work, discussed the issues of users and clients as a ‘risk’ but it became apparent in the data that particular groups of women were more at risk, women working without social networks and/or no secure status to remain in the country. Anna tells,

*No, I don’t tell anyone. My friends I came with do not do prostitution; I tell them nothing about what I do. Because of my status, I am not here legally, so to find work is very difficult*

However, even the women who felt less at risk were not adverse to the concept of needing to be guarded of the risks that were ‘out there’ within prostitution. Helen, who talked of how she enjoys her work, who is educated and owns her own home, also, was aware of the risks she faced,

*there is always that risk, you know, I mean people, yet, it’s a crazy world out there, wherever you are there is always that risk, that (Pauses), somebody could walk in there and put their hands around your throat, and if you’re alone, who is gonna know?*

This section ‘users and clients of prostitution’ will be presented further in reading two - reading for relationships, of the findings with respect to relationships which occur for women involved in prostitution.
Financial and emotional responsibilities

Why the women became involved in prostitution was outlined earlier in this chapter (Sections on before and entering prostitution). There was a strong link between prostitution and financial reasons and with this brought the emotional responsibilities of family. For this reason it became necessary to locate these financial and emotional responsibilities and how they impacted on the women while engaging in prostitution on their psychological health. All the women talked about the financial and emotional responsibilities while engaged in prostitution, thus this merited a heading and required exploration. As the data was collated, it became apparent that themes emerged; addiction, their children, their families and, sexual health prevention.

Within street prostitution the findings suggested a strong link between addiction and prostitution. Drugs payments were often subsidised by prostitution. This environment attracts dealers and/or pimps which reinforces and encourages addiction.

...It sort of starts off like that, he makes you, you to believe that he is your boyfriend, then the drugs, and he falls in love with you, more difficult, definitely, look you are, you are on the drugs because of this person, so once you are gone from the person, you are gone from the drugs, do you understand what I’m saying? (Emma)

Substance abuse and control alongside a chaotic lifestyle can impact on the women’s psychological health.

Of the women interviewed who had children, only some of them had their children living with them. The women who lived apart from their children these children remained in their countries of origin and were being brought up by a family relative (Grandparent or sibling). The women engaging in prostitution had a financial responsibility to send money home,

...yes my kids live there (in Brazil). I talk to them every day, every day and I miss them. They are 15 and 12, one boy and one girl. They are happy I send them money (Anna)

The impact of separation weighs heavily as Bridget tells of how she is separated from her seven year old son who is cared for by his grandmother,
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... Oh my god (laughs) it is very hard to be here, knowing him there, so, but I talk to him every night or every time I need to call. But it is certainly hard to be so far away from him... It was a little bit hard because I used to study and work and help my whole family. My mum is sick, and I got two, two, a sister and a brother. I'm the oldest one, so I always help my family, you know, so about everything, house, food, clothes, school for my young sisters, so everything comes from me, no, so.

The children learn to adapt and the separation and distance become the accepted norm for both the women and their children (Ehrenreich and Hochschild, 2004). Therefore, the findings linked financial and emotional responsibilities as having an impact on the women’s psychological health.

Women also talked about family and separation from their families while engaging in prostitution. Patricia, now in her fifties, talked about how prostitution made it difficult for her to have a family or indeed meet a partner or form a relationship.

... Sometimes I think, maybe I have sacrificed other parts of my life? Because the money was so good, em, i.e.; relationships, I don't have time for them anymore, and I don't particularly want one because, well, but I don't want to explain myself to anybody, and I am quite happy the way I am...

The other women in this group who were foreign nationals and where their families remained back in their country of origin expressed responsibilities towards their families and this is why they are currently engaged in prostitution. Orla told her story of how she sends money home to Ghana where her younger siblings can access education,

I'm the second one (child), so I have to take care of the rest of the family, starting with my parents and the rest and most of my brothers and sisters they are been in school, they are in colleges, and I think if I can give them a better education, they will not ever be like me...

This burden of financial and emotional responsibility further extends to secrecy, as often the women do not tell their families that they are prostitutes. The findings confirm that living a double life can lead to loneliness and isolation which greatly impacts on the psychological health of the participants.
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She thinks I work here doing cleaning and hairdressing, that’s, I, I took a course in Brazil of hairdressing, so she thinks I’m doing this here. (Pauses), em, maybe she knows what I’m doing but, she don’t say anything, she don’t tell me nothing. So I have to keep with lying all the time. (Bridget)

Sexual health prevention

From the findings it became clear that all the women had a strong knowledge of their sexual health. They were well informed and proactive in their care. However, it became apparent through their stories that their sexual health was compromised by three key factors; pressures from clients to have sex without condoms, pressures from clients to perform risky sexual acts and thirdly the conditions which they worked in could impact on their choices and control. These issues created stress for the women and constant anxiety around maintaining their sexual health, subsequently impacting on their psychological health.

Condom use

The women were often asked to perform without a condom. This put the women under great stress as they fear the client will leave. As Patricia explains:

...yeah and there is always the risk that you will go along with it because they leave if you don’t, you know, do a little bit more and a little bit more...

This means loss of earnings, as the client may become aggressive.

...now, we generally try not too but it is becoming very hard not to, the clients are getting, oh they are just getting horrible. I can’t think of a word for it? Oh, no, no, if you, they wouldn’t threaten, they would wear you down, for the want of a better word, they would wear you down, they are saying,

These excerpts were from Patricia’s story; Patricia was in her early fifties and had been working in Ireland as a prostitute for over 25 years. She felt a lot of pressure from her clients to do what they asked as she knew they would go to other prostitutes. Patricia also talked about how her age may affect her work. She talked about how her regular clients were dwindling due to the new phenomenon of sexual activities now available to men on the internet and her previous sexual services seemed no longer enough. She now practiced in a much riskier fashion than she had
in the past and found this a great stress. She added that she had never been screened for sexually transmitted diseases until recently as in the past she felt always in control. Patricia was concerned how the landscape of prostitution had changed over the years and had become much more sexualised as she explains,

*I suppose there is a reason (Long Pause), they (Clients) are wanting more and more and unsafe sex and... The customers want more and more unsafe sex, yeah they do and they are getting more and more adventurous, the clients are getting, oh they are just getting horrible. I can’t think of a word for it?*

The working conditions

The women worked out of apartments or from the street. The conditions they meet clients in were not always conducive to a safe environment for maintaining safe sexual practices. This became an added burden and stress for the women. Gene tells of how her working conditions put her at risk despite her knowledge of safe sex practices.

*... yeah, the skin was covering the head, and I didn’t want to push the skin because sometimes it hurts them, so I respect, if you, you know, I always respect what they, I try to see what they want, or they don’t want, so I just put the condom very carefully, with the skin covering and, then, we didn’t do oral, we just start normal sex and I was with him like that (describes how she was on top), then he took off from inside, and there was loads of blood and I said; look...*

This information tells of the sexual health risks the clients can bring to the women. Gene was in an apartment room with this particular client and fortunately she was able to assess and manage the situation. However, for other women, they talked about how the girls were putting in long hours and were tired and not always able to assess the situation correctly, putting themselves at risk of a sexually transmitted infection or an aggressive client. The rooms where the women meet their clients were not always well lit; this could have been for effect or simply poor conditions. Jenny talked about how important it was to practice safe sex. This is something she felt strongly about. She had a husband and a young baby and was not prepared to take any risks. However, she told how the room conditions can compromise this:

*but, it’s like it’s going ok, I didn’t have any trouble, but just last week I had 1, I had*
Chapter Four: Findings

I like when I was working, and the room was dark and like I had put the condom on, and then we started, and then he stopped for a second, and then he started again, then I stopped, and I looked, he had taken the condom off, yeah, so he paid for an hour, and I only stayed 20 minutes, but, I just, I didn’t care, you know, he was wrong, he shouldn’t have done this, then I came here, and did a blood test which I’m just going to get next week (HIV test).

Misconceptions
Throughout the interview process most women talked about the misconceptions of prostitution. For this reason it became apparent that this should become a theme. The women felt anger about how they were perceived by society, as Emma tells,

But everybody thinks it easy, the girls, em, they are vulnerable, they are not, and they’re not bad people. The rest of the people look down on them and say they are dirty, you know that...

The findings thus highlighted the misconceptions as important to the women and they were discussed with attention to discrimination, living in Ireland as a foreign national, loneliness and secrecy.

Discrimination
Most of the women interviewed felt they were discriminated against for being involved in prostitution. As Bridget so eloquently told:

...you heard sometimes people say ‘they have eh, an easy life, they only open their legs and get the money’. But it’s not like that you know, so, we got problems too but we don’t have anybody to talk about that.

The impact of being discriminated against or feeling discriminated against appeared to weigh heavily on the women and impacted on their psychological health.

Being a foreign national in Ireland
Over the last decade there has been a large increase of migrants coming into the country (Immigrant Council of Ireland, 2009). The main purpose of entry is to seek employment, to study or to seek asylum. For these reasons there are many types of visas which accommodate this happening. There is also, as discussed earlier, the
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process of seeking asylum and the stages that occur. As Fiona, seeking asylum reflects:

...yeah, 19 euro in a week (laughs), 19 euro in a week, you don’t pay rent, nothing, but you don’t have...

The findings suggest that living in Ireland as a foreign national is complex and each situation can be unlike the next. To break down misconceptions Helen sums up:

...because the whole point is, em, you can’t look at anything in an isolated situation, you have got to like get the whole picture, and you can see where the needs fit in...

How women access work or social welfare depends on their particular visa and status in the country. The findings suggest that there is a direct link between status and poverty and of course status and prostitution. This is a key finding within the data as a lot of women interviewed were foreign nationals.

Loneliness

The women talked about loneliness and how people did not understand how lonely they were. The women spoke about how they could not tell anyone what they did, as they were practicing prostitution illegally. Here is one quote from the Anna which supports this finding:

No I don’t have nobody, I don’t have friends. I arrive there; I meet some other girls....

Secrecy

For legal reasons the women talked about living a secret life where they could not discuss what they do (prostitution).

... Yes, she said 'please, please don’t tell the police I’m a prostitute here, no, no...' (Lynne)

They spoke about the negative impact that this had on them, creating feelings of shame, isolation and poor self-esteem. It is illegal to engage in prostitution in Ireland; more than one woman in a shared space constitutes a brothel under the Sexual Offences Act, 1993.
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This was the predominant reason why the women engaged in prostitution in secret. Secrecy is further supported by legal status to remain in the country. Their visas or application to seek asylum could be rendered invalid if they were caught engaging in prostitution.

The other factors were stigma and families and friends were unaware they were involved in prostitution, as Bridget explains:

*I love Ireland. Yes, I have friends but my friends don’t know what I do. This is difficult sometimes. Because sometimes they ask; ‘how are you?’ Or ‘where were you? ‘ ‘Come to our house’ or ‘can we come to your house?’ Because I stay in different places all the time, it is difficult*

*Support services*

The findings highlighted that service provisions are weak throughout the country. These findings were important as they were provided by the women themselves.

*Identified needs*

The women spoke about what they perceived their needs to be within the context of emotional support (For advocacy and healthcare professionals to listen to them) and the need for more services and support regarding their sexual health. Overall, the findings suggested a strong link for psychological and emotional supports for women actively engaged in prostitution. As Bridget tells:

*...Some women they, they like they say they strong they don’t need anybody to help them. But it is not true. Like the physical and the mental, em, the emotional it is very, very affected when you work like that. If you get more help from the most part. I think it is the good things that you can do for us, you know?*

The women talked about having ‘no voice’ and the need for healthcare practitioners to advocate on their behalf as Helen explained:

*...it’s because you know. I want you to know because you have the power to go out there and put it out there for us, on our behalf, you know and.. Yeah, we need advocates, we need advocates, all the time there is people like, like you know, against us, but, because of the misconception, because of that stereotypical thing...*
Chapter Four: Findings

Most of the women felt they needed to be listened to. They needed emotional support and for practitioners to listen to what it is really like for them within prostitution. Many of the women expressed concerns such as ‘Who can we talk to?’ This suggested a strong sense of isolation and psychological vulnerability as identified earlier.

_They don’t go anywhere; they would just be quiet and forget it... (Fiona)_

The women talked about the value of The Women’s Health Project (HSE), the venue where the interviews took place. The women as explained by Gene acknowledged the undoubted value of this service:

...yes, it’s good; it’s very, very good. But it’s like we have support and we have attention here. So I think it’s, if em, can open more things like that, I think it is going to be helping.... yeah, yeah, it would be very nice if you had more, more supports like that.

The women also provided strong findings which linked the need for support services in relation to their sexual health. It was clear from the findings on sexual health (under psychological health) that the women were well informed and proactive in their sexual healthcare but they felt this must be supported through services and service providers as access to screening for sexually transmitted infections and information on and using condoms for safe practices.

Service provisions

The interviews were held in the Women’s Health Project (HSE), Dublin. This service provided a drop-in clinic twice a week with access to trained contact staff and access to an on-site doctor. The service was free of charge and confidential. All the women spoke highly of the team and facilities available to them but despite this service, it became clear that there were many barriers still at large for women engaged in prostitution in terms of access to service provisions and healthcare. In the stories the women told of barriers in relation to fear of being identified, lack of information, and the difficulties of being on the move and not knowing where to access services? Such barriers contributed to negativity around their psychosocial experiences of engaging in prostitution.
The women did not want to be identified as a prostitute because of the law and their legal status in the country. For this reason, they refrained from accessing other services around the country not specific to prostitution. As Cathy recounts:

... they asked me why I was here (in Ireland) and I said I am here on holiday and that’s it... no, I tell them I’m a student or I’m on holidays

Cathy lied about her reasons for being here in Ireland and her experiences were in an acute setting. The doctors who attended to her accepted her answer and did not probe any further. As Irene also adds:

No, if they say `what are you doing here? ', I say I’m a tourist. I don’t say I’m a prostitute, yes, if I go to a private doctor, I don’t say I’m a prostitute!

The women also talk about lack of information in particular, the foreign national population. They were unfamiliar with how the Irish health care system worked and simply where to go? Cathy recounts how she was in Ireland for a whole year before she came to know of the WHP in Dublin.

I think not many escorts know about this thing, because if they knew, they would all come here. I don’t think every week you have 700 hundred women here? Like you will find on the website...

Although the interviewees could attend the WHP and other services such as Ruhama and the Immigrant Council of Ireland in Dublin, it was not always realistic for them to travel to access these services.

It is the nature of prostitution in Ireland for women involved to be mobile with their services concentrated in the capital. With Service emphasis on sexual health primarily, which emerged as a response to the concern for a HIV epidemic in the early 1990’s.

The law

As it stands in Ireland under the Criminal (Sexual Offences) Act 1993, women are not permitted to engage in prostitution unless alone and in the privacy of their own abode. Therefore, working on the street (soliciting), or working indoors in apartments with another woman (brothel), leaves no room for the current definitional
configuration of prostitution to remain inside the law. Therefore, all the women in
the study were breaking the law on a daily or weekly basis. For the women, the main
issues that arose were; their perceptions and experiences of the Gardai (as law
enforcers), being identified and how this could affect their application for ‘Leave to
remain’ (seeking asylum in Ireland or refugee status in Ireland) and, trafficking for
the purpose of sexual exploitation. Although no woman within this study disclosed
that she had been trafficked into prostitution, the women were aware of this
phenomenon and discussed their knowledge and information on the subject.

The women were reluctant to seek support from the Gardai in the event of theft or
rape as they did not want to be identified as a prostitute. As Gene notes:

... but I don’t think we would go to the police or, well to the police especially, if
something happens I don’t think so because I wouldn’t trust the police (pauses), I
think they are, you know (pauses), they would be prejudice yeah, they would have
authority; you know if you tell them something happened to you. I wouldn’t feel
comfortable...

The women talked about how clients know prostitution is illegal and they could
threaten the women with this which left the women feeling vulnerable. Fiona, like
other women, feared the Gardai:

I would say there is three types of risk; one is the Gardai...

This was the overall perception the women held towards the Gardai. However, the
women that had actual contact with the Gardai spoke positively of their experiences.
Helen became known to the Gardai as they were informed she was ‘entertaining’
men from her apartment:

... they were fine, they were very nice to me, they were very polite, we are not here to
put you out in the street, we are not here to take you out of your home, but em, you
know em, there have been complaints and if there are complaints again, we will have
to put you out..

Mary, a street worker, became known to the Gardai when she was soliciting in a
designated area familiar to prostitutes and clients. The Gardai often patrolled the
area to become familiar with the street workers.
I never gave them cheek, I never got arrested, never got in trouble, I only was only brought in to get my picture taken, and ID’d in case anything ever happened me, that was all, that’s ever... yeah, I have always found them to help me, well you know what I mean, I have never heard them say; oh, leave it, you know you’re just a little junkie, get away from me, you know there was never anything like that...

The Law was an outstanding issue in particular for the women who were in Ireland and under review of their visa applications (seeking asylum or awaiting refugee status). The conditions of their application required them to be law abiding and positive citizens within the community. Whether seeking application for asylum or awaiting refugee status approval, the issues of poverty and financial reasons for entering prostitution were primary considerations. This, alongside the law on prostitution, placed the interviewees in an extremely vulnerable position. Fiona, who was seeking asylum in Ireland and involved in prostitution for financial reasons, said she feared the law as she wanted to secure refugee status to avail of social welfare payments. She feared her application would be refused and deportation to become her only option:

... yeah, you know, when you, when you are not fully, like you don’t have letters like stamp four you know,? Yes, if you don’t have this, you know, maybe if you are Irish born, it is ok, you can also see, at least if the police come at least you have something to present (documents)... If you don’t have anything to present then it is risky. You know some people they have family, they have friends, they have brothers who can take care of themselves (you), I don’t have nobody...

This group of women remained underground and were less likely to seek protection under Irish law. Although this group were not trafficked for the purpose of sexual exploitation per se, it created a market whereby traffickers could execute control over a certain population of women more vulnerable to coming forward and seeking help. The women on the ground were aware of this. Gene shares her information:

... around the country, they are all over Ireland, and the police knows that, the police is going around every apartment trying to find these girls because they have no documents, I don’t think they are ... but they are in traffic, you know, human trafficked, so the police is trying to get them, and to get the pimps as well. It is going on now...
4.4.4 Aspirations for the future

An interesting finding within the data was how the women spoke about the future, hence the heading `Aspirations for the future`. The stories centred on their futures within prostitution and their futures post prostitution. Some women talked about the short term future and how they saw changes as observed by Irene:

*I think maybe, I think maybe in the future I will come to Ireland, for my regular, clients, customers for...*

Helen would like to stay long-term in Ireland and continue to work in prostitution but would like to see better legal provisions for this.

... *You know, if I was afforded the rights and the protection of any other profession, I would be happy to pay my taxes like anyone else, I would be happy for that. I don’t want to live off the state, I don’t want hand-outs, I just want to be allowed to live, and study, and contribute to society.*

Kate had a financial plan or goal outside of prostitution:

... *I’m em, probably quitting next year, as soon as I have 2 houses bought. I own an apartment in Dublin and then I want a holiday apartment, but that’s for next year hopefully, I’m optimistic.*

Interestingly, Kate was Irish and held a third level education or professional qualification. Kate reported she was currently happy engaging in prostitution and felt she had a certain level of control and choice in her life.

The women who had families and children living in separate countries from them also talked about a future without prostitution. Their legal status was primarily insecure and they perceived their time here in Ireland to be short term. Cathy used specific words to distinguish between her life in prostitution and her life after:

...*she (long pause, grasps her knees with her hands), she is worried of course, but she says, ‘do what you need to do’, faster and go out and get a normal life like she has now. It’s harder than a normal life, no stress, it’s better to be normal, have a normal life.*
Chapter Four: Findings

Emma, who had a drug addiction and worked on the streets, talked about leaving prostitution in the future. For her, this requires addressing her drug addiction and she sees leaving prostitution as an option only if the right supports are in place for her to do so:

yeah and I’ve been off the streets for a month and a week now because of the help I have got here, but in South Africa I never could have done it. It’s only a temporary, yeah. But they will get me next, we are planning on the housing, you know; all that. Earlier, yeah, earlier intervention of supports; it would be much easier for them to get out, yeah. Oh yeah, I do have a lot (support) and I’m grateful for that.

4.5 Reading two - reading for relationships

The researcher identified the ‘relationship’ experiences of the participants’ voices as required, using Voice centred Relational Analyses (VCR). Relationships with their families, partners and with others were explored. How these relationships both past and present influenced social support and resilience?

The findings identified significant persons in the women’s lives and their key influences. These relationships were discussed under three themes: children and family, connections through prostitution and relationships which occurred through supports (services). The three main themes were then examined and sub headings emerged. These relationships identified how the participants interacted with their micro and meso systems.

4.5.1 Children and family

The overriding themes were family breakdown and separation from children and family. Family breakdown was a strong theme among the stories of the women who were engaged in street prostitution. This supports the evidence that street prostitution emerges primarily from family breakdown, homelessness and experiences with the care system (Coy, 2008). As Emma identified:

... no, it is normally something else that triggers it, usually it would be either something happened to them in their, in their childhood or maybe it’s, me, what got me there was initially, there was a close family member, my brother died, and I just, I didn’t bother about life...
Chapter Four: Findings

This particular story told of the grief, and a family’s inability to recover from this loss of a family member and how to support each other. Emma felt she was closer to her brother than the other members in her family and she turned to drugs to numb the pain and hence entered prostitution to fund her habit.

Or Mary explains:

... From home, after a fall out with my family, and I moved in January, would it have been 2005, 2006, anyway I was 17... So I literally saw this number like that was literally stuck to a lamppost, you know so I rang it and he said; come on down to the social welfare place...

Mary continues about her family breakdown. Leaving home due to conflict with her father and became homeless. She accessed emergency accommodation for homeless women in Dublin and there she met a girl of 17 years already living in the care system and involved in prostitution who groomed Mary for street prostitution.

I’ve no money, I’ve nowhere to stay? So I never even knew what the dole was at this stage and he said; are you homeless? And I said (defiantly), I’m not homeless, and he said; your homeless and I was like, oh my God I am...

In relation to the findings ‘separated from family’, this occurred mostly for the women who were foreign nationals and who had entered the country to seek employment to send money back to their families in their country of origin. Family breakdown was not evident here, but rather families subject to migration and poverty and/or political conflict as Fiona from Nigeria tells:

... You know some people they have family, they have friends, they have brothers who can take care of themselves (you), I don’t have nobody... I can go home (To visit), I can come back, to go home to see my mom (becomes emotional)... yes (long pause), yes, I talk to her on the phone.

Fiona was very emotional when she spoke of missing her mother. Although she has made friends here and has met a boyfriend she does not see this as support like her real family she has left behind. Other women had not initially intended to work in prostitution but they found it difficult to find adequate employment and they had the responsibility of sending money home to their families so they decided on
prostitution. Their stories were harrowing as they spoke about being separated from their children, as Anna describes:

*My children need money, they live still in Brazil with their father, he is sick and he cannot work so I make money for my children... Yes my kids live there (in Brazil). I talk to them every day, every day and I miss them.*

Bridget further emotionally explains:

*...yes (said with assurance) I love my family, that is all for me. Right now I’ve got a son too, so my son is with my mum (participant is emotional reflecting on her son) oh my god (laughs) it is very hard to be here knowing him there, so, but I talk to him every night or every time I need to call. But it is certainly hard to be so far away from him...*

All the women who talked about separation from their children and families were emotional during this part of their story telling. The constant dilemma of remaining in prostitution at the expense of missing their children growing up weighed heavily on the women. It is the culture of countries of poverty for mothers to leave home and go to another country to work and for these women it is common amongst their peers. The findings confirm the link between poverty, migration and prostitution.

4.5.2 Connections through prostitution

Relationships also occurred for the women through their work in prostitution. These relationships were spoken of in respect to their connections with pimps and organisers of prostitution and also with other women involved in prostitution.

Other women involved in prostitution

The women found themselves developing relationships with other women involved in prostitution. This was inevitable considering the dynamics of the industry. The findings provided evidence to support the relationship between the women as a link to entering prostitution, for example, due to similar or shared circumstances, they were introduced into prostitution. As Mary explained; when she found herself homeless she met other girls within the homeless community and became involved through the relationships she formed with other women involved in prostitution.
Chapter Four: Findings

... `No she goes, we will ask him for business, here I will do the talking, and I was like alright well he mightn give you a free taxi but he might, you know and he said, alright girls come back to my apartment and I was like, 'Oh My God, what's this'?"

Mary was Irish and was accessing homeless services, however for other women (foreign nationals), like any community that exists in another country, this community finds itself through geographic location, events etc. Such women formed relationships with other women and information was shared and they supported each other. For example, Gene tells the story of how her Brazilian community here in Ireland introduced her to prostitution after she had lost her job. Her peers explained the prostitution landscape to her and how to become involved and also gave her information on the Brazilian men she could hire for security.

... We met a girl, she was a cleaner and she used to clean apartments for girls, for Brazilian girls, and I said, look, why didn’t they clean themselves? Ah, she said because they make a lots of money, so. And then we started asking, and she said, ah the girls make lots of money per hour, so, and they pay me just like 10 euro; and, I said, what do they do? And then she told us, and we said, ah, ok, we have to find, and then we just look at each and say, well what are we going to do now? And, em, first we look for a guy, a Brazilian boy, he would, he used to be kind of security...

Herself and her friend, together, became involved in indoor prostitution and travelled together and shared rented apartments/accommodation to meet clients.

The women on the street describe how they looked out for each other as a survival mechanism. They knew what women were out there and they knew their patterns of movement. However, there is little discussion on relationships or friendships within street prostitution (most likely because the issues which were presented in the findings centred on addiction mostly). As a consequence of this, friendships appeared to be inhibited as obtaining drugs was their immediate priority. For the foreign national community, the women spent a lot of time travelling around the country and accessing apartments to work from. For this reason, accompanying friendships were formed.

... Yes exactly, yes we share (apartments) and sometimes they say to me, `do you want to go to Clare, or somewhere? (Orla)"
Chapter Four: Findings

These were positive findings as these relationships provided a social network which could indicate and support resilience. While working from apartments, the women spoke of feeling safer with another woman in the room next door. Helen explained:

... Yes, because when you rent an apartment there are two rooms, one for you and one for another girl.

But this is of course was compromised by the law.

...em, sometimes I tour with a friend, you know, I’ve got a few girls that I work with that I have become friendly with, and em, so usually I tour with a friend, em, unfortunately it is against the law for two ladies to work together, which I think is like really unfair because it does put us at a risk

Other important findings reflected heavily on legalities around prostitution. The women also spoke of their difficulties in trusting other women and how they were sceptical of forming relationships with their peers. For the women, their dominant concerns related to safety and in order to protect themselves they would choose to be guarded around forming relationships with the other women. Gene highlighted this within her story as important to her:

..I prefer to be, you know, I know how I work, and I know, I feel safe the way I do, and some girls work in a way I don’t feel so safe, being with them, you know?

Such findings suggested isolation within the field. Kate chose to have no relationships with other women in prostitution as she preferred the discretion of always working alone.

... I kind of keep to myself, I don’t know any of the other girls, so, yep, I know some girls here and there but I try to keep to myself... so, em, girls can be bitchy huh?

For others who practiced particular prostitution, such as transsexual prostitution as Niamh did, she felt very strongly about remaining unidentified as her experiences in the past suggested violence and abuse from others when her identity had been disclosed.

Maybe for others doing prostitution they can have friends, I don’t do this...
Chapter Four: Findings

Furthermore, the women worked within a minority group, a sub sect of prostitution which further excludes them from relationships with the other women. As Niamh continued:

... *Maybe for others doing prostitution they can have friends, I don’t do this. Anyway, I do it for money for the operation, I will do this until I finish, maybe, I don’t know?*

Users of prostitution (clients, pimps, organisers)

The relationships with clients and, in particular, the organisers of prostitution were often destructive and abusive according to the women. The cohorts of men that typically surround themselves among the women were there to organise apartments for them to rent to meet with their clients and to provide security for the women while meeting their clients. The women’s stories provided insight into how the users of prostitutions’ involvement with the women shaped the current nature of prostitution in Ireland today. The topics which the women talked about centred on abuses, alcohol misuse, unwelcome sexual demands and theft and underground organisation of their activities. The primary headings subsequently emphasised physical, sexual and verbal abuses. Theft is addressed in this section also, under the heading abuses as often this was the underlying concern which was central to the other abuses, in particular theft by clients. All the women talked about anticipated abuses also.

*...somebody could walk in there and put their hands around your throat, and if you’re alone, who is gonna know? (Helen)*

This particular quote is important because the women talked about the psychosocial implications of engaging in prostitution. This went hand in hand with life in prostitution. Other women talked about specific incidents that had occurred to them and it was clear that their body language and verbal accounts reignited anxiety and stress.

Sexual violence was also discussed and fell into three categories: fear of sexual violence, actual sexual violence, and after having sex with a woman, refusing to/or taking back payment. Again, the women discussed sexual violence predominantly in relation to their clients and the findings suggested that the fear of sexual violence is
very real and impacted on their day to day interactions with clients. Orla tells of her fears:

... cause now I’m, your health is at risk from the health and safety aspect, you know, because you are at the risk of anyone walking through the door and doing anything to you, you know, you could get raped, em, by a guy who rips off the condom, rips off the condom and rapes you, throws you over the bed and rapes you. He could have HIV, he could have hepatitis, and he could have any other sexually transmitted disease...

Lynne shared her harrowing experience of abuse as one particular client accused her of using drugs while meeting with him; he physically and sexually assaulted her and refused to pay. This experience occurred when she was a minor. Although she is now no longer a minor, this traumatic experience has stayed with her.

...yes, you know, and em, he was drunk and em, I had a problem with my teeth, and I was taking pills, and he thinks I’m taking drugs, and I say, it’s not drugs, but look what the pills it is? And he gets out of control, he say; ah you take drugs, and beat me, and em... yes and em, makes sex with me, anal, and me I don’t want this, I don’t do this never, thank God...

The reality of having sex with a client and not being paid brought up a lot of emotion for the women. Although they had consented to sex, they felt used and abused when the client refused to pay as Fiona explained:

... yes of course, I told you someone I stayed with, he took back the money, you know in that case, if they tell you they want the money back and you don’t give the money back, then there is a problem, for you to say; give him (The client) the money, let him go, let him go...

The power here remained with the client as the women were disempowered on several fronts.

Verbal abuse was also common within the stories which indicated disrespect towards the women from their clients.

...when they shout, I don’t listen (laughs), I don’t listen to something they tell me, I switch off (Anna)
The women found this difficult to cope with and verbal abuse could extend to when they were identified by clients in a different setting. Bridget talked about meeting her clients accidently in a social setting such as a pub near where she was living:

*They say, that everywhere we go, `she is a bitch, she is a hooker, and she is a ....and we feel very, very bad*

The verbal abuse often extended to threats such as threats that the clients would report them or steal from them. Helen tells:

*... And, em, then he was calling her and threatening her to em, to expose her.*

There were incidences where interviewees had their (personal) mobile phone stolen from them, and threatened that if she did not give him a particular sum of money, he would phone her personal numbers to family and friends and expose her for engaging in prostitution. A lot of the women in these circumstances simply handed over money to avoid this happening. In this regard, verbal abuse weighed heavily on the women and often disempowered them into submission as Irene shared in her story:

*Because I have experienced it, the boy, he come into my apartment and he say 'give me 3000 euro or I kill, I kill your friend'*. 

Such abuse could present itself as written abuse also. For example, if a woman was advertising herself on an escort website, the client could go onto this site and as a customer could rate the woman in terms of the service she provided. Despite being psychologically damaging for the women, it was also misused by clients to do harm according to the women. Cathy tells where she was beaten up by a client, who later went onto the website and wrote a damaging review of her stating that she was not as her picture had described and that she provided a terrible service:

*... like the review things, like, if a person who sees you with a bad guy can have friends who put you a bad review and destroy all your work, so...*

In this situation Cathy had not actually received the client herself but rather another woman in the apartment. She had tried to protect the other woman as the client had become aggressive and as a consequence, she herself became the target of the client’s abuse.
Chapter Four: Findings

When talking about particular types of abuse the women told of alcohol fuelled violence from clients who met with them while drunk. This was a general concern for the women and they found that the men were difficult to manage and could be volatile. Gene explains:

... it’s like 3 o’clock in the morning; this guys had a few drinks, what happens if his erection, if he’s not getting an erection or his erection, he’s not going to manage to have his orgasm, it’s going to create a situation...

Gene continues:

They forget how to treat the woman.

Most of the women said they preferred to work during the day as they felt clients were less likely to have alcohol taken. The ‘night time’ men were more likely to be drunk and aggressive which also led to sexual demands and expectations being greater and were more likely to seek risk taking behaviour according to Anna:

...Sometimes they say; ‘no condom, I pay you 1000 euro’ but I never, never, always condom for sex, oral and anal sex too...

If the women did not want to perform certain acts the client, who was drunk, could become abusive. The women talked about a culture in Ireland of alcohol misuse amongst clients and wanting to have sex without a condom. This combination created stress for the women and puts them in unsafe situations both physically and mentally.

Theft by clients of personal belongings was not uncommon as Emma tells:

... usually guys will come up to you, they wouldn’t even, they wouldn’t even, they wouldn’t have the idea of paying you, they wouldn’t even have a penny in their pocket.

This theft extended to the men that were involved in organising the apartments for the indoor women to pimps, dealers and criminal gangs as Gene outlined:

... I know a place for sure, it is like this; a girl is a pimp and a boy is a pimp in the same town, they have 2 apartments, ok, they put, she puts her girls in there and he
puts his girls in there. But then she knows that he has girls, and so she tells her boys to go there; beat them and take their money, and the phones from these girls...

In this situation two rival apartments run by pimps or organised gangs competed with each other and organised robberies to occur within the apartments to create fear and control. Such circumstances of abuse inevitably impacted on the women’s wellbeing and safety.

The underground activity of prostitution and organised gangs was something the women on the street and indoors were wholly aware of. As already mentioned above; the organised aspect of prostitution centred on apartment organisers, drug dealers and pimps. In this environment the women were not acting alone or independent but rather without choice and/or in control of their service. Gene was very interested in trafficking as part of her story:

...around the country, they are all over Ireland, and the police knows that, the police is going around every apartment trying to find these girls because they have no documents, I don't think they are ... but they are in traffic, you know, human trafficked, so the police is trying to get them, and to get the pimps as well. It is going on now...

Support services

In the above section ‘within prostitution’ under reading one, the findings for support services were presented. It is not necessary to present these findings again. However, they were significant in relation to reading for relationships as the women had come into contact with The Women’s Health Project and they did talk about their relationships with service providers. Therefore, it was important to acknowledge this here under the heading ‘reading for relationships’.

Yes, I, I feel like the first time I met with here, with Kathryn (project worker), we talked a little bit about that. So I feel good, you know, it’s like you can put everything out so, since like the first time I met her, but (pauses), how can I say? A person you can trust, that is very good, yeah, very good... (Bridget)
Chapter Four: Findings

The Law as a barrier to developing relationships with services

The women identified the law as infringing on their access to services and forming relationships with service providers as Helen clarifies:

*I would say we are probably we are more at risk because of the law as it stands for the moment*

They felt that because they could be criminalised they would not engage with health care practitioners with regard to their involvement in prostitution or indeed seek out relationships from service providers.

...yeah, but I don’t think we would go to the police or, well to the police especially, if something happens...I don’t think so because I wouldn’t trust the police (pauses), I think they are, you know (pauses), they would be prejudice (Gene)

This was further enforced by the foreign national participants who felt they existed within a vacuum of double legal problems as Jenny explains:

...and for these girls that are here like; 6 months or only a year, or a few months, they don’t go to school, they have no English, nothing and some other girls would not helping, not help them, so it is very hard to get to see the doctors

For example, they felt that their legal status with respect to asylum seekers, migrants’ visas stipulations and indeed undocumented populations hindered their ability to form relationships with health care professionals or support services.

Limited Services outside of the capital

Many of the women moved around the country from city to city, town to town yet the women could not access support outside of Dublin as Bridget explores:

...There should be one in the bigger cities, cause in Dublin it is just too far maybe from the other ones and it is good to have a thing like this in every city

As Ireland has limited service provisions specifically for women involved in prostitution, the women had limited contact or relationships with support workers outside of Dublin. This was a strong issue for the women and they felt that their needs in respect to housing, addiction and sexual health were not easily addressed as Emma emphasises in her story:
...I would say, most supports, the types of supports they would need is housing, accommodation wise

Where necessary, some of the interviewees reported they could access a GP or present within the acute setting but would not disclose their involvement in prostitution.

The women talked of advocacy and how they would like practitioners to advocate on their behalf and to speak for them by outlining their health needs and necessary social supports.

...yeah, we need advocates, we need advocates, all the time there is people like, like you know, against us, but, because of the misconception, because of that stereotypical thing (Helen)

Advocacy was an important topic for the women. They spoke about identifying the need for support and how healthcare professionals could advocate on their behalf, not just in the capital but also throughout the country. Emma added that early intervention would be an important factor in achieving successful outcomes.

...earlier, yeah, earlier intervention of supports; it would be much easier for them to get out, yeah

All interviewees were accessing the Women’s Health Project (HSE). Although they recognised that the service had its limitations because there were only two clinics available per week and more importantly the service was in Dublin city only, they spoke highly of the team of support workers on site and how they supported them in a non-judgemental manner as Bridget explains:

But, right, I think that the project you guys have here...yes, it’s good; it’s very, very good. But it’s like we have support and we have attention here. So I think it’s, if em, can open more things like that, I think it is going to be helping. Yeah.

It is clear the women had good supportive relationships with the team at The Women’s Health Project and found this service to be extremely beneficial with respect to their psychosocial experiences and needs while involved in prostitution. On the other hand, these positive relationships were not constant in the women’s lives on a daily basis or when the interviewees left the capital.
...yeah, it would be very nice if you had more, more supports like that (Bridget)

4.6 Reading three - reading for the voice of `I` `we`, `you` and `they`

The reading of `I` located how the participants spoke about themselves. For example, what exactly was the participant saying and what journey or experiences were they locating with the use of `I`, `we` and `you`? How did the women refer to themselves in certain scenarios? For example, when do they talk about themselves in the first person or when do they project themselves in the language of `you` or `we` to avoid personal attachment to a particular incident or conversation. The themes which emerged from the data were: choice, health and wellbeing and working within prostitution. It became clear that when the women were talking about their families or personal attachments, they very much spoke in the first person, often using the word `I`. This changed when the women talked about experiences of abuse within prostitution or indeed when they spoke about their clients in general. It was `they` or `them`, an apparent disconnection from the events. This was also the case within the international literature.

4.6.1 Choice

The concept of choice is an ongoing debate amongst feminists, academics and healthcare professionals when discussing prostitution. The paradigms are created through social and political influences which exist in society and influence our value systems and standpoints (Healy, 2005). However, the findings are representative of how the women perceived their choices to be. Seven themes were identified.

*Chosen as a selected profession*

The women stated they chose to be involved in prostitution regardless of what influenced that choice and the findings clearly indicated that some women do enjoy this work as Kate outlined in her story:

...because I could enjoy as well (laughs), I enjoy, I enjoy, if you, if you don’t enjoy what you do, then don’t do it. I love my work, I love my customers, I love my job, I love my lifestyle so...
Chapter Four: Findings

Kate felt that prostitution provided her with a lifestyle that she could enjoy which involved travel and good financial rewards. This particular set of participants emphasised that they were in control and that they decided which clients they see. They had a familiar client group that they worked with so it was less likely they would be at risk as Helen explained:

...I’m not a person who forces myself to do anything, and I don’t see clients if I’m not, even if I’m not in the mood to see clients I don’t see them, I’m, I’m in control of myself never see clients just because of the money, you know, I see them when I’m able to work and when I’m feeling good enough to see them, otherwise I don’t, and I also like to take time off now and again, just me time.

These participants also talked about having an education and despite other work prospects this was the area that most accommodated their lifestyle. The women in this group were very much in the present and used ‘I’ frequently when they were discussing their choices and experiences.

Chosen because of visa status

For the women who were not in the country legally, either as undocumented migrants, or seeking asylum within the asylum process, they said that they became involved in prostitution as they had little or no other choices. As Anna’s voice represented:

...Because of my status, I am not here legally, so to find work is very difficult

They chose prostitution because they could not engage in Irish society as equal citizens as Fiona explains from her experiences within the asylum seeking process:

...not yet, not yet, that is why I say, I’m working on it, but I have to pay my rent, I have to pay my bills, I have to take care of myself, I’ve no receiving social (welfare payment)

They further added that although they chose prostitution and they accept that there were women who enjoyed it, they themselves said that they did not enjoy what they were doing and would have chosen other work if they could get it. As Fiona further tells:
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...yeah, you know because some people they like doing it (prostitution), they like money, money, money, money, but for some people they don’t, well I don’t like doing it...

When the women were talking about their status they used the term ’I’, yet when they discuss prostitution as being a negative choice they shifted to the word ’they’ as others in prostitution as opposed to themselves.

Chosen due to homelessness

Homelessness was linked to family breakdown within the findings and for the women this often occurred before the age of 18 as Lynne tells:

... Ah, it’s a long story. I have been doing it since I was fifteen years, fifteen and half, sixteen years, and I em, my mother and father were moving from the building into a house and I don’t like him there, no I didn’t like it there

Lynne felt she had no other option but to leave her home. There were no other social supports available to her at this time in her life.

For this group of women the choice for entering prostitution was to earn money for food and shelter. All the participants were introduced to prostitution by peers they met while living on the street. This group was particularly vulnerable as they had limited support networks, as Mary confirms Lynne’s events as familiar to hers:

...oh my God, and I’ve no one to help me, Oh my God, what will I do?

Mary confirmed that access to homeless services was difficult and how and where she began to meet other girls involved in prostitution in this environment:

... Oh my God I have no help for me now, Yeah I am homeless, Then I met a girl, and I was told not to hang around with her, we went shopping, we went robbing.

Chosen to support drug addiction

Drug addiction was often part of street prostitution as Emma talked about in her story:

...it’s a package, definitely, yeah, I will tell you now, if I, I have to, if I, for instance, If I struggle financially and I thought ‘oh let me just go and do one night on the
street to make some money’, now that I’m clean (free from drugs) Its gonna be very difficult

To pay for drugs the women chose to sell sex. Often, behind the women there were drug dealers who were also their pimps which created an organised crime and control element which impacted on the women’s choices. Emma discussed in her story how these events played a large part of her life in prostitution:

...more difficult, definitely, look you are, you are on the drugs because of this person, and so once you are gone from the person, you are gone from the drugs. Do you understand what I’m saying?

Emma used the word ‘I’ when she talked about herself and the choices she had made to support her drug habit. However, when she referred to her boyfriend/dealer/pimp, she appeared to remove herself from the conversation and used the word ‘you’. This was an interesting finding as this correlated with ‘disassociation’ as discussed in the literature.

Chosen to support education

Some of the women were in education and chose to enter prostitution to pay their fees. The women were either travelling escorts whereby they studied in their country of origin and then came to Ireland to earn their money for school, as family circumstances meant that they had to support themselves like Cathy talked about:

...because I was having school, but this time I had to stay longer because my mom had to pay for the radiotherapy, and I decided to (implying to stay and work in prostitution longer to financially help her mom). And if I have exams, then I will take them in summer

Jenny, from Brazil, came to Ireland specifically to study and was registered in a private college here in Ireland. In Ireland, fees are more expensive for foreign nationals and this appeared to have posed a huge concern. The women were very present in their stories, using the word ‘I’ throughout.

... Ah it was terrible but like (Long pause), but I had to do something
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Jenny decided that rather than leave education and its perceived future prospects, she would enter prostitution to meet her costs.

Chosen to support family

When the women talked about their families they all remained in the present and connected. The word ‘I’ was always used to speak about family. This was particularly clear for the migrant women who were in Ireland to earn money to send back to their families in their countries of origin as Bridget’s story told:

...it was a little bit hard because I used to study and work and help my whole family. My mum is sick, and I got two, two, a sister and a brother. I’m the oldest one, so I always help my family, you know, so about everything, house, food, clothes, school for my young sisters, so everything comes from me, no, so

The women made an informed choice to leave their country and come to Ireland. They chose to enter prostitution because they either could not find suitable work, or their initial work did not provide a suitable income to sustain their living expenses while living in Ireland, and make enough extra money to send to their families back home as Orla shared:

... I’m thinking, as much as I am afraid, I still have to do it, I still have another option, I can work in a factory for 5 Euro for half, for 1 hour I don’t know what, but here if I can make 100 Euro for half an hour, do you know I send money to Africa to my family, I can give a good school, I can give a good education to my brothers and sisters

Trafficked

The women talked about trafficking for the purpose of exploitation. They were aware of the issues and they were aware that trafficking did exist in Ireland. However, they talked about trafficking in the third person ‘they’, ‘she’ and so on. Gene’s story told of trafficking in relation to the traffickers and the trafficked:

...around the country, they are all over Ireland, and the police knows that, the police is going around every apartment trying to find these girls because they have no documents, I don’t think they are ... but they are in traffic, you know, human
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trafficked, so the police is trying to get them, and to get the pimps as well. It is going on now

As Gene explained, the women did not see themselves in the same situation as trafficked prostitutes. Whatever their own reasons were for entering prostitution, they did not feel forced to sell sex and saw trafficked women as more vulnerable and in need of help and support:

...they go and they rob the girls and then the next day, this other apartment, because they fight (the 2 agents); the only one that suffers from that is the girl; the girls...

4.6.2 Health and wellbeing

The primary focus of the research is to understand the psychosocial experiences of women involved in prostitution. How do the women see and talk about their health? This section focused on emotional wellbeing, physical wellbeing and service providers. The key focus is to locate the language they use when referring to themselves and their experiences.

Emotional well being

As previously found, the women always used the term 'I' when they were discussing their families and their children. Although they may be apart they remain connected emotionally. Anna’s story told of this:

...Yes my kids live there (in Brazil). I talk to them every day, every day and I miss them. They are 15 and 12, one boy and one girl. They are happy I send them money

This appeared to become a different story when the women talked about prostitution itself. For Jenny, rather than directly refer to the experience or situation in the first person, her language became collective 'we’, ‘you’ or ‘they’ when referring to the buyers of sex.

... it’s terrible, you know, because you’re like first they like, you know, some of them is very weird, you know, they want crazy things, now, you know, like, some wants crazy things like, crazy things you never thought you would ever hear
The findings continued to show that the buyers themselves were often referred to as ‘they’ and they are a collective ‘they’ alongside robbers, dealers and violent abusers. Throughout the interviews they were usually unnamed as Irene discussed:

... *They want more things and their time is finished, and they still want to stay because, they didn’t finish, or, who knows what is in their brain and scandal*

Emma talked about rape in her story, but presented the information as ‘the girls’ or ‘you’, not in the first person:

‘.... ‘yeah, yeah, yeah’, they can take you and try to rape you or feel you up, without paying anything, but yeah...normally the girl just goes back to the street.

Orla, like a lot of the women who may not have talked about abuse occurring directly to them, spoke about the fear of abuse, or what they had heard has happened to other girls. She talked about how she is constantly afraid but talked about this fear using the word ‘you’

...if you are not careful, you don’t survive it, as I told you, I told you, you are constantly afraid...

In respect to the general public, Cathy used the words ‘you’, ‘they ’ and ‘we ‘ which suggested they as individuals felt secondary or separate from society:

...because sometimes people look at you with different eyes and you are imagining things, maybe you are hallucinating and it’s just in your mind but with this work it is very stressing and we don’t know what to think and you are scared.. (Pause) You are scared all the time

Irene also talked about how she experienced others to view her and how much this bothered her. She too refers to herself the prostitute as ‘you’:

... Yeah, it’s for a few people if you work in this job, is not a problem, but some people look at you like this (gestures; looking down).

For the women who talked about exiting prostitution or their future plans for exiting prostitution they revert back to using the word ‘I’ again as Cathy’s story suggested:

.... Yes, I will start all over again (laughs but does so with emotion)
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Irene has two daughters and plans to leave prostitution and move back to Spain shortly:

... Yes, I will go, definitely, I will go.

The women referred to themselves in the first person when they were discussing family, or their lives outside prostitution. Inside prostitution the language changes outward from them which indicated the impact of using language to locate their emotional wellbeing.

Physical well being

Overall, the women were very aware of their physical health and wellbeing. They were connected with this process and discussed it in the first person `I`, as Helen’s story represented:

...I’m just getting older and I’ve used and abused my body so much, oh well with the stripping and everything and you know the dancing and I thought it was just like stiffness coming on, you know my knees, this and that

Due to the nature of moving around the country, Cathy told how she was subjected to the cold and physical implications of the weather and not eating properly either because of limited time or the unfamiliarity of a place, which contributed to poor diet habits:

....I’m tired (laughs) and the food here, I’m not used to this food, and I don’t have my mom to cook for me (laughs), I’m very lazy to cook for myself. So many times I just order something, but it’s not like just normal food that you make at home. It’s not so healthy

The findings were very clear that the women took care of their sexual health and were well informed:

...if you do oral, em, without condom for example; I think it is the most risk you have. Because you know, sometimes, you are eating and you bite yourself, and then you kind of bleed (Gene)

Despite pressures from clients to perform sex without a condom, most of the time they did not succumb to this pressure:
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...No never. Also, I always use condoms. Sometimes they say; 'no condom, I pay you 1000 euro' but I never, never, always condom for sex, oral and anal sex too (Irene)

Furthermore, the women appreciated the need for sexual screening and healthcare. Their only barrier was access. The scenarios outlined by the women showed a strong identification with their individual physical needs and responsibilities, always using the word 'I', 'my' or 'me'.

Service providers

The findings indicated a strong use of 'I' when talking about service providers that the women have previously met with in relation to prostitution. This service was primarily the Women’s Health Project (HSE).

....yes, it’s good; it’s very, very good. But it’s like we have support and we have attention here. So I think it’s, if em, can open more things like that, I think it is going to be helping, yeah... (Irene)

Emma talked about her recovery from cocaine and used ‘I’ in a positive way to indicate her positive frame of mind and environment while within the right service provider environment:

...oh yeah, I do have a lot (support) and I’m grateful for that.

Emma was also linked with a domestic violence shelter that was working with her towards accessing housing and social welfare.

However, when the women were referring to acute settings that they may have accessed in emergency settings their language changed. They would not identify themselves as involved in prostitution but rather said they were a tourist as Fiona shared:

...They don’t go anywhere; they would just be quiet and forget it

They appeared more guarded and vulnerable in such settings and their language changed to use ‘they’, for support services in this capacity. This use of ‘they’ also extended to the Gardai as Gene explained:
...I don’t think so because I wouldn’t trust the police (pauses), I think they are, you know (pauses), and they would be prejudice...

Often the women used the word ‘you’ when speaking about themselves as opposed to ‘I’. This was a consequence of the law and how they projected their health and wellbeing to certain situations as positive or negative.

Working within prostitution

The women talked about their experiences within prostitution throughout the interview process. Again, it was important for the researcher to capture not just what they were saying, but how they were saying it. The events were owned by the women, and their use of language ensured that the researcher primarily attempted to present their findings as their voices. To capture the use of ‘I’ ‘we’ or ‘you’, the data was coded under the heading ‘self-reflection’. This was to take the pieces of the data where the women appeared to be reflecting on their experiences or events within prostitution. Safety was a reflection theme and the subthemes of this were abuse, addiction and theft. The other themes that emerged were sexual health and trafficking. These themes have already been presented in this chapter. However, it is important to signpost them again in direct relation to the women’s use of language.

Safety within prostitution

The women spoke of safety as a recurring theme throughout their interviews when discussing their experiences within prostitution. Whether the women had experienced anything bad or not, they were aware of the safety issues and spoke about always having to be on guard, which they found very stressful. The three main concerns for the women were abuse, safety as a consequence of addiction and theft. An interesting finding was that when the women were talking about the risks of abuse in a more general way, they used the word ‘I’ and spoke in the first person.

...well it is kind of difficult, but if, I mean if I meet a quite client, it is like they don’t want scandal or they are not rough or, if they treat you like a normal human being, it is ok. It helps you a lot. (Niamh)

The women appeared very much connected to the potential risks and environment of prostitution. However, when the stories became more specific or personal, such as
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talking about rape, the language shifted to ‘you’, the third person. Therefore, it is not always clear if the women were talking about themselves in a dissociative manner which was identified in the literature, or in fact they were simply generalising about what goes on. Emma’s story provides this view:

...usually guys will come up to you, they wouldn’t even, they wouldn’t even, they wouldn’t have the idea of paying you, they wouldn’t even have a penny in their pocket, and they would say, ‘yeah, yeah, yeah’, they can take you and try to rape you or feel you up, without paying anything, but yeah.

To dissect the ‘I’ and ‘you’ here, provided a significant contribution to how perceived or experienced abuse impacts on their psychosocial health.

Addiction within prostitution

Addiction, in particular, remains strongly linked to street prostitution and a history of homelessness. According to the literature, and indeed the findings of this study, it appeared that addiction often comes before prostitution and prostitution is a means to support the addiction. They then become intertwined. Emma reflected on her safety while using drugs and this became an interesting find:

...it’s a package, definitely, yeah, I will tell you now, if I, I have to, if I, for instance, If I struggle financially and I thought ‘oh let me just go and do one night on the street to make some money’, now that I’m clean (free from drugs) It’s gonna be very difficult.

Emma had a long standing history of drug abuse. At the time of the interview she was in a rehabilitation programme and was taking ownership of her addiction. For this reason, one can understand her use of ‘I’ when discussing her actual relationship with cocaine. However, when she reflected on events which shaped her experiences she shifted to the word ‘you’. This is when she was talking about her boyfriend/pimp/dealer that was controlling and abusing her at the time:

...more difficult, definitely, look you are, you are on the drugs because of this person, so once you are gone from the person, you are gone from the drugs. Do you understand what I’m saying?
Again, the events described through use of language allowed the researcher to locate the perceived experiences through the lens of the participant indicating the impacts of safety on their psychosocial health. The women also reflected on the impacts of theft on their safety. Interestingly, theft was a very strong theme for the women, it was one of their top issues on their lists of concerns, yet the women, such as Orla, talked about their experiences in the second person, ‘you’.

...yes, because you have to take care with the police, you have to take care with the robbers, in case there are clients who come to rob you, with rough clients, with people that rent apartments that just want to take your money, we have to take care of everything. Like everywhere you have to be like looking always.

It appeared that theft was an inevitable part of working in prostitution, either by a client not paying, or organised theft which occurred primarily for women indoors as explored by Orla:

...you are never know when you open the door. Or police or person for robs, because here in Ireland it is not legal. This is the problem, if you have legal, you have a person there for you or, who will look for you but here it is not possible. In Ireland it is a little bit difficult.

The findings could conclude that there was an acceptance that this is part and parcel of prostitution and although the women tried to take precautions and protect themselves they remained vulnerable. Probably, for this reason, it was easier to reflect in the third person for them.

Sexual health within prostitution

Sexual health was something the women reflected on when thinking about working in prostitution. When the women were reflecting about sexual health in general, they remained in the first person, ‘I’. They conversed about always using condoms and being aware of safe practice. They reflected that customers often asked or put pressure on them for unprotected sex but they tried to remain in control and always aimed for safe options (ss outlined already within the findings).

However, as Helen’s story addressed, when the women talked about sexual violence and their sexual health, the first person reflection shifts to a more removed ‘you’.
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...our health is at risk from the health and safety aspect, you know, because you are at the risk of anyone walking through the door and doing anything to you, you know, you could get raped, em, by a guy who rips off the condom, rips off the condom and rapes you, throws you over the bed and rapes you. He could have HIV, he could have hepatitis, he could have any other sexually transmitted disease.

The women’s sexual health could be compromised even with their best intentions. This was an important finding which impacted on their psychosocial health and wellbeing.

4.7 Reading four - reading for the cultural context of prostitution

It emerged that when reading for the cultural context of prostitution, the issues pertinent to this section had already emerged and had been addressed in reading one; reading for the narrative/main events. Therefore, it became unnecessary to devote a replication section here. Nevertheless, in meeting the criteria for using an adapted voice centred relational model of analyses, the key themes from a cultural/societal context are renamed here; before entering prostitution, entering prostitution, within prostitution and aspirations for the future. Prostitution in Irish society today exists within society which has been shaped and influenced by global trends, legal frameworks and health policy. Therefore, it became clear that a second phase to the research needed to be developed which became the perspectives of agencies working directly with women involved in prostitution.

The women involved in prostitution do not participate in policy and legislation but they are affected by them. Stage two emerged to develop the cultural context of prostitution and to meet the requirements of reading four of the voice centred relational analyses process.

4.8 Introduction - stage two

This section presents the findings from stage two which were the views of agencies in the field of prostitution. As the study located itself within an ecological framework, the research required a macro account from those who can provide this. The women themselves could not provide this perspective but rather those working in a supportive or interventionist capacity in accordance with local and national
service policies against the backdrop of current legislation (legal and health). The local agencies were chosen as they were specifically involved in working with women in Galway who were experiencing homelessness, addictions, violence and rape and also who engaged with migrant communities and asylum seekers. The national agencies included were specific to prostitution as service providers all of whom were based in the capital and worked directly with women involved in prostitution around exiting strategies, migration and advocacy.

As Ireland is steering towards the Swedish model of prostitution, it was necessary to include the perspective from a Swedish agent central to the field of prostitution. Each section will be dealt with separately as three sets of questions were used depending on whether the agency was local, national or from Sweden.

4.8.1 Local agencies

The local agencies did not work with women in prostitution. The findings clearly acknowledged that locally services did not deal with specific issues pertaining to prostitution but rather only the specific issues that their service was set up to address.

Prostitution

*Risk factors to becoming involved in prostitution*

The local agencies were all in agreement that service users could be or were susceptible to prostitution. For example, one local agency expressed their concern with the link between homelessness, addiction and no fixed abode. If Irish women, in particular, were homeless with no address they could not access social welfare payment and support.

*...This is a difficulty and this is a huge gap in the system and that if someone is sleeping rough or moving between different types of accommodation without an actual address, say whether it’s hostels, it’s difficult to access social welfare, I mean you’re not able to access social welfare unless you have an address so many women who come to us wouldn’t have payments set up or they’ve been without payments for some time...*

This extended to foreign nationals who did not meet the Habitual Residency Condition (criteria are living in the country for two years before meeting the habitual
residency status to avail of social welfare services). This, therefore, left the women at risk or already involved in prostitution.

Another local agency also identified its service users as `could be involved in prostitution’, in particular this agency highlighted the issues of unaccompanied minors coming into the country to seek asylum:

…now I know they don’t do unaccompanied Minors in Galway anymore but when they did, I mean it was never directly said but things they’ve picked up that young girls were groomed immediately when they came in and pimped out when they came into the hostel by women…

According to this agency, in reality there are hundreds of unaccompanied minors who have come into the country and have disappeared and the government have no links to their whereabouts, the local agency goes on to include the women living in Direct Provision accommodation (asylum seekers).

... I worked directly with Asylum Seeker women for three years, I think they’re really, really, the most at risk from prostitution because they live on 19.10 (Euro) a week. They’re living in horrific places, their kids are asking them for money and they can’t give them the money and I do think they’re groomed for prostitution. I have seen a lot of stuff to believe that there are a lot of girls working in prostitution and women and I’ve seen young girls going into the system...

The local agency tied this information in with concluding that there was also a strong link between child sexual abuse and prostitution according to their figures. This comment is not specific to foreign nationals but included women here in Ireland and globally. The findings in phase one support these comments.

The third local agency added to the above comments by firstly agreeing that their service users could be involved in prostitution and also tying this in with the status of their service users as a consequence of the system and the systematic poverty imposed on this group (asylum seekers). Furthermore, asylum seekers were particularly vulnerable as they did not hold the necessary papers to remain legally in the country and for this they are preyed upon.
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... And then the other is there, their, isolation their vulnerability and they have em... ...God for want of a better ah expression, easy pickings ye know they’re just... here I’ll show you around, I’ll show you this and they’re, they’re almost in it before they’ve realised what has happened

They are less likely to have confided in anyone as they feared deportation, and pimps alike were aware of this.

**Known involvement of service users in prostitution**

The local agencies talked about knowing, or being aware, of service users involved in prostitution. One local agency told of a time when it identified a service user that was involved in prostitution:

... *Em yes but it would have been very rare, em it would have been women who maybe would have been involved in prostitution years ago... Em I’m just thinking maybe of a service user we would have had. Em, you know a few years ago, and she did have a history of prostitution, she would have talked about it...*

The service user’s immediate needs presented to the service were shelter/accommodation so this was the main criteria for this particular referral. Another local agency also answered ‘yes’ to knowing service users who may be involved in prostitution, again with a strong emphasis on foreign national populations:

... *I think so yeah. When I was working in the Asylum Seeker Clinic, there was certainly one woman who said she used to be a prostitute, and she was a child prostitute. We met a lot of women who were used as prostitutes in the trafficking process...*

This statement was followed by the agency adding that the women she was referring to had agreed to be smuggled for the purpose of sexual exploitation rather than brought here against their will. The local agency also mentioned particular women they knew as service users accessing a hotel regularly in what appeared to be meeting with clients. Other women they knew as service users were getting on and off buses which brought them to different counties and towns throughout the country:
... And it wasn't just her that I had seen at that hotel it was other clients getting on and off at the bus stop there and em, yeah just people with money, people saying they were going to Cork...

The women were guarded and private about their whereabouts. This supports the findings of women involved in prostitution as moving around the country.

A further local agency answered `no` to this question:

... No... Not to my knowledge I should say... No one would, disclose to me...

This was consistent with what a local agency had stated earlier that often the women would remain silent for fear of compromising their status in this country.

Suspicion of service user’s involvement in prostitution:

The local agencies were asked if they had suspicions that particular service users who presented to their services may be involved in prostitution. It was clear that all the local agencies had concerns for particular service users being involved in prostitution and this had raised significant concern amongst local agencies.

Yeah absolutely, well both... we’ve had experience of having suspicions around em, people being involved in prostitution based on I suppose their lifestyle, their em, you know what they’re doing, their comings and goings, their mobile phone use, this is completely anecdotal but just from our observation, you know, getting phone calls at very late in the evening and leaving and coming back to the hostel so that they’ve met people, but it’s been, you know suspected that it’s...

Although this answer was anecdotal it became clear that there were particular signs to indicate prostitution. The participant was very keen to assert her suspicions and entered into a dialogue to support this:

Yes, yeah....yeah....em....for a variety of reasons, I mean some things would be what was said to me by other....em...people living in in the Direct Provision Centres or....em....from people outside, who might be walking by, be it em.... I’ve had reports from residents, em...from male residents who have been approached, or who have reported to me they’ve been approached by Irish men asking them to hook them up with women...
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The local agencies were clearly aware of prostitution and its relationship to their service users. Although this information was vague or hearsay, they all felt strongly that prostitution was occurring locally and their concerns were, in particular, for homeless and foreign national women.

Health

Determinants of health for service users:
Local agencies identified mental health as being a significant issue for their population group. As a consequence of their current lifestyles, the risk factors were predominantly drug use (including alcohol and prescription medications) and addiction.

...you know use on a regular basis and we’ve seen an increase of heroin users too over the past five years I suppose…

The interviewees also mentioned sexual health issues such as unsafe sexual practices (sexually transmitted infections) and unplanned pregnancies. For the homeless community, in particular, there was a direct link between homelessness and the care system similar to the literature outlined by Coy (2008).

... Most of them would I’d say, a large number of the women are coming from childcare residential or had histories of being in care. We’ve seen an increase over the past couple of years of women the age group of eighteen to twenty four and most of them have come through the care system... and another cohort of women who are somewhat older, em who have experience of being in institutional care as children

Other risk factors were re-victimisation as discussed by one local agency:

Em well there is the big risk of re-victimisation, em it’s been shown that if you were sexually abused you’re seventeen times more likely to be raped as an adult...

The agencies emphasised that their service users were mostly Irish women and/or from the Irish Travelling community. According to this agency, there seemed to be a strong link between Irish street prostitution, homelessness, child sexual abuse, addiction and coming out of the care system, which is similar to findings presented in the literature (e.g. Coy, 2008).
Enforced idleness on asylum seeking women according to one agency working directly with foreign national populations was a concern. This particular group were not permitted to access education or employment and were provided with a weekly subsidy of €19.20 from the state which the agency termed as ‘enforced poverty’. Also, because of the current system for seeking asylum, the women were forced to live in circumstances of uncertain periods of time as it could take anything from six months to six years to process an individual’s asylum application for leave to remain in the host country. The final outcomes of this could present as deportation, so uncertainty and dislocation could impact on the women and their children.

…which is a result of their circumstances; the, the system of Direct Provision, the asylum process em, the…..the…..forced idleness the forced poverty and the length of time they’re left in that system

According to the agency, a consequence of potential depression and or abuse was that prescription drugs often were used.

Supporting the health needs of service users:
The local agencies addressed the needs of their service users by using a standard generic assessment process pertaining to their particular service ethos. They discussed a referral system whereby the specific needs of their women would be ‘referred’ out to professionals holding particular skills as opposed to the host agency meeting these requirements. The issue of prostitution was not part of the assessment process per se but rather came under the umbrella term of ‘health’ and ‘sexual health’ and/or ‘mental health’. The external local referral agencies were also nonspecific to prostitution.

The agencies discussed with fluidity the ongoing barriers to the specific area of prostitution in meeting the women’s particular needs. For women experiencing homelessness, their practical needs could be supported via homeless services. However, the shortfall outside of their basic practical needs of emergency shelter compromised the agency’s ability to often move forward with long term plans for the women.

... but there are a lot of barriers to that in terms of someone who might need mental health and positive mental health is something that I think is really important...em
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within the hospital it’s strictly a medical model so in order to access counselling......or supporting mental health through the hospital you have to have a diagnosable psychiatric illness

Often the women fell through the gaps as the nature of their client group’s chaotic lifestyles meant that it was difficult for their service users to attend follow up appointments. Also, the sexual health clinic in Galway inadvertently established its own barriers, according to the local agencies, because of stigma and inflexible clinic times.

... and the stigma as well I think that for someone say attending the STI clinic up at the hospital, it’s not ideal by any means how people have to attend that clinic...It’s an open door and you know em the opening hours aren’t flexible, it’s very limited, em, any woman, I think needing to attend that clinic there’s gonna be some anxiety or hesitancy around it

The local agencies included group work as a strong focus to their work. For example, if they felt there was a concern around a certain issue they would invite expert guest speakers to come and give an information session to the group.

... So, say for instance last week in the group we would have the ‘Aids West’ in and then we’ve done that several times who talk to the women about contraception and you know STD’s and that kind of stuff and answered their questions and we’ve also had a Doctor in to talk to them. So they’re in the group they trust

One local agency did, however, discuss the low turnout rate of service users within the groups, or how numbers in attendance declined as the weeks went on:

... They know that it’s there em.... part of it is that em.....eh people are becoming kind of disheartened and detached and....ye know they just, they’re not motivated.

Again, none of the local agencies mentioned prostitution within their agencies or as part of the referral system. National agencies were mentioned here as a referral port for women who may present as involved in prostitution. The local agencies centred their assessment and referral process on their agency criteria which was specific to homelessness, sexual assault or migrant issues. Interventions were addressed within the resources of the local agency remit which proved to be a barrier in addressing the
needs of prostitution specifically and therefore the holistic needs of these women’s psychosocial health requirements.

Moving forward

**Barriers**

Local agencies did not feel equipped to address the needs of women involved in prostitution within their service. Some agencies stated that for homeless women in particular, they would not identify themselves as prostitutes as they may engage in this activity infrequently and not in the usual circumstances of street or indoor prostitution.

...someone that might be sofa surfing or in need of money because they are not accessing payment and they would exchange sex for those type of things

This agency further added the concept of ‘normalisation.’ It was stated that the women could normalise their behaviour and not see their sexual activity as something they need to discuss. The concept of ‘victim’, ‘victimised’ or ‘vulnerable’ to ‘sexual exploitation’, according to this agency, ‘is part of our language and worldview and not necessarily theirs’ (the service user). Therefore, it remained a difficult topic to address with service users. Furthermore, crises intervention services targeted initial needs as they presented and may not continue to remain working with the service user for long periods of time where trust and relationships could be formed according to these local agencies addressing the needs of homeless women.

The local agencies felt that the current law on prostitution hindered how they could involve themselves in this matter. They also added that the law meant that women would not disclose their possible involvement in prostitution to practitioners. The agencies decided upon that if someone disclosed involvement in prostitution, then they would have to refer the service user to an agency or professional with greater knowledge, training and expertise in the area of prostitution.

The local agencies confirmed that prostitution policy, such as the needs and proposed support of women involved in prostitution, was not incorporated into their agency policies at a local level. One local agency did, however, draw attention to the national standards of her network which does identify the word ’prostitution’ within its national guidelines and policies. This is particular to migrant and asylum seeking
women who were currently residing in Ireland. Local agencies to date, acted in accordance with their service policies which incorporated the standard guidelines such as: child protection and the role of staff/practitioners in the event of a service user disclosing abuse (Duty of Care) only.

Recognition of need:

Local agencies expressed the need for local services to provide information and support to women involved in prostitution. They clearly saw this as a gap in providing a service to this group.

... It would be very beneficial to be able have information here available generally for people around other supports......specific to prostitution.

A local agency added that they population of service users were supported in their immediate needs but long term supports and interventions were poor and the women who accessed their services were not on the radar for prostitution in particular.

... I see a huge need. Yeah, yeah, I do. Because I think they seem to be very, very isolated and I think in isolation I think there’s a lot of danger

This agency proceeded to make the link that women involved in prostitution were isolated by virtue of the law and its deviant association. They were also further isolated by services which excluded them and their specific service needs.

There was specific concern amongst local agencies for women who fell into the category of undocumented status. Such women remained excluded from the health services as they could not become known or identified to staff because of their illegal status. According to one agency, this had become a concern for local service providers as it had been noted that some asylum seeking women who had not been granted refugee status had ‘gone underground’ rather than accept deportation:

... It is, I know it’s happening. I would know of it happening and I know of.... ...a few people disappearing, em....I don’t know how they’re supporting themselves. I had a case recently of em....a woman who, who disappeared for, for, some time, became pregnant and is now, kind of resurfaces to try and access medical support and is terrified

Asylum seekers, according to local agencies, may become vulnerable to prostitution or trafficking for the purpose of sexual exploitation. All the above points raised by
Chapter Four: Findings

the local agencies indicated the need for local services to consider their assessment process to include prostitution health. They stated the need for an advocacy role both locally and towards national policy implementers.

Conclusion:
In respect to their client groups, the local agencies called for increased awareness around prostitution and the multifaceted, complex issues which go alongside this industry. Local agencies sought a breaking down of stereotypes among healthcare professionals which they felt reinforced misunderstandings and assumptions. They added that prostitution permeates their services and yet, due to funding constraints and service expectations, they remained limited in providing appropriate services and support.

4.8.2 National agencies

The national agencies worked directly with women involved in prostitution. They engaged in face-to-face contact with the women and or in an advocacy role.

Prostitution:

*The current situation*

The national agencies stated that prostitution is essentially harmful for the women involved and, therefore, they viewed the current situation from this paradigm. The national agencies outlined a massive shift from street prostitution to indoor migrant women. The agency specifically working with migrant women around their legal rights had encountered many women who engaged in prostitution for economic reasons:

......ahm....as they would be of course not one monolithic group, they would be various people and they would have various reasons for involvement in prostitution, some of them would be....compelled to do it, others would be controlled in some way, others would be doing it out of desperation ehm.......mostly, mostly what unites them is that this is all done because of poverty...

The women involved in prostitution were driven by the need to get money and were subjected to physical and psychological trauma, according to this agency. As the women were primarily working indoors, they remained isolated with limited access to external social supports. The agency stated that particular migrant women who
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were more exposed to this lifestyle were: undocumented, asylum seekers and migrant women working for low wages within the service industry.

... *I haven’t come across eh women who are highly motivated, migrants who do high level degree courses, my observation is that those who are here and hold a student visa while they work in prostitution*...

According to one agency, some women entered the country by obtaining a student visa. It was her view that the women used this as a form of access as opposed to the opportunity of a suitable path to education:

... *they would be attending very low level courses, and will be not the education that has brought them here, it would be the other way around, it does, it would be again the motivation for earning, the need to earn money that has brought them here and the education is rather a consequence or way to, to remain in the country*...

The agency stated that it is often difficult to determine an individual’s status or try to tailor their support which best accommodates their needs. The women presented as ‘on student visas’, ‘asylum seekers’, ‘undocumented’ or of European nationality which allowed the women to freely enter the country. So, the issues were complex and required a specific tailored approach.

... *So right across the board but it is a critical issue and it will inform the responses and it will inform eh, the resources that might be available to those women as well in the Irish state*

The participants added that many women working indoors as escorts felt more vulnerable to violence and abuse. She also added that:

... *There are issues there for em, for the women themselves and I think there is on a larger cultural level there is great confusion about the issue of prostitution.*

This national agency added that the women involved in street prostitution were a more homogenous group and they were primarily Irish nationals. Although they may openly access services they often chose not to because of the stigma attached to prostitution, both culturally and legally. For these reasons, women involved in prostitution often remained excluded and isolated from support services.

... *And that of course has implications, for the women indeed for their health, for their wellbeing and of course if they have any kind of legal status issues, to be*
Chapter Four: Findings

arrested probably means to be deported so there are major issues, those kind of legal ones

Health:

The determinants of health

The risk factors for health according to the national agencies were: stigma, fear and isolation and they added this to be particularly relevant to migrant women. Sexual health was stated as impacting both physically and psychologically on women in prostitution. The women did not work in normal working environments where they could be open about what they did.

…living in hiding, it's a very diffic...different kind of...do you know, discretion or exercising of discretion ah or a low profile in your life, from uhm, for example a migrant employed improperly, for example, on the black market...kind of avoiding normal social contact because of this

The agencies also talked about the double edge sword for asylum seekers who had come to Ireland to seek asylum from political unrest. They came here with possible trauma and then were further subjected to possible abuse and traumas by virtue of enforced poverty, uncertainty of status and poor social support networks.

The women involved in prostitution were actively participating in sex regularly and it was stated that this impacted on their physical and mental health.

…but women talk about having to go somewhere else in their head for instance...

The physical violence within prostitution was stated as a concern for the women’s health. They were often treated badly and left alone with limited services to intervene.

…but eh it's usually dust yourself down and eh, kinda get back on with it

The physical abuse was discussed by the agencies using the techniques and theories used by Domestic Violence Programmes: The Wheel of Power and Control (The Duluth model, DAIP, 2013), to understand how women arrived to prostitution and
Chapter Four: Findings

how their abuses by clients and or pimps and organisers of prostitution were projecting control. For the agencies all aspects of prostitution were abuse against women.

The cultural norms and practices of prostitution were discussed by the national agencies in relation to the health risks,

…the lived reality of what it means to be involved in prostitution and the impact on the women, on the users and on society.

Such factors were identified as crucial in understanding the women’s psychosocial experiences and for seeking necessary services nationally. The agencies called for harm based analyses and approaches to locating the extent of violence, addiction and the women existing in a state of ‘Otherness’. This was in response to the current law on prostitution, limited services available to women involved in prostitution and/or migrant status’ which were listed as key determinants of the women’s health.

Psychosocial experiences of women involved in prostitution:
The psychosocial experiences of the women involved in prostitution according to the national agencies centred on women ‘moving around the country’; the key concerns were their psychological wellbeing impacted by limited supports and protection, limited information of services and experiences of isolation and loneliness while engaged in prostitution.

...where they could go if they needed to...So I think information is em, one probable issue and I say that speculatively because that’s not a question, I’ve actually asked them so em, but I suppose the other thing is the fact that women are moving, it is often a transient existence...

All the above factors contributed to the women not prioritising their own health and wellbeing.

Services:

Barriers in accessing support

The national agencies expressed their concern for the lack of service provisions throughout the country.
...No I don’t think so. It’s not addressed by the healthcare service and by other potential services or agencies that may need to be involved

The agencies also mentioned that the women did not know of services and relied on other women to inform them of where to go for support.

...that there is healthcare available, it is available em, just eh a lack of awareness of the em, of supports that might be available because I know there are Government clinics around the country and things like that but if women don’t even really know the geography or don’t have the language you know would maybe rely on other women in prostitution to tell them...

Services around the country, according to the agencies, were not specific to the needs of prostitution (as identified by the findings of the local agencies), and women were not disclosing ‘what they did’ so their treatment and care may not have been holistic or relative.

... Women they’re already connected with a lot of services. Often none of those services know that they have any involvement in prostitution

The national agencies talked about the role of the current law on prostitution. It excluded women and in particular migrant women. For this reason, access to services was compromised.

...of course it prevents them, it prevents them in general terms because they wouldn’t be holding a status that allows them access, but it also keeps them in this semi, quasi-illegal, quasi-criminal position all the time

The agencies suggested that Ireland needed to become an active player and work alongside other Nordic states such as Sweden in their approach to prostitution. The agencies discussed current debate on the campaign ‘Turn off the red light’, to locate in their views on the direction for prostitution. Each national agency was a member of ‘Turn off the red light campaign’, a national campaign to end prostitution in Ireland.

... Em the legal framework is part of that as well and as I mentioned we would you know as an organisation would be advocating a model that completely decriminalises and so that would include and involve decriminalising the issue of soliciting on the street as well because you know that, that is an issue that em, you know when women still are criminalised but also just being that explicit in the law
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that it is not illegal to be a prostitute but at the same time we would see the most em, meaningful way to reduce the sex trade in Ireland would be to criminalise the purchase of sex

The agencies addressed the issues of `misconceptions` and `attitudes` as something that could prevent women from accessing appropriate healthcare. The agencies discussed how the sex industry was a billion dollar industry and one that thrives off a certain image. Organised crime and trafficking were the hidden realities behind prostitution misconceptions. The national agencies felt that trafficking and prostitution needed to be dealt with under the same laws and as an organised crime unit.

...yeah, yeah, and I mean without the resources to go, I mean that’s what we were saying, I think you can’t separate prostitution out from trafficking or trafficking out from prostitution

In Ireland, trafficking is dealt with by the Immigration Bureau and prostitution lies within the Gardai remit under public order offences and so according to the national agencies, appropriate services cannot exist while this situation remains the same.

Outreach work was a concern for access as currently there are only two clinics a week held in Dublin by the Women’s Health Project.

...Two clinics a week in Dublin just isn’t sufficient

Each clinic is two and a half hours long where the women opt to see the GP on site and the team of support workers. Outreach work across the country is non-existent specifically for prostitution. As a national agency added:

That group has very little ah public sympathy? And therefore I think that is very evident even in media coverage, in discussions, in radio phone-ins, any of these places where you might put your finger on the pulse to feel what is the...ah vibe towards these women, that I think is huge, that there’s still so much shame, opprobrium, ya know heaped on these women, rather than seeing that...for whatever circumstances they have found themselves in, that the...ya know....the impact on their health....
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Moving forward

The agencies addressed the current issues of services by explaining how interventions could occur, this centred on interagency work and learning from other models of care.

… to set up both an interagency relationship between all of those diverse bodies, and to see if we could actually map a journey for the women through all of those agencies and services that are available; journey that would be seamless, that would be connected, and that would at the end of the day be in the interests of the women themselves

In order to provide necessary health services, the agencies stated a need to draw from other models within Europe. The example given was ‘Project Daphne Fund’, which provided a research grant for preventative measures against all forms of violence and support for victims and groups at risk; children, young people and women. Daphne is the European programme for projects to assist women, and was carried out by the Dignity project. The findings were disregarded at the last hurdle by the statutory health bodies, namely the HSE (Health Service Executives).

... We had statutory bodies responsible for policy, like the Department of Justice, Anti-human Trafficking Unit, we had the Garda Siochána, and we had the HSE and what developed then during the period of the project, the new Anti-Human Trafficking Unit within the HSE... and the NGO side (including migrant services, homeless services etc).

This document brought Sweden into the debate as the start of Ireland seeking to implement the Swedish model for prostitution. All national agencies stand by the findings of this document and seek to move forward by implementing a model similar to that in Sweden.

Current Legislation:

The legal framework

This section outlined the findings on how the national agencies viewed the current legislation on prostitution. The agencies all stated the current legal framework does
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not work. They added that the legislation in particular for migrant women in Ireland did not work in the women’s best interest.

... It puts ehm an intolerably large number of.... vulnerable migrants...in situations where their health, physical and mental is endangered

The legal framework they were referring to was both the current legislation on prostitution and on migrant laws and policies. The focus was to learn from and incorporate the Swedish model on prostitution into Irish law and practice.

... Is that they took a position as a state that it’s just not OK for one person to be able buy the body of another person for sex and in the interest of equality em, they enacted that piece of legislation as part of a Penal Code, as part of the violence against women bill

The national agencies talked about the notion of ‘consent’ within law. The law, as it stands, distorts the notion of consent, as the agencies believed that buying a prostitute, the punter was buying the woman’s consent. The law reinforced this by criminalising the seller according to the agencies and where in fact the responsibility should lie with the buyer.

... You’re buying consent and that in itself negates (laughs), you know, em, you know the true definition of ‘Consent’ and so we would, what would be critical for such a law to be enacted would be a recognition of the actual law is of harm in prostitution... em, and again international studies again and again and again show you know those interviewed who are involved in prostitution in excess of 90% want out but it’s a lack of other viable

This supersedes that as the law currently stands it remains harmful to women involved in prostitution and calls for an immediate revamp. This debate is happening and a report has been compiled by the Minister and the Department of Justice and awaits review and conclusive attention (2013- to date).
Women in prostitution remained punishable under current Irish law which leaves them to face discrimination and prosecution, leaving them vulnerable and less likely to come forward in the event of a crime being committed against them. The agencies state that organised crime behind the scenes such as pimps, accommodation organisers and so on are the ones who should be targeted.

*It is heavily organised, em, and that connected to eh, obviously to criminality and organised criminality which makes it a very dangerous. The national Agencies believed that the issues pertaining to women involved in prostitution lie with governments and policies and require re-evaluation and intervention conducive to the Swedish model.*

Conclusion:

*Suggestions for moving forward*

All the national agencies considered support/services as an appropriate link to facilitating change. Supports were placed in context of particular ideologies of legislative change. Public perceptions were being challenged and discussed within the forum of 'Turn off the Red Light Campaign' which discussed prostitution openly as harmful and exploitative. The agencies also saw radio and television as useful tools to discuss and debate prostitution by raising awareness, seeking harm reduction principles and promoting the Swedish model on prostitution for criminalising the punter and decriminalising the woman selling sex. The idea was to deactivate organised crime and lower demand.

The agencies fundamentally stated that prostitution should reside with the organised crime unit like in the UK and not continue to remain within the public order offences. This in their view would be achieved by implementing the Swedish model. The agencies seek policies which work towards supporting this brief.

The agencies see change by recognising prostitution within trafficking and trafficking within prostitution and not as separate entities. They felt that trafficking for the purpose of sexual exploitation exists mainly because of prostitution.
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... Yeah, yeah, and I mean without the resources to go, I mean that’s what we were saying, I think you can’t separate prostitution out from trafficking or trafficking out from prostitution

An agency stated that the current global sex industry cannot be included in the approach to tackle prostitution locally:

*We shouldn’t be….mixing our obligation towards global inequalities with prostitution…*

While another agency recognised that while Ireland tackled demand, this only shifted prostitution to another country:

... *I think if the demand drops, ah we will see that the industry will just go elsewhere.*

This will not eradicate prostitution but only move it to somewhere else. In particular, women who are migrants and resided in Ireland under precarious visas will go elsewhere but for these women the issues remain unresolved.

A national agency added the ‘feminist movement split’ to the interview. In particular, the debate between feminist groups themselves of two views forced or unforced prostitution/sex work. This debate centred on the concept of ‘agency’:

*…..maybe servicing men in their lunch time, ya know, when we talk to those, some of those women it’s like ya know, ‘don’t talk to me about agency love, if I’d agency, I’d have your job.*

The interviewee stressed that she did not wish to demonise other women’s views, or indeed other countries approaches but she did feel that in an Irish context, prostitution is inherently harmful. Despite the academic approach and theories she added that it is important not to lose focus of the women themselves within prostitution and she questioned where such conceptual academic frameworks can focus on agency against the backdrop of the women’s voices and experiences themselves. There is a need for continued dialogue which invites the complexities of prostitution into the forum she adds:
Chapter Four: Findings

...of the argument, for a moment I do not underestimate the complexity and nor as I said do I em......attempt to demonise, and that is what has happened in the women’s movement I think...in an Irish context we’ve all been at every barricade so...

4.8.3 National coordinator of prostitution in Sweden

The national coordinator of prostitution in Sweden was interviewed and talked about the Swedish model and how it approached prostitution in Sweden in respect to the women and the law, support services and outcomes. It is clear from the findings that the Swedish model is ever evolving as the sex industry continues to expand and change and yet the findings suggest that Ireland is eager to incorporate this model wholly and on its own terms. For example, the Swedish agency clearly stated that the model is not designed currently to meet the needs of migrant populations satisfactorily yet the national agencies in Ireland discuss at length that prostitution in Ireland is predominantly indoor and of migrant women.

Prostitution in Sweden

In Sweden there are three types of women involved in prostitution, firstly, the Swedish national who is a Swedish citizen and has access to the social welfare system.

...Like social welfare in Sweden, is that we can say that no one has to sleep on the streets...

Secondly, illegal immigrant women engaged in prostitution (women from non EU countries). This group is not entitled to social welfare, and if they come to the attention of authorities, the only support provided to them is support to assist them back to their country of origin.

...If I meet a girl on the street from say like Romania and I can’t see that she has a pimp behind or that she’s organised, in that case it could be a huge problem because we can offer them at that moment when we talk to the girl and she says ‘I’m here voluntary, I’m here by myself’, what we can offer her if she needs is a ticket back home, obviously...
Chapter Four: Findings

Services, where possible, try to grant them temporary permits for up to three months so they can apply to seek employment outside of prostitution while they seek support for repatriation.

...That’s why we are working with this National Rehabilitation Programmes because what we try to work out now is to find possibilities for these girls to have another kind of job, education, we try to involve NGO’s together with the state agencies to work something out...

Then, thirdly, women from EU countries were protected by a particular legislation which understands the rights of the women to move freely around Europe.

... We have to follow the E.U directives of travelling’.

Women who were identified as trafficked will automatically qualify for services and support. They were also issued with a permit to remain in Sweden while their case is being followed up.

... If you are in investigation as a victim of trafficking of course we will have a permit, a six month permit or a reflection period of one month and when you have this permit you will be surrounded by the same possibilities as a Swedish citizen

Legislation:

The Swedish model
The Swedish agency for prostitution in Sweden began by clarifying that the Swedish model was not written to combat trafficking as trafficking was not yet considered an issue when the law came about.

...Yes and the most important part here is that the intention when we took the legislation in Sweden was not at all against the fight against human trafficking because at that time we didn’t have legislation against human trafficking...

The legislation was rather a tool for tackling prostitution, trafficking and organised crime. Essentially the legislation came about as a reaction to violence against women and as prostitution, trafficking and organised crime can encompass violence against women, then it was decided that this legislation should be used as a tool.
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...I think it’s easier to talk about the trafficking but then we are talking about people who are forced....we are talking about modern slavery, we are talking about maybe minors who are into it and shouldn’t be of course... When it comes to prostitution it’s more this discussion about your own free will, existential questions: Is it possible for a person to choose this or not?

The agency felt that having strong law enforcement can often deter from the social perspectives which were most important. The discussion should not be about whether the person chooses prostitution or not but rather why they have chosen this. This is often linked to poverty or financial vulnerability.

...Yeah, so I think we will always have people who say that they will do this and this is great to do but if you follow the persons and then you can look at the history behind poverty, financial and social security, it’s a minimum of this in most of the backgrounds...

The 36 task action plan for addressing prostitution in Sweden emphasised multiagency work existing under a national plan which created national rehabilitation programmes and information campaigns which raised public awareness and support for women who wanted to exit prostitution. It was a social policy issue according to the Swedish agency.

The discussion should not centre on risk per se; the discussion should concentrate on the 90% of women who say they would prefer to have another option. Swedish legislation on prostitution does not condone the choice to do prostitution, but preferred to understand why and support those who wish to leave by providing proper infrastructure.

...And with my background on an operational level I could say that, as I mentioned before, in my opinion of course if you make this choice I wouldn’t say that it’s a good choice but I wouldn’t be too aggressive to try to change your mind...

The Swedish model prided itself on its social model for health and embraced a holistic approach to care and support.

...but at the same time what we are looking for is that the person with money in their hand who pay, or have the possibility to pay to use of another person’s body and
then we have this group who needs the money and mostly we can say that without the demand we wouldn’t have this problem...

Therefore, the demand needed to be eradicated by virtue of criminalising the buyer and supporting the seller. High demand also created criminal organisation.

... So that’s why we are looking at the demand and also of course when we have the law enforcement perspective again we can see in many times in the bigger cases that we get here we could see a close link to organised crime...

The Swedish legislation seeks to include the broader population of prostitutes and aimed to create general equality. However, as many women in prostitution were no longer just from Sweden but rather cross boarder countries, the issue then became tied up with the law enforcement and the issues of migration.

... But today we still have the Baltic girls and of course some from Russia but the bigger part is from Central Europe.

The findings suggested that this model is effective from the perspective of the Swedish agency.

*Well the numbers are of course very low...*

It is not realistic to think that prostitution no longer exists in Sweden, as the agency asserts, as with any law there remains exceptions.

...It would be stupid to think that this legislation would make it impossible. I think it’s more of a statement from society that we say that we want to try to protect our women and children and of course young boys and men also in this kind of business.

For this reason, prostitution remained on the political agenda and within social policy in Sweden.

...but sometimes, like with this I would say once again the majorities...it’s so much it is one of so much on the society this kind of business or doing too much bad things to the society so I think it’s a good thing that we make a statement from the government side.
For Sweden, the model worked because they had the support and backing from the government.

The Swedish agency emphasised that where a woman or, indeed, a man chose this work, it was their choice but this was not wholly the discussion as the majority of women in Sweden involved in prostitution chose prostitution as their ‘other’ choices were limited. A democratic society favoured majority rule, so in this case this principle must remain.

Health services:

Healthcare for women in prostitution in Sweden

The health issues identified by the Swedish agency included HIV and a range of sexually transmitted infections. Although Sweden boasted a good infrastructure of support for the women, their concerns centred on meeting this population’s long-term needs.

...Yeah, yeah, psychologist or a therapist, that wouldn’t be a problem. The problem is that what kind of, I mean what we need to think about here how long is this person’s involved?

Options were available for the women to take up another job or training, but in most incidents the salary or estimated income did not match the money they were generating from prostitution.

...They are making a lot of money. At the same time when we offer some other kind of work, it will be less money of course. It will be may be a third, or just twenty five percent...

The longevity of the intervention was seen as crucial to the Swedish agency.

What can I offer even in the longer term?

For the agency these factors needed to become part of the exiting solutions for the women.

After some information you give them the right, proper information and tell them about the Swedish legislation and how we look at it, they are really surprised
sometimes and they are happy to hear that we look at it from this side or from this point of view, because they said ‘I thought I was a criminal’...

Sweden had three specialised units within the social welfare system in the country specifically to meet the needs of women involved in prostitution all of which came under the National Task Force. The objective of the National Task Force was to ensure effective communication between the units. This way, all supportive bodies were working in unison and also became familiar with the women themselves and coordinated the sharing of information etc.

..So they can support the rest of Sweden of course, if they need some kind of support in the case in the North of Sweden they can contact me and I link them to one of the prostitution units

There was a strong social perspective linked to this healthcare approach. The Swedish agency confirmed that it was easier to seek care for those who were identified as trafficked and he was keen to add that not all trafficked people saw themselves as trafficked or victims.

...in the first part because they don’t know anything about the legislation, they think that they have made a bad agreement maybe ...or maybe they are willing to make this bad agreement just to get into Sweden, or Western Europe.

In Sweden, healthcare providers were educated on the issues of prostitution but the agency stated that it was more complex than this. Education and training was one thing, but unless this training and education was put into proper structures then it held little significance. He stressed that face to face work was essential to supporting the women.

...I think this is really important because without the contact with the client you would never learn and you would never put your theoretical knowledge in a practical way...

There were support workers who were the first port of call for the women and they acted to make appropriate referrals and follow up interventions on behalf of the women. It was evident that their initial presentations or diagnoses were addressed first, such addiction, abuse etc. But this is addressed within the context of their lived
experiences within prostitution. The Swedish agency added that in Ireland, local agencies did not have resources and more often did not ask the questions such as *`are you involved in prostitution?`* Because they did not have the resources or indeed the information to proceed further with this.

...even to girls who are drug addicts, young girls with drug problems, they don’t ask it because they didn’t know where to go with the information...

...You have to veer to ask the question...are you selling sexual services or have you been abused or whatever but for many years people don’t even ask those questions...

In Sweden it was the role of the agency to explore all the issues and formulate a paper trail. For example, where the woman was from? Did she have anyone she knows already in the country? Were young girls presenting earlier with addiction problems? All these factors map the women’s entry into prostitution and could highlight concerns such as organised crime, trafficking etc. Family breakdown and/or a history within the care system as a minor could be identified. The Sweden State attempted to approach support for the women by examining the whole picture as a life course approach. This was supported by social policy, legislation and government.

*Can Ireland learn from Sweden?*

According to the Swedish agency it was not just a case of training every healthcare practitioner. This was not realistic and so the key was to place training and education amongst its professionals

...I mean you could say all doctors, all nurses, everyone should know everything about prostitution and trafficking. No it’s not possible? You wouldn’t

Sweden had a National Cooperation Plan via government and social policy and this fed into the National task force. Another key focus was to identify particular issues such as drug use and prostitution for example: asking the questions, was there addiction before prostitution? Or did this addiction develop after entering prostitution?

*And in some cases in the years that I worked you can see that it started with these sexual services before they started with drugs so maybe it could be a problem here to*
look out for, maybe they started with drugs because of they were assaulted or they were abused or whatever...

This was the key to understanding drug use and care holistically. The agency was using drug use as an example for issues that could present or more importantly the issues that existed before entering prostitution. Early intervention was crucial and part of the Swedish healthcare approach. They used a health promotion model of care: education, prevention and outcome.

Conclusion

For the Swedish government the issue began with violence against women which came to include prostitution. The government there use this legislation as a ‘Tool’ for trafficking for the purpose of sexual exploitation and they now recognise the need for further discussion and new approaches to include the phenomenon of migrant workers as the agency stated that women who were in Sweden illegally could not access support currently.

...and at this moment we will look for other forms of exploitation. It’s a lot of...we have berry pickers, we have problems with the berry pickers, and we have problems with the Tinkers from England and sometimes from Ireland...

The government in Sweden recognised the potential investment to the economy by opening its boarders to migrant workers who earned less money and work seasonally, yet located the complexities for other social deficits within Sweden, such as prostitution, undocumented populations and organised crime

...It’s all forced labour, it’s part of the deal with the open borders, I mean we have a lot of people coming here so I think it will be the next big issue...

Such factors created demand and remained the central focus of the Swedish model.

Yeah. Yes. I think this is more a political question that we have to discuss with the open borders and the possibilities to travel as you like, you also have to see that the difference between our countries are huge and people don’t realise.

The Swedish government recognised that an open boarder policy and the right to travel was a good one that they shared with most European neighbours. However,
were women remain excluded from the debates within their own countries of origin; they remain subject to poverty and poor education attainment which remained an ongoing issue for Sweden according to the agency. It remained an issue as women knew or heard that they cannot be criminalised for prostitution in Sweden, but irrespective of this, Sweden remains firm on criminalising the buyer of sex only.

...people sometimes ask, ‘why don’t you criminalise prostitution too’? I would say that you can’t criminalise a person who don’t make a criminal act... Yeah. So that’s why we don’t close the door to these girls who can’t...and of course they can run their business here but we try to get them out...

The findings from this chapter will be discussed in the next chapter considerate of the literature and an ecological approach to locating the psychosocial experiences of women involved in prostitution.
5.1 Introduction

The previous chapter presented the findings of the two stages of this study. This chapter intends to discuss the findings inclusive of the literature to answer the research question. Health Promotion has been defined by the World Health Organization's (WHO) 2005 Bangkok Charter for Health Promotion in a Globalised World as ‘the process of enabling people to increase control over their health and its determinants, and thereby improve their health’ (Ottawa Charter, 1986). Therefore, to adequately address this, prostitution needs to be assessed in the context of its environment or ecology. Thus, to consider a social ecological approach to prostitution lifestyles, behaviours and patterns, it became necessary to develop a perspective that included the external or structural determinants of health such as social, political, economic and environmental factors. To address this, an ecological framework was chosen.

Bronfenbrenner’s (1986) model of the Ecology of Human Development serves to give attention to both the behaviour and lifestyles of the individual while realising the effects of environmental determinants. Bronfenbrenner divided environmental influences on behaviour and lifestyles into the micro, meso, exo and macro levels of influence. The micro system refers to face-to-face influences in specific settings, such as interaction with one’s immediate family, informal social networks or groups. The meso system refers to the interrelations among the various settings in which the individual is involved. These maybe family, schools, peer groups and church. The meso system is the system of microsystems. The exo system refers to forces within the larger social system in which the individual is embedded. Examples might include unemployment rates which effect economic stability. The macro system refers to cultural beliefs and values that influence both the microsystem and the macro system (Mc Leroy, Bibeau, Steckler and Glanz, 1988). The discussion chapter critically discusses the ecological model to explain the psychosocial experiences of women involved in prostitution, with the added layer of ecofeminism to secure that a gendered perspective to the ecological approach and the experiences of women involved in prostitution are located within a feminist framework, and ultimately, to
suggest a solution to delivering necessary health services and provisions for women in prostitution. The findings outlined in chapter four are discussed here with respect to the Voice Centred Relational Model of data analysis which promoted and ensured that the 'voice' of the women remained at the forefront of the discussion.

The model below represents Health Promotion Actions as set down by the Ottawa Charter (WHO, 1986), to build healthy public policy, create supportive environments, strengthen community action, develop personal skills and last but not least reorient health services. To achieve these actions, it is important to locate the individual within an ecological framework.

![Ecological model](Office of Behavioural & Social Sciences Research, 2013)

Figure 5.1: Ecological model.

This chapter is divided and discussed in the following way: the first section explores family, representing the micro level, drawing from the findings and literature provided in the literature review. The main discussion will centre on the findings which identified the relationships which the women involved in prostitution engaged with in face-to-face contact, including family members and other women also engaging in prostitution. This will also include migration and its impact on family and the experiences of the women. Section two discusses health with respect to the identified health needs of the women themselves, alongside health services and health policy. Section three discusses the current legal framework to include its impact on users of prostitution, pimps and those involved with the women as criminal players, dealers and organisers of prostitution. This section also includes the
Chapter Five: Discussion

Gardai and their role in prostitution. Section four critically assesses the role of the Swedish model as a perceived tool for Ireland to combat prostitution and human trafficking. This model has been chosen within the discussion because as mentioned in the literature, the Irish government, influenced by national agencies (the agencies which participated in this research) are advocating implementing this model to address prostitution in Ireland.

Conclusion and recommendations are provided and state the case for implementing an ecological framework to address the psychosocial experiences of women engaged in prostitution also, to further adapt an ecofeminism justification to enhance wellbeing within prostitution and the Irish healthcare system.

5.2 Prostitution and the family

5.2.1 Family breakdown

To consider the micro system in relation to prostitution, this section examines family breakdown and if the consequences of this can impact on ‘pushing’ women into prostitution, as highlighted in the literature. The first part of this section focuses specifically on family breakdown by using Hardiker’s (1991) scale for level of need for intervention and support: Level 4 primarily focusing on the dysfunction level of a family of severe nature. Prostitution and dysfunction at a micro level was identified in the literature where family breakdown occurred and the care system stepped in to provide care for the young person. The literature highlighted the expanding consequences of family breakdown to include child sexual abuse and physical violence, homelessness, poor education attainment and addiction. By assessing the literature alongside the findings, ‘the voices’ of the women within an ecological framework, the discussion needs to understand family breakdown as Bronfenbrenner suggests; ‘what happens to an individual in his or her family, can only be understood by the relationship of the family to society at large’ (cited in Muuss, 1996, p. 338). According to Crespi (2003), the family is gendered and gendered roles impact on socialisation. For this reason ecofeminism must be included within the discussion as it arguably requires analyses of ecological theory to include a gender discourse within its framework to both understanding the family in relation to society, but more specifically societies relationship with the family (Besthorn, 2002).
5.2.2 Family breakdown and the care system

Within their stories, the women explored their relationships with their families and in particular a family member that caused them to leave home. Emma shared the experience of her brother’s death and how this greatly impacted on the family as a unit, they struggled to support one another through their grief and Emma spoke of how she was particularly close to her brother. Lynne also talked about her relationship with her parents and how she felt excluded; it appeared she did not feel comfortable with her relationship with her father. Her parents decided to move and she decided not to move with them. Her parents moved anyway and her father continued to remain in the family home which left her no alternative but to separate herself from them. This relationship scenario was not uncommon; as Mary also told how she came from a financially stable home, but her poor relationship with her father also meant she felt she could no longer stay at home. Although she felt close to her mother, this relationship was not strong enough to override her relationship with her father.

Bronfenbrenner (2009) suggests the family does not exist in isolation but rather with the wider society. Ferree (2010) argued that, contrary to popular perception, the family is not a private sphere which is immune to the inequality that exists in wider society. She believes that family cannot be understood separately from the economic, political and other systems of male power. For this reason, the family is connected to all the systems which have the power and influence through public and social policy, legislation and equal rights for its members, as she further questioned the assumption that families are singular units where men and women share a standard of living, class, position and set of interests. To consider the Irish constitution (1937),

The state therefore, guarantees to protect the family in its constitution and authority, as the necessary basis of social order and as indispensible to the welfare of the nation and the state

(Article: 41.2.1 and 41.3.3)

This clearly frames the family unit in the context of an ecological model. As Eshleman (1997) concluded, the family will never be an egalitarian institution while women remain dependant on men for resources and status. For this reason,
relationship breakdown within the family must include gendered family policies and supports whereby the most vulnerable within that unit is not the one who must leave. Otherwise, there remains a possible link between family breakdown and prostitution.

Although the family is recognised as integral to society through community, policies and law, we need to hear the stories of the women and their voices which resonated that they had to leave the home as opposed to the cause of the conflict. For Mary and Lynne, the person who was causing them stress and grief remained in the family home. An expanded ecological framework must also advocate for an alternative vision for a good life (Besthorn and McMillen, 2002). According to the Children First Guidelines (1999), where the interests of the parents and child or young person appear to conflict, the young person’s interests should be paramount. However, in this case, for Lynne or Mary this failed. As a consequence of this their options became the care system and homelessness.

Sanders (2001) identified that 38% of women involved in prostitution had spent time in local authority care. A more recent study by Thompson (2005) identified 21% of the women surveyed had care backgrounds. The findings here suggested that some of the women involved in prostitution today, had experienced family breakdown and the care system. Women working on the streets such as Emma, Mary and Lynne and to include Niamh, who worked indoors and who was of foreign national status, they talked of becoming homeless before the age of 18 and having accessed emergency shelter and supports.

Coy (2008) stated that 50% of young women leaving the care system either prematurely or without follow up interventions became engaged in street culture and become involved in prostitution through introductions by their peers within the street setting. They identified themselves with other young women who were selling sex. The story of Mary, who was 17 years old when she experienced family breakdown, is consistent with this view. Mary met a friend while staying in emergency hostels who introduced her to street and brothel prostitution. Niamh also reaffirmed this in her story, she never felt connected to her family and stated that she left home very young and always took care of herself.

Thus, care systems for this age group failed to meet the women’s needs. This in itself was a distinct finding. Mary talked about leaving home at 17 years of age and her
Chapter Five: Discussion

experiences with social services as a minor under the Child Care Act (2001), which was an emergency accommodation placement only. She felt that this was inadequate and simply provided an introduction to street culture and prostitution. Her story outlined how she left the care system voluntarily.

This presents a failure, or a gap, in the care system for teenage or young women experiencing homelessness. Emergency accommodation for this age group does not accommodate the care and attention that these young women require to keep them from the streets but rather facilitates the ‘push’ factors into street culture. It was important for me as a researcher to explore family breakdown and the care system as I previously worked with young women experiencing homelessness and the care system who were engaged in juvenile prostitution. They had been groomed through street culture and, indeed, through meeting other girls within the emergency accommodation setting who introduced them into prostitution. It was interesting to learn from the findings that this is still the case ten years later. The literature identified poor care provisions and periods of homelessness as responsible for women becoming involved with exploitative men and lifestyles (Melrose et al., 1999; Home Office, 2006). Such risks factors created environments where some women can be coerced into prostitution and drug taking through developing ‘romantic’ relationships with local pimps (O’Neill, 1997). This clearly remains evident of prostitution in Ireland today.

If we are to adhere to the notion that ecological/systems models of social and healthcare practice conceive of problems in living as a result of stress associated with inadequate fit between people and their environments (Besthorn, 1997; Kemp, 1994; Kemp, Whittaker & Tracy, 1997; McDowell, 1994) than these are set out within the ecological/systems tradition. Women like Emma or Mary, to name a few who found the micro systems to have failed, needed a ‘new fit’ between their person and their new environment. Ireland today, when a young person becomes homeless, they are to be cared for with alternative supports under the Child Care Act (2001). According to the Children First Guidelines (1991), if the child's parents/carers cannot be contacted, the health board is obliged to take such steps as are reasonable to offer the child accommodation, pending further assessment. A consequence of this has been Section 5 of the Child Care (1999) Act which was envisaged to be an
emergency measure to respond to the accommodation needs of homeless children. However, in practice children remain under Section 5 and in emergency hostels for considerably longer periods of time (Ryan Report, 2009), which directly affected the young women in this study. It is clear from previous and current policy and legislation that an individual is understood in respect to their social environment, however, one of the most poignant critiques of conventional ecological/systems theory rests on its heavy reliance upon personal or individual adaptive processes as the cornerstone of stable system. The expectation is for the young person to adapt to their available options. It is clear from the Ryan Report (2009), and the stories told by the women that this is not effective.

Ecofeminism calls for a `care system` not to be shaped to meet all as one, but rather, without a feminist analysis of social domination supports necessary for full human development remain compromised (Fook, 1993; Gould, 1987; Kemp, 1994; Kemp; Robbins, Chatterjee & Canda, 1998; Whittaker & Tracy, 1997). The literature talked about how women’s experiences of the care system and homelessness are different from boys such as the care system as presenting risks, primarily peer introduction to exploitative men and lifestyles and the lack of support networks available to care leavers (Melrose et al., 1999; Home Office, 2006). The women’s stories of street culture, and grooming as discussed in particular by Mary and Emma, mirror this. Therefore, it is not enough to expect the individual to adapt to the current dominant environment but rather adapt an ecofeminism, gendered analyses of homelessness, care and policies and legislation. The stories told suggested that the young women’s environments after leaving home also played a pivotal role in their entry into prostitution.

5.2.3 Family breakdown by migration

This section discusses family breakdown in respect to conflict migration and forced separation. This is when the main care giver, usually the mother, leaves the family home to migrate to another country to find work to support her family. The findings represented an overwhelming amount of women working in prostitution in Ireland to fit this profile. Migration itself is an example of how individuals interact with their environment at all levels.
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Table 5.1: Summary of backgrounds of Prostitutes in Ireland in 2012

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sex</th>
<th>Nationality</th>
<th>Age</th>
<th>Status</th>
<th>Type of Service</th>
<th>Dependants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Female</td>
<td>Brazil</td>
<td>33</td>
<td>Undocumented</td>
<td>Escort</td>
<td>1 child in Brazil</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td>South Africa</td>
<td>34</td>
<td>Seeking Asylum</td>
<td>Street worker</td>
<td>2 children in S. Africa</td>
</tr>
<tr>
<td>3</td>
<td>Transsexual</td>
<td>Brazil</td>
<td>21</td>
<td>Student Visa</td>
<td>Escort</td>
<td>None</td>
</tr>
<tr>
<td>4</td>
<td>Female</td>
<td>Ireland</td>
<td>22</td>
<td>Citizen</td>
<td>Escort</td>
<td>None</td>
</tr>
<tr>
<td>5</td>
<td>Female</td>
<td>Nigeria</td>
<td>25</td>
<td>Seeking Asylum</td>
<td>Escort</td>
<td>None</td>
</tr>
</tbody>
</table>

The table above shows a significant shift since 1995 in relation to the profile of women involved in prostitution to date. They are primarily foreign nationals, including: asylum seekers, refugees, holiday visas, student visas and undocumented populations.

This deconstruction of the family unit can impact on all its members, in particular the women who have to move for financial necessity. The literature identified 51 different nationalities of women involved in indoor prostitution in Ireland (Immigrant Council of Ireland, 2009) and of them; nearly 40 per cent of migrant women in prostitution who attended the Women’s Health Project (HSE) in the last few years had children. Only a minority of the women had their children residing with them (Immigrant Council of Ireland, 2009), which, too, was consistent with the findings. As Brennan (2004) outlined, women involved in prostitution through migration are independent and dependant at the same time, they are resourceful and also exploited. The women were local agents who were caught up in a web of global economics.

The findings identified a high number of women working in indoor prostitution in Ireland to be foreign nationals. The women presented as seeking asylum,
undocumented, on student visas or having the right to travel freely through European borders under the Freedom of Movement Act. The women talked about family separation in the context of their situational circumstances for entering prostitution, in particular, Bridget from Brazil became very emotional talking about her son who was living in Brazil with his grandmother. There was no male figure within this extended household and Bridget had become the sole earner to provide money for food and her younger siblings’ education.

It was clear from the findings that the women saw Ireland as a place of opportunity and to escape conflict or poverty in their countries of origin. From 1995 to 2000 more than a quarter of a million people migrated to Ireland to avail of its prospering economy (The CSO office, Population and Migration Estimates, 2000). This phenomenon included women on the move globally whilst leaving their children in the care of relatives back home (Ehrenreich and Hoschschild 2004). Migration policies at a macro level indicate restrictions on individuals travelling to Ireland which, according to the local agencies working with refugees and asylum seekers, has enforced poverty. Such agencies endeavour to work with this population with limited funding. One agency in particular felt strongly that this group were particularly vulnerable to prostitution and poverty. Ireland is only one of two states that do not permit asylum seekers (at some stage in their asylum application) to work. The Government acknowledges the problem as regards long term ‘residency’ in direct provision centres (European migration network, 2012), but has yet to address it. Therefore, on achieving refugee status, this population have been deskilled and issues of mental health and wellbeing are often prevalent (McDonnell, 2009). Further to this, for example; women entering the country from Brazil may enter on a holiday visa, but this visa only extends for a certain period, As Anna explained in her story, she came into the country on a holiday visa, became involved in prostitution to send money home to her children, her visa ran out and she chose to become undocumented. Local and national agencies spoke of how they, too, were aware of this new phenomenon of ‘going underground’. Clearly, some women became hidden to services, and services are limited in their ability to help them as agencies were working within the limitations of national policies and guidelines. This is a crude example of how individuals are not only shaped by their environments but as a limitation of the ecological model itself, the women must do
the ‘adapting’, as opposed to the environment adapting to their needs. Such migration policies, as discussed in the literature, support migration, cheap labour and economic benefit to the country, but the darker side of migration is exploitative by governments, reiterating Brennan’s (2004) argument; women involved in prostitution through migration are independent and dependant at the same time, they are resourceful and also exploited. The women were local agents who were caught up in a web of global economics. However, seeking a social ecological framework has the potential to enhance health promotion and social work approaches to practice by understanding the broader determinants of women involved in prostitution. This can be understood and developed far better by reviewing this model through an ecofeminism lens, as migration itself is gendered.

International migration is seen as part of a revolutionary globalisation process which is reshaping economies, political systems and our whole cultural parameters (Munck, 2008). The author added that migration is not unified as presented by the economic theory of migration as one dimensional and centred on reductionism and a neoclassic model of the rational individual, but rather this model escapes the realisation that migration is subject to gender, class and culture. As Urry (2000) comments, those outside a unified model of migration such as the economic theories of migration are difficult to categorise. Munck (2008) seeks to explore the family theory of migration in respect to gender and the family. Here the family is the core decision makers in the process of migration rather than the individual. For instance, what is in the best interests of the family for a member, in particular the mother, to migrate? As Munck (2008), states: ‘we need to unpack migration’ (p.1233). The findings of this research clearly identified migration as a gendered issue, which is supported Ehrenreich and Hochschild (2004), stating that women are on the move globally now more than ever. The women had families left behind in their countries of origin and it is these families that are the driving force behind their decision to migrate. For a minority of women this process can be an empowering experience, but as migration is gendered, as are the lines of the labour market, for most women the experience was migration into domestic labour or the sex industry subject to isolation and exploitation and remained outside of labour market provisions (Ehrenreich and Hochschild, 2004; Munck, 2008). The findings supported this as the women who were involved in
prostitution in Ireland while their children remained in their country of origin, felt their choices were limited and prostitution would not have been their first option.

The majority of the women were of single parent households and were solely responsible for their children’s material needs and wellbeing. The women interviewed for this study expressed sadness and despair by being separated from their children and felt it were their sole responsibility to earn money for their families back home. Although migration was a means to do this, migration itself can choke and diminish the family unit.

Women migrating to Ireland and existing outside of the parameters of normal society and the labour market suffered from family separation and family disconnect, along with stringent gendered migration laws which have detrimental consequences for the health of the mother and child. The psychosocial impacts of family separation are clearly mapped out by the women. Migration itself is a determinant of the women’s health and wellbeing alongside that of prostitution. If we are to accept that migration is a consequence of neoclassical economics, then the migrating family should be understood as existing within these larger macro environments.

At best, if a woman is identified as working in prostitution and of illegal status, her alternative is deportation. It is clear that the national agencies are advocating for a ‘Swedish type model’ to decriminalise the woman involved in prostitution as they all agreed that women were not accessing services for their health and wellbeing. However, a strong contradiction here was given by one national agency who stated that ‘we shouldn’t be mixing our obligations towards global inequalities with prostitution’. These particular agencies were advocates of migrant rights and women involved in prostitution. These services fail to understand the gendered nature of prostitution, and how the women they were working with came to be here in the first place as part of the global migration web. Using an ecological framework, it is possible to address the person within their environment perspective. Using an ecofeminism layer would show how, in this incident, services are not adapting to the migrant individual’s needs. Likewise, national agencies clearly advocate a ‘Swedish model’, yet, in interviewing the Swedish agent, he too added that they have not created yet sufficient strategies to address migrant women working in prostitution in Sweden. So why are national agencies advocating for this legislative approach at the
expense of excluding service provisions and health supports? This was not part of the discussion for the ‘Discussion Document on Future Direction of Prostitution Legislation’ (2009), it has, to date, still not emerged as part of the discussion within agencies and policy makers, and it remains to date only discussed and assessed within this study. As a consequence, services throughout the country remain limited and constrained in what they can do for this group.

5.3 Prostitution and health

5.3.1 Biomedical model

The biomedical model of health works on the principle assumptions of neoclassic economics, individual responsibility absent of the individual within their experiences, events and the environment which influences life choices and experiences (Heywood, 1998). From the literature it has been confirmed that, as a major power discourse, biomedicine impacts on health policy, education and institutional structures. Health equity should extend to equality of access and equality of utilisation to consider socio-economic circumstances and an ecological interpretation of need. For women involved in prostitution it has been recognised from the findings that the women are more likely to go nowhere to seek health support because there is nowhere for them to go specifically that meets their needs. The women told in their stories of how they only accessed and knew of the WHP in Dublin so while they were travelling throughout the country, they refrained from accessing any type of care outside of an acute, emergency environment. As the women were not consumers of healthcare within the Irish two tier health care system, they were inhibited from being included. They did not have equal access for the reason of lower socio economic backgrounds and/or migrant status. Orla, in particular, talked about this as barrier, as a Kenyan refugee who now holds Belgium citizenship, she often travelled back to Belgium to address any arising health concerns as she felt the health service in Belgium was more accessible and more familiar to her. She did not want to access health in Ireland, apart from the WHP. If health is measured by equality of utility, then this is hindered too as, services do not filter through to outside of the capital. If we draw from the literature that social-political reasons are determinants for entering prostitution such as poverty, drug use, sexual abuse, pre-care (Coy, 2008), and that due to the current nature of prostitution
women in prostitution are suffering addiction, mental health, poverty and/or violence, they can access supports nationally for these conditions, but not in the context of prostitution. From the findings it became clear that in Galway city local agencies working in the field of women and rape, homelessness, migration/asylum and poverty, although experienced in their field, were not equipped to address or support the needs of women in prostitution in their jurisdiction. This is best explored under the headings of equity outlined in the literature: distance, voice and health beliefs and health seeking behaviours.

**Distance**

Both the literature and the findings confirmed that prostitution in Ireland is not isolated to any one geographical area but extends to all pockets of the country (Immigrant Council of Ireland, 2009). This was also confirmed within the national agencies interviews as well as the women’s stories. Furthermore, the prostitution profile is no longer a small drug using street population alone with needs centred solely on addiction and sexual health required services as previous, outdated research identified (EUROPAP, 1996; O’Neill, 1997; O’Neill and O’Connor, 1999). The issues now extend to migration, underground activity and touring populations. Their health needs are determined by their psychosocial experiences and location. For these reasons, distance needs to be acknowledged as a barrier to accessing health. The local agencies could not and do not provide a service for women involved in prostitution. As services are not unique to the women’s prostitution needs locally, this is an identified group consistent with inequality of access and service utility as proposed by Dixon-Woods *et al* (2003). Dixon-Woods *et al* (2003) make the distinction between access and utilisation of services. Equality in terms of access requires only that all individuals in need have the same opportunity to use the health service. Equality of utilisation requires that people actually use the service. Local agencies within this study, argued that there was a need for services locally for women involved in prostitution because in their professional view they believe that women who accessed their services may be or are vulnerable to prostitution. They were aware of the issues but felt restricted in the care they were able to offer. For this reason, it becomes imperative to locate distance within an ecological perspective. Irish health policy is based on a two tier system of public versus private. This is the
starting point of inequality. Privatisation is justified on the basis that it takes pressure off the public health system. It could also be interpreted that it is in the interest of the private (largely for-profit) health care providers for the public health system to fail, that building up and funding private health care undermines the public system (Burke, 2009). Not only do the women fit into the public category in accessing health, they travel around the country to meet clients, and yet services locally, either do not come in contact with this group or as a consequence of health policy are not in a position to meet their needs. These measures hit hardest those with least income who are also those with the poorest health, who need services most. To assess this from an ecological position, health policy should adapt to locate the individual within their environment to consider universal healthcare of equal measure throughout the country. Health policy needs to incorporate such factors. In recessionary times, people need quality, public health services more than ever. However, if budgets continue to be cut, staff numbers and places of care reduced, the cuts will continue to impact on those who have the greatest need for services (Burke, 2009). This is not just for women involved in prostitution, but rather all populations existing on the periphery of current health policy.

Voice

According to Dixon-Woods et al (2003), often minority or disadvantaged groups are less likely to express their views or opinions to healthcare professionals and this is often a problem in measuring access to healthcare, as their voices are not represented. The attitudes and views of the healthcare practitioner thus remain the powerful discourse. If we consider the methodology used in this research, a feminist epistemological standpoint within a Voice Centred Relational Model of analyses, which focused on drawing out the voice of the participants and highlighting what they see their needs to be, this method as a tool can influence the worldview of the practitioner. Often practitioners are middle class, and removed from the lived experiences of those they administer care to. They cannot claim to fully know these experiences. In Galway city the local agencies expressed concern in not knowing the voice of the prostitute, this along with limited training and information on the subject of prostitution in Ireland and locally left them inexperienced and ill-equipped to address this with service users or indeed the staff members working within the agency. Such limitations meant that they as support services could not provide an
advocacy role for the women involved in prostitution locally, and therefore, the women remained excluded from services and hidden for these reasons. Health promotions actions (Ottawa, WHO, 1986), states advocacy as an action for healthcare and health promotion practice, yet practitioners continue to play a limited role on behalf of women involved in prostitution locally.

National agencies in this study argued that prostitution is harmful and all women are victims. This is reflected through the ‘Turn of the red light campaign’ (www.turnofftheredlight.ie), a national campaign run by an alliance of civil society organisations, unions, non-governmental organisations and individuals. Its objective is to end prostitution in Ireland. However, this campaign does not address or appear to acknowledge the broader context of prostitution as discussed by the women in their stories within the research of family breakdown, migration and poverty. An ecological framework seeks to locate these concerns and to understand prostitution in this context. The voices of the women which were identified within this campaign are presented as victims; ‘I feel like nothing. I feel dirty. I feel confused and upset all the time. I want to get out of this work. I want a normal life. I am tired of all the lies... lies, lies, lies to everyone, to my family, my friends’ (www.turnofftheredlight.ie). Although this story is real and will mirror the voice of lots of women involved in prostitution, in particular women trafficked for the purpose of sexual exploitation, this is not in keeping with the objective of giving all women involved in prostitution a ‘voice’ to empower them and include them in the solution for change. For example, one leading national agency representative talked about the women having ‘no agency’, yet within the findings, the women themselves talked about family, friends, cultural values and experiences which all suggested agency and a sense of identity. Furthermore, the women spoke about their involvement in prostitution as a choice; a choice most often influenced by family breakdown, poverty, migration; nevertheless they used the word choice. Therefore, findings from this study suggest that women in prostitution do have an agency. It is clear that the reasons for their choices were the determinants for prostitution, and leads the researcher to argue that these reasons need to be addressed by social policy and legislations on migration and so forth. It is naïve to seek an end to prostitution without exploring these choices through the lens of the women involved. The women involved in this research were not victims but rather subjects of circumstances
affected by their environments. An ecofeminism approach also acknowledges that the women alone cannot adapt to their environment of already shaped policies and conditions, but rather such policies and conditions need to adapt to them and their reasons for entering prostitution.

**Health seeking behaviours**

As outlined in the literature, women involved in prostitution in Ireland were slow to seek out healthcare and support (WHP, 2007). This is also true as the findings suggested that the women were less likely to access health services because of limited availability, illegal status, illegal practice and the nature of a chaotic, on the move existence. As a result, many of the women relied on self-diagnoses and self-care without appropriate professional intervention. Fiona brought this to the discussion within her story as she talked of women remaining quiet and possibly using alcohol or drugs to numb their pain. Such health seeking behaviour was a consequence of the law, illegal status and stigma. This was reinforced by current health policies and cultural values and norms of Irish society. Prostitution remains illegal and health services do not currently have the training or facilities to address the specific needs of this group.

How the practitioners colluded with this is important to discuss. The local agencies felt strongly that there was a need for support locally but they felt their hands were tied in respect to funding from government which often dictated the direction of their practice. They, too, were subject to the constraints of neoclassic economic driven health policies which reinforced victim blaming and individual responsibility; in fact, they too felt victim of health policy and guidelines due to the same constraints which meant prostitution care itself was practically non-existent. Although they felt they had a huge health promoting role, it in itself was limited as policy affected staff numbers, security of contracts, specific duties etc. As a consequence, they felt there were definite barriers and continued exclusion for this group. The ideal solution would be gendered policies specific to vulnerable women and their broad sense of need. For example, agencies locally working with homeless women, identified concern that this group was or could become involved in prostitution. One local agency in particular made the direct link between child sexual abuse and prostitution, sexual abuse and prostitution and asylum seeking women in the city with limited
social support and histories of abuse that were of great concern. Another local agency discussed the migrant population as being vulnerable to prostitution. All the agencies emphasised a holistic approach to care and an understanding of the social determinants that impacted on their service users’ psychosocial experiences.

Women in prostitution are primarily migrant or Irish women from lower socio economic backgrounds. As health policy continues to support victim blaming and a lack of acknowledgement for the person within their environment, women in prostitution will remain excluded and hidden. If we consider the health promotion actions as a framework for care, we must first recognise and come to address the power discourse within health, only then can health promotion move forward in reorienting health services, but also to create a knock-on effect on developing personal skills and strengthening communities. This needs to begin with building healthy public policy. Government policy is the framework for local services, and here it appeared that local services are constrained by macro policy and expectations. This was clear as each agency was required to have an agency policy, which in a way is a miniature tailored version of government policy. Local agencies did not have guidelines that included prostitution or prostitution service provisions.

An ecological understanding of the determinants of health can open the pathway for further discussion and research on this issue. This along with a gendered, eco feminist framework for health promotion can begin to seek solutions for the multifaceted needs of women involved in prostitution throughout the country by providing an overview of their lived experiences within the layers of their environment rather than just the individual as responsible alone. What the women are saying is in direct contrast with current healthcare services. This has been further supported by adding the views of agencies working in the field of women in Ireland to highlight an existent need, yet with no appropriate interventions. Its implications for practice are continued social oppression for this group.

5.3.2 Economics

The current economic framework in Ireland has been decided upon as a neo classic economics which equals free market and individual responsibility (Heywood, 1998). Economics as a macro system and its relationship to health and health policy has already been discussed in the previous section (biomedicine). Nevertheless, if an
The key issue here is individual responsibility as Heywood (1998) pointed out; this notion has led liberal thinkers to view society as simply a collection of individuals, each seeking to satisfy one’s own needs and interests. Agencies, both locally and nationally, were forced to align with this view. For instance, it is clear from the findings that both local agencies and national agencies essentially work in isolation. There was no formal network for sharing information; this again depended on agency management, their foresight, or indeed, their agency constraints. For example, a national agent talked about her role in her particular forum (Dignity Report, 2009), which was to bring together all agencies with similar interests on the subject of prostitution. It was concluded that different agendas and budget interests
alike prevented agencies from working together. The main objectives of this programme were to get the NGOs and statutory bodies in the country to work together. It was centred on the principle of sharing information and to alleviate stress for the women who were actively engaging in or attempting to engage with different organisations. However, despite the concluding recommendations the HSE refused to sign up to this. According to the national agent, the HSE responded by forming an Anti-Trafficking Team which was set up independently as a separate department, separate from the already established Women’s Health Project (HSE). Such views do not align with an ecological theoretical interpretation, in that the individual is part of a wider system including family, community and society. This, in turn, reinvents the notion of individual accountability and thus, within welfare and health services a ‘deserving versus undeserving’ dichotomy emerges. It is not accepted that everyone begins life on an equal footing by this notion, but rather that we are all free agents to do as we choose. This is certainly the notion reflected through current economic policy today and a recurring theme through a two tier health system based on neo classic economic ideological interests. In particular, migration is a direct consequence of weak economic policy within migrating countries. Nevertheless, we cannot assume that opening the doors to the east provides a target population ready and waiting with the resources to participate in a western economic state. It should be assumed that support, integration etc. should be priority. At large current economic policy does not allow for this, but rather reinforces poverty through its economic agenda of individualism (Becker, 2009).

Economic policy is neither women nor child focused. It is still clear that women earn less than men in the labour force (Becker, 2009), and also women and children make up 2/3 of people living in poverty both in Ireland and globally (Becker, 2009; Kristof and Wudenn, 2010). Therefore, economic policy is a gendered concern and prostitution can be used as an example of this. Economics is driven by profit and it stands to protect those that can contribute to this profit.

Whether the women involved in prostitution of both Irish nationals and foreign nationals like it or not, they have no say, or indeed, influence over economics at a macro level. They are subjects of an already existing distinctive economic system. If Ireland is to make changes to address the psychosocial needs of women involved in prostitution, then economic ideology needs to be reviewed. It is responsible for
shaping all other policies, in particular social/health policies. In Sweden for example, prostitution health care, unlike Ireland, is a positive consequence of legislation which is gender sensitive and inclusive of the psychosocial experiences that women in prostitution face. As a direct result of this, it scores high on their economic agenda and services are provided throughout the country and there is a centralised system where information is stored and communicated throughout the country to support service providers in the delivery of care (National coordinator of prostitution in Sweden, 2013). In Ireland service providers cannot claim to wholly know this information as economic policy does not allow it, healthcare providers remain in the dark in respect to this cohort and equally the women remain hidden. Cutting health and social care services now costs more in the short and long term, economically but more vitally, in terms of people’s health, well-being and quality of life. Given how badly Ireland managed the health system in times of plenty, it is unlikely Ireland will do it any better in these times of less (Burke, 2009). This will be further assessed with respect to the law, legal framework on prostitution which shapes society alongside economic policy and biomedicine discourses (Healy, 2005).

5.3.3 Health services

There is only one centre in the entire country dedicated to the needs of women in prostitution by the Health Service Executive (HSE). This centre is in Dublin and was founded in the early 90s’ specifically to meet the needs of the drug using street prostitutes in Dublin city. Its initial focus was sexual health in response to HIV fears that were emerging for perceived target groups at the time such as prostitutes and the gay community. Drug use among street prostitutes was high and still is today (Women’s Health Project, 2007). Drug use amongst prostitutes is reinforced by the media and current advocacy agencies such as Ruhama who recently highlighted Irish women, with a history of drug use, homelessness and a history of child sexual abuse (Ruhama, Discussion paper, 2007). This creates the image of the typical hooker/victim in Ireland within Irish society. However, this group is now in the minority as the prostitution profile in Ireland today has changed dramatically since then to non-drug using, indoor escorts who are foreign nationals. This is indicative of the findings and from the literature (ICI, 2009). Over 700 women per day are advertised on escort sites here in Ireland (ICI, 2009). Yet, the remit has shifted but
the focus of care has not. Sexual health remains the primary focus, yet it is clear from the women’s stories that the key determinants of health and health behaviours were not sexual health, but rather poverty, migration, addiction, homelessness. The women who were experiencing migration were not using drugs or alcohol. They stated that their main healthcare needs were emotional and psychological support.

Yet, no research has been carried out before this research to identify the health needs of women throughout the country and to date the HSE has not sought to create new service developments throughout the country. There are sexual health screening clinics throughout the country, however, these are for the general population and not specific to prostitutes. If services for sexual health screening were to adapt an ecofeminist perspective, it would become clear that services should adapt to meet the needs of individuals and individual groups. For example, generic services do not design their care to meet the holistic health needs of women involved in prostitution. This research argues that this service provision is inadequate and as discussed by the women, they are less likely to disclose their involvement in prostitution. Here lies the dilemma as other health disorders are not addressed such as depression, disassociation, abuse etc. (Beltan 1998; Ross et al, 1990; Vanwesenbeevk 1994).

This is a response to health policy which promotes the biomedical model of health, and indeed, individual responsibility, with disregard for the individual and life circumstances. Subject to this, health promotion frameworks could be materialised through the actions set out by the Ottawa Charter (1986), specifically the reorienting of health services, whereby an ecological approach could permeate policy. It is clear from the Slan Report (Morgan et al., 2007); higher risks of experiencing clinical levels of psychological distress are particularly noticeable for women with poor levels of social support and experiencing loneliness. Women involved in prostitution spoke of loneliness, poor social support and isolation in their stories, and yet, policy has failed to provide resources to this group. The current socio economic climate is impacting on the public provision of health and social care in a more subtle and perhaps insidious way than it is in other areas (Burke, 2009). The women themselves spoke very positively about their experiences with the Women’s Health Project and how they felt supported in a non-judgemental environment. They all recognised the need for this service and would like to see more services available to them throughout the country. They are less likely to disclose who they are to a medical practitioner outside of The Women’s Health Project. The women themselves

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prioritised their health needs to be emotional support (to be listened to) and the need for more services to accommodate this specific level of support, this is not part of the generic sexual health clinics’ remit. Sexual health alone was not their main focus as they were all well informed and for the most part were responsible in their sexual practices.

The barriers to accessing health discussed by the women centred on fear of being identified, limited information as to where they could go due to their constant travelling around the country, and limited services available to them throughout the country. These were the barriers and yet service provisions or research has failed to address these issues. It is true that this is a consequence of the legal framework on prostitution, but if Ireland attempted to change the legislation and explore the decriminalisation of the women, then infrastructure within health and social policy must work alongside this. Focusing on the demand as a means to eradicating prostitution should only be one aspect, as this alone does not address the psychosocial determinants of the women’s lived experiences. Furthermore, it does not give them a voice in the decision making process of their health needs or provide an empowerment framework for practice. The principles of health promotion include advocacy, mediate and enable (Ottawa Charter, 1986), this can only be achieved by recognising and including the prostitution voice, for all voices within prostitution not just a particular voice or paradigm. As discussed earlier, it remains clear that the national agencies present a particular paradigm that all prostitution is harmful and all women involved in prostitution are victims. This is not consistent with the named principles of health promotion and social work and has directed the debate in one insular direction only, towards a review of the law. Instead, the responsibility for exiting prostitution or addressing migrant issues has been placed with other agencies such as Ruhama and the Immigrant Council of Ireland. They have strong advocacy roles however; neither service is equipped to respond to health. For the women who do not see themselves as ready to exit or those that are not migrant, have little need for these services and do not see them as meeting their immediate needs. This research identified the greater social determinants for health and the need for service provisions and the training of healthcare providers throughout the country, an ecological approach to healthcare. The women are not availing of healthcare from the HSE; their interaction with health services remains minimum within their meso
systems, thus women are remaining behind closed doors and support services are struggling to evolve alongside these changes.

In conclusion, it is clear that there are barriers for the women in accessing appropriate healthcare. These barriers are that services simply do not exist throughout the country. The services that are in existence provide limited contact hours with a direct focus on sexual health. In short, it is evident that the women's psychosocial experiences are not the priority of health services as they currently do not stand, nor do they adapt to the changing nature of prostitution which is indoor migrant women. Therefore, positive engagement and the practice of health promotion are limited within their meso systems. It appears that the women have far greater contact with the clients and organisers of prostitution than they do support services. An ecological and ecofeminist perspective can support locating the women’s experiences within an environment context, which is not currently conducive to meeting their needs. The women partake in a system or systems which are happening around them, already designed and in situ to determine health supports and services as a distinctive barrier.

5.4 Prostitution and the law

5.4.1 Legal position

The literature has explored the particulars of the current legislation on prostitution. It is now known that the government, in particular the Department of Justice and Equality, required a review of the legislation which is currently underway, but as no formal decisions have been made Ireland is still actively working from the legislation, 'The sexual offences 1993 Act' which currently places prostitution within the public order offences. The nature of public order offences is to determine acceptable and not acceptable behaviours for the general public to be exposed to. So therefore, in essence, it is the general public who need to be protected from the prostitute. Prostitution is not illegal per se, but ‘must be subject to various kinds of restraints in order to prevent it becoming a nuisance or an affront to public decency’ (O’Malley, 1993, p. 20). Such legal propaganda lies within the ideological discourse of neoliberal thought where it is the individual’s responsibility for their deviant behaviour and should be punished accordingly. The legal system is meritocratic in
structure and does not give allowance to social determinants such as poverty, addiction, migration, or indeed, gender (O’Malley, 1993). For these reasons, it is clear that Ireland requires a review the current legislation, but the discussion remains, if an ecological approach to rewriting the law becomes apparent as proposed by myself in the document I have forwarded to the Department of Justice to be included in the final report?

There has been a shift in thought whereby law enforcers are focusing primarily on demand (Department of Justice and Equality, 2012), where the woman involved in prostitution is less likely to be criminalised. The criminalisation process now focuses on the buyers of sex and criminal organisations, in light of trafficking concerns and new legislation on trafficking (The Criminal Law (Human Trafficking) Act 2008). Ireland is rapidly moving towards discussing prostitution and trafficking in the same vein. National agencies argued that they co-exist and must be tackled accordingly. If the law is used as an instrument to enforce a society’s given moral views, and if it is also an instrument as Byrne and McCutcheon (1986) claim, to represent current ideals and values, then law drives policies accordingly. In Ireland this centres on the notion of individual responsibility, which demonises prostitution and supports minimum health care and support. National agencies advocate a change in the law without calling for a review of current social policies and analyses of the social determinants of prostitution as part of the discussion. The national agencies in this study indicated that they were not health experts or understood in depth the nature of the women’s health needs; their role centred on advocating a change in the current legislation. It is clear that the agencies view the law as making a difference in the women’s lives, rather than the law being reviewed in response to a review of the social determinants of the women’s lives. This is inconsistent with an ecofeminism approach to change, and leaves the discussion open to interpretation, that of individual responsibility. As a further consequence of this, local agencies are given less room to advocate and provide support to this group. This approach to care works on the principles that exclude social determinants and excludes a health promotion framework. In theory, the current support services are guided by this view when considering the needs of women involved in prostitution. In order to explore this, it is useful to consider the popular view that prostitution and trafficking for the purpose of sexual exploitation should be considered as one and the same. This view is driven
by the view that there would be no trafficking for the purpose of sexual exploitation was it not for prostitution as suggested by the national agencies. This perspective has pushed government and law enforcers to focus primarily on trafficking and trafficking legislation, assuming that all women involved in the sex industry require the same interventions. This has detracted from developing and exploring health strategies and services to meet the current needs of women involved in prostitution.

Therefore, the law must act in accordance with such views. However, here lies the dilemma, not all women are trafficked and not all women identify themselves as victims. To assume this takes a judgemental view which isn’t in keeping with the principles of health promotion, or in fact the principles of social work and community development. This view is consistent with a law enforcing model rather than a holistic understanding of the broader social determinants.

This brings the issue of demand into the discussion. It may seem likely that by tackling demand from a law enforcement perspective, prostitution numbers should go down. In theory yes, however, this does not change the broader social determinants that were in existence in the first place before the act of prostitution. So the act of prostitution may change or simply become more hidden, which brings us back to the original focus of the law, which was to keep prostitution away from view. As O'Malley argued (1996), it therefore proceeds from the assumption that prostitution must be contained within certain limits and hidden from public view. Furthermore, the women may just be forced to travel elsewhere outside of Ireland. This still means prostitution exists, it simply relocates itself. The practice of prostitution may cease or become less common in theory but the social problems remain the same, thus forcing women to reinvent themselves in another guise to overcome the social determinants that exist in their lives. This is discussed further in the section `reviewing the Swedish model`. The law should not be used as a moral instrument for society and service providers should not succumb to such practice as they are further victimising the woman.

If policies continues to play such a significant role and essentially acts in accordance with the law (Healy, 2005), then how will this resolve the issues of infrastructure? Health services will remain limited and will remain focused on the view that prostitutes need saving and the focus for care remains sexual health and exiting
strategies alone. The social determinants continue to remain unaddressed and unidentified when considering the psychosocial experiences of women involved in prostitution. The implementers and executers of the law need to be careful of how it is used and its potential to provide power and control over, and influence a society.

Furthermore, the same law does not seek the same result or rights for migrant women. They are not afforded the same protections, nor does it consider the particular social determinants of this group as asylum seekers, undocumented and so forth. At best, they may not be criminalised if caught acting in prostitution under a revised legal model, but they will be criminalised for their status, thus this group remain further isolated and hidden. The issues here are the laws relating to migration in this country and how they create barriers for women accessing health services. In conclusion the law as it stands risks demonising women in prostitution with no regard for the psychosocial determinants which impact and shape the lives of women in prostitution. It is apparent that society must be cautious of the messages imposed by law in western societies, including victim blaming and individual responsibility. This research proposes an ecological approach when implementing law and consideration of gender and gender specific analysis.

To review the law in the context of the current discussion and progress towards the Swedish model will need to be reviewed with careful consideration to identify a possible moralistic approach to care inconsistent with the principles of health promotion. Furthermore, are we merely at risk of singling out certain women and not others, such as migrant women who make up a large percentage of women engaged in prostitution in Ireland today? Ireland, due to its historical political journey of strong Catholic influences within law, politics and the family still resonates within Irish paradigms today. It is reasonable to assume that legalising prostitution is not likely to come into existence or any similar model which condones such practices. Therefore, we must consider if the law has a function and what this function is best suited to? When discussing the law, it is necessary to open this to the insidious aspects of prostitution which weave within and outside of the legal loopholes, such as the clients and organisers of prostitution. This comes to include a section on the Gardai and their role as frontline law enforcers. The table below indicates how the law in all its form can impact on the women’s psychosocial health and wellbeing as identified and told by the women themselves in their stories.
Chapter Five: Discussion

Table 5.2: Women’s fears of forms of abuse

<table>
<thead>
<tr>
<th>Fears</th>
<th>Disclosed abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal abuse</td>
<td>15</td>
</tr>
<tr>
<td>Physical violence</td>
<td>10</td>
</tr>
<tr>
<td>Rape</td>
<td>2</td>
</tr>
<tr>
<td>Robbery</td>
<td>8</td>
</tr>
<tr>
<td>Loneliness</td>
<td>15</td>
</tr>
<tr>
<td>Isolation</td>
<td>15</td>
</tr>
<tr>
<td>Drug and Alcohol use</td>
<td>2</td>
</tr>
<tr>
<td>STIs</td>
<td>3</td>
</tr>
</tbody>
</table>

5.4.2 Clients

The women engaged with the buyers of sex on a daily basis. These interactions had a direct consequence on the women’s psychosocial experiences. This section draws from these themes specifically in relation to the clients which included subthemes of abuses, sexual demands and theft. It is necessary to note that all the women talked about these subjects either from first hand experiences or in relation to the fear of such events happening to them. Violence and abuse occurred in the form of physical, sexual, emotional and economic abuse; the women talked about the fear of physical violence in the context of never knowing ‘who might come through their door?’

Habermas in Ganis (2010) discussed human agency as the authorship of one’s own life and the ownership of one’s own body that results in human agency. However, Derrida (Ganis, 2010) then considered the potential and limitations of human agency as it, too, is political. If the meso systems are shaped and interact with the larger macro environment, then this too must effect and extend the debate on human agency and how the women come to experience violence and abuse from particular clients. Within the findings the parallel remained, living in or experiencing abuse versus the broader understanding of why women engage in prostitution. According to the national agencies, prostitution is inherently harmful and a law enforcement approach needs to exist, i.e. criminalise the buyer, similar to Sweden’s approach to tackling prostitution. However, this approach does not tackle the determinants of prostitution such as migration, poverty, addiction and so on. If agencies were to view this from an ecological perspective then health policies and social policies alike, as a tool for addressing the needs of the women, would have greater impact for their wellbeing as opposed to focusing on the law alone. As Ekberg (2004) claims, the
buyers of sex will not disappear they will just become more careful and strategic of how they buy sex.

The sexual violence that occurred included clients having what appeared as consensual sex but after the act of sex, refusing to pay. However the sexual violence or fear of sexual violence happened when the client felt it was his right to force the woman to engage in a sexual act she has not agreed to such as anal sex or sex without a condom. The women tell these events in relation to fear of sexually transmitted infections but also their lack of control over the situation, they cannot, and do not, report these crimes and it was clear from the stories that this ’type’ of client was very aware of that fact.

Clients had often further abused the situation by adding emotional abuse, threatening the woman that they would report her for being a prostitute if she said anything. The women added that on the escort websites there was a space for clients to rate the women they had paid for. It is said that clients abused this tool by placing false comments about a particular woman so as to reinforce power and control which consequently interfered with her business.

The women were subjected to theft or the fear of theft on a daily basis, not knowing who they were allowing through their front door. As mentioned above, some clients may steal free sex, but others came intentionally to steal money, laptops or other personal belongings of the women and would often take personal phones from the women and threaten to call family or friends and inform them that the woman was involved in prostitution. Again the women remained helpless here as they all felt that they could not report these crimes as they themselves were acting illegally. It is fair to point out that not all clients engaged in violent manners and that not all the women had experienced such negative experiences. However, they all were aware of situations that other women had found themselves in, and they all expressed living in fear on a daily basis that abuse could come through their door.

Although it is illegal for the women to work in pairs as this constitutes a brothel under Irish law, some women preferred to take this risk as it made them feel safer. They knew that when they allowed someone to enter their premises they were taking a risk of physical violence and this was something that stayed with them on a daily basis, in particular for the women who did not have regular clients. According to
Farley, Lynne and Cotton (2004), 75% of women involved in prostitution have experienced injuries from violence in prostitution. The women talked about the demands or requests from clients and they feared refusing such requests as the client may, or had become violent. This violence extended to include sexual violence. The rape myth as discussed by Moon (2013) is the attitudes and beliefs about rape and sexual assault that help fuel rape culture. These widely held, culture-based beliefs may place blame on rape victims, excuse the actions of perpetrators, or blur the lines between rape and consensual sex. The myth that prostitutes cannot be raped reinforces a male dominated view, as the women talked about rape and prostitution and how this is ignored by society and the law. Furthermore as Farley (2000) points out that in respect to our broader social and political systems, harm and the experience of rape are often invisible. Local agencies who worked specifically with women who have experienced rape, talked about how they felt inequipped to address the specific needs of women in prostitution, despite feeling strongly that the women they worked with were currently, previously or vulnerable to prostitution. It is clear from the findings that although these agencies quoted statistics offering a direct link between child sexual abuse and family breakdown and rape, this research did not extend, as Coys (2008) research did, to linking family breakdown and prostitution. For this reason, services became limited to the support they could provide. If an ecological approach were to be adopted then it becomes clear that the individual, and individual experiences are in isolation from the family, community and wider societies. From an eco feminist perspective we can challenge rape myths discussed by Moon (2013), as patriarchal, reflected by current policies and law which again reflect cultural norms and practices of a society. Ecofeminism calls for policies and values to adapt to the needs of the individual, gendered sensitive guidelines for practice. Local agencies all stated that prostitution policy did not exist in the local agency policy guidelines for addressing rape or violence. Yet they were all struggling to meet the demands of the new phenomenon of migrant populations such as asylum seekers, refugees, undocumented populations and so forth. They felt that national policies which guided their practice were insufficient and this was echoed by funding cuts and inadequate resources. This emphasised how marginalised groups remain on the periphery of society, in particular women, and in particular, women involved in prostitution.
The findings confirmed that abuse from clients exists within prostitution in Ireland. Furthermore as discussed in the literature, when one is prostituted for any length of time, a state of intense, unbearable fear develops. Dissociating disorders, depression and other mood disorders were common among prostituted women in street, escort, and strip club prostitution (Beltan 1998: Ross, Anderson, Heber and Norton 1990; Vanwesenbeeck 1994). Dissociation in prostitution results from physical, sexual, emotional and economic violence in adult prostitution. The women reflected on abuse within prostitution, how they felt isolated and as Emma commented, ‘yes, of course we can be raped’ and Fiona confirmed this isolation by letting the researcher know, ‘where can we go?, some women take pills or alcohol just to forget’.

4.4.3 Organisers of prostitution

It became clear from the findings that despite the women being independent escorts or working the streets without pimps, there were, in fact, organisers behind the scene. These organisers appeared in the form of drug dealers and accommodation organisers for the women. The literature highlighted pimps and drug dealers and the organised crime aspects of running a brothel or trafficking women for the purpose of sexual exploitation (Ruhama, 2006). In respect to drug dealers or pimps, the literature emphasised a strong link between dealers zoning in on vulnerable women. The women who were recruited by this method would acknowledge that they were addicts before they turned to prostitution (Kennedy, Klein, Bristowe, Cooper and Yuille, 2007). According to Erikson (2005), the financial stress of maintaining a drug habit left the women feeling trapped. Evidence also suggested that the women first perceived their dealers to have been their boyfriends, they were ‘in love’ and had formed emotional attachments to their pimps or drug dealers which turned into a manipulative, abusive relationship with detrimental consequences (Dalla, 2002, O’Neill 1997). Although trafficking for the purpose of sexual exploitation was not a primary feature of this research, it did come up within the women’s stories. Some of the women talked about trafficking; they were aware it existed and they were aware of the criminal aspects and organisation that it involved. Nevertheless, they spoke about it as ‘the other’, separate from their lives in prostitution.

There is little research on the other forms of organisation, that of renting accommodation to the women and the men that make themselves available to the
women as security for a fee and, the creators of websites for the women to advertise. There is a covert population working behind the scenes of prostitution which help shape its current nature and act as networks which the women engage with on a daily basis. These particular organisers featured heavily in the women’s stories. Although independent, the women can contact particular individuals who will organise apartments for them to work from and then they pay the rent to this organiser. It was the organiser that leased the property from the landlord. This was often a straightforward transaction, but as the women also added, it could be a scam whereby they paid the organiser for an apartment which did not exist. Also, the women spoke of how nervous they were when they first began working in prostitution; some of them took the option to hire men who provided security for the women while they were with customers. The security men would hang around the apartment in the event of any danger arising from clients. The women paid the security men from their earnings. They did, however, state that these men were not pimps but were hired independently. These men were not associated with any security agencies, but rather independent men who became known to them on entering prostitution.

This untapped resource and hidden group require further research in terms of understanding the multifaceted phenomena that is the current nature of prostitution in Ireland today. In conclusion, these organisers behind the scenes are part of the intricate structure that is prostitution and require greater understanding.

5.4.4 The Gardai

Law enforcers of prostitution are at the front line. The interaction between the Gardai and the women was an important finding. It is illegal to sell sex on the street and it is illegal to work in pairs or more as this constitutes a brothel under Irish law. For this reason the interaction between the women and the Gardai is one of caution and mistrust according to the women. In their stories, the women do not talk badly of the Gardai, in fact some women found their experiences with them to be supportive. Nevertheless, the women preferred to not come to the attention of the Gardai and would not disclose abuse or theft to them. It is important to state that the findings were not just about disclosing their involvement in prostitution; it also extended to their legal status to be in the country. The women feared deportation or simply being exposed. According to the literature (EUROPAP, 1996), the Gardai were aware of
their precarious relationship with the women and know that the law, in effect, creates this environment.

In the same report the Gardai recognised the need for training to address prostitution within their remit of public order offences (EUROPAP, 1996). Training was highlighted as particularly important for their colleagues in rural settings who had less experience with prostitution, and yet we now know that from the literature and from the women’s stories that prostitution exists in every pocket of the country (Immigrant Council of Ireland, 2009). Furthermore, the Gardai have progressed in that it is the buyers of sex that they need to target as opposed to the women, this is a changing view and comes out of the Swedish approach to tackle demand and to recognise a more comprehensive understanding of the socio economic determinants of the women involved in prostitution. The Gardai stated "The women we are dealing with are just ordinary women; they are human beings, not criminals" (EUROPAP, 1996, p.12). This shift was also about tackling the organised crime elements of prostitution since 2012/2013 which have been predominantly raised by high numbers of migrant women working in prostitution and, indeed, the new trafficking legislation which guides their practice. Different operations were carried out throughout the country to diffuse brothels and incarcerate organised activity such as in a building in Limerick as part of their crackdown on prostitution where they found 18 Romanian women and a number of men inside the house.

In conclusion, the findings clarified that there was still mistrust on the part of the women in respect to the Gardai. It still currently stands that the women are acting outside of the law and the Gardai are essentially law enforcers. Despite new approaches to decriminalise the women involved, and the new legislation for trafficking and to tackle criminal organisation of prostitution, it is important to recognise that these were not the primary focus of this research and are interpreted as two separate issues as trafficked women are, in effect, victims who according to the legislation require support. This is not inclusive of the other women who are not victims of trafficking, but rather prostitution. Even if the Gardai decided to target the buyer and not the women, they still remain unengaged and are not in a position to provide care and support. Not just because the women still mistrust the Gardai, but also because other than The Women’s Health Project (HSE), where can the women go to access support? It is not currently within the Garda remit to extend their non-
prosecution perspective to their health needs. The women themselves within the research stated clearly that although they have had no bad experiences with the Gardai, they do not wish to engage with them and do not see the Gardai as having a health promoting role.

Furthermore, to be caught in the act of prostitution as a foreign national without proper visas carries separate consequences such as deportation with little other options; despite the fact that the vast number of women engaging in prostitution in Ireland are foreign nationals. It is clear that the policing of prostitution are moving forward and the debate is becoming broader in respect to their roles and expectations, but as it still stands, prostitution itself, exclusive of trafficking remains within the public order offences and does not extend to health supports or interventions. The Implications remain the same; women prefer to remain hidden and still choose to refrain from disclosing abuse from clients or organisers of prostitution.

It is necessary now to examine the Swedish model, as this is where Ireland is seeking guidance from, both national agencies and legislators. The next section assesses this debate in the context of an ecological approach to see if Ireland can benefit from this model. Research has occurred to identify the benefits of this model and or its weaknesses (Ekberg, 2004; Eriksson, 2005; Farley, 2006; Ward, 2010). In respect to the lived ‘voices’, experiences of women involved in prostitution in Ireland and drawing on an ecological framework its utility will be located.

5.5 Sweden as a model for prostitution 'The Swedish Model'

As addressed in the literature review, Ireland’s historical journey has been very different with a different political ideological position. Gender has impregnated Swedish policies for some time. Unlike Ireland which has only now beginning to emerge from its patriarchal control of women and their bodies, which has greatly impacted on the Irish psychic and hence women’s roles and expectations in society. This is clear still today within the Irish constitution as discussed within the literature (Article 42.2.1, 1937-to date). Irish policy and legislation, unlike Sweden has not centred on gender or violence against women as a priority for its people. The Violence Against Women Act only came into law in Ireland in 1996. Considering these determinants alongside the literature and an interview with the Swedish
Chapter Five: Discussion

national coordinator on prostitution, the research addressed key issues identified in relation to these factors and health.

Most importantly, when Swedish citizens’ discussed prostitution, it appeared that they were well informed and this permeated society’s views and understanding. When a country decides to draw policy from a gendered perspective and maintains a zero tolerance policy for violence against women, they are stating a certain view towards women (National coordinator on prostitution, 2012). This is an important starting point to this discussion. Policies inform practice and this is evident in Sweden, as there are many centres throughout the country which work with women involved in prostitution, unlike Ireland. This is supported by a large budget which also extends to training healthcare practitioners and society at large. Sweden does not focus on sexual health and exiting strategies only, although such issues are of great importance, they are accepting that not all women want to, or are in a position to leave prostitution so such supports are in existence to (National coordinator on prostitution, 2012).

Sweden has a robust social welfare system and broader options as part of their exiting strategies. Its system appears non-judgemental and ecological in its understanding of how the women interact and engage with their environment. Ireland falls short here on all accounts, thus stands to learn from the Swedish model.

In Ireland the changing nature of prostitution results in more indoor migrant women who are here illegally as undocumented or on particular visa stamps such as study, holiday or work visas and are involved in prostitution. This group of women also extends to women seeking asylum. Sweden has also opened its borders to foreign nationals under various stipulations. However, in Sweden if this group is identified as involved in prostitution, they will not be criminalised, but they cannot access Sweden’s social welfare system or partake in society as Swedish citizens can. The best they can do, is support the women to return home. This view changed where a woman is identified as trafficked for the purpose of sexual exploitation as procedures and legislation are in place for the women to remain in Sweden to access support until a conclusion is reached for re-location depending on safety. Therefore, this model as it stands in relation to foreign nationals working in prostitution, in Ireland has nothing to offer as a solution. Yet, Irish national agencies continue to demand
change in the legislation without acknowledging the needs of the largest group within prostitution in Ireland today which continue to be foreign national women. The researcher argues that this focus alone will do nothing to address the health needs of women involved in prostitution and rather support the argument made by Eriksson (2005), that women will simply ‘go underground’, pushing their health needs further into the background, alongside isolation and further ignoring the psychosocial wellbeing of women involved in prostitution.

This identified a further problem concerning targeting demand. As mentioned above, Sweden has a robust social welfare system (Wolfgang, Petring, Henkes and Egle (2008) and good service provisions to support women in and leaving prostitution. This is reflected through policy and budget allocations and in itself is an ecological approach to care. However, if we argue that demand alone does not change the social determinants which brought these women to prostitution in the first place, well then migrant women still stand to be exploited and the women that remained on the streets were subject to more violence and where more likely to practice unsafe sex as clients were more difficult to access. Interestingly, it was one of the national agencies core roles to work with migrant groups and migrant rights, yet supportive and financial infrastructures were not in place for migrant women in prostitution set down by agency policy because of national policy and its non-recognition for this group. They are acting in accordance with national policies which may address the needs of some migrant communities, but not those involved in prostitution. An ecofeminist analysis is required here, whereby adapting policies to meet the needs of this group as opposed to a requirement that should they adapt themselves appropriately, only then can they access support.

Ireland seeks to implement the Swedish model, yet it fails to provide answers to the issue of migrant women involved in prostitution. Ireland also seeks to view prostitution and trafficking combined, yet Sweden itself states that their model for prostitution can only be used as a tool to fight human trafficking, it was not designed originally to address trafficking and they themselves seek further research and development in this area.
Chapter Five: Discussion

Sweden also draws on a law enforcing model which primarily focuses on the organisation of prostitution and the buyers. They claim that this is not perfect as a total approach but believe in the services provided as meeting the women’s needs. Ireland seeks a law enforcement policy but little is discussed around prevention, health and infrastructure to support the ecological context of prostitution both in policy and service delivery.

It is clear that Sweden provides guidance for Ireland as it attempts to transition its laws. However, the model is not perfectly adaptable. We first need to broaden the discussion within Irish society. This is not just a prostitution isolated discussion; it taps into the broader social issues of gender, social determinants of poverty, migration and requires an ecological framework to support positive health promotion strategies and services. Such principles must locate prostitution within the micro, meso, exo and macro systems.

Conclusion

The concluding section confirms that considering the findings and in keeping with a feminist standpoint epistemology of interpretation, ecological theory as a framework can guide healthcare practitioners and educators alike. It can be used to understand and meet the needs of women involved in prostitution. This framework challenges social norms against the backdrop of political ideology and media driven propaganda. It allows Irish society to broaden the debate in order to refute a ‘one voice’ or one view model approach which currently exists amongst agencies today. Prostitution is multifaceted and requires a multifaceted analysis and approach.

5.6 Prostitution and ecological theory

The research has provided the evidence to show that an ecological framework is both useful and necessary not only to answer the research question ‘the psychosocial experiences of women involved in prostitution’, but to seek a health promoting framework which will address the health needs of the women. From the literature it became apparent that women involved in prostitution are viewed by society from a neoclassic lens and of deviant disposition as clarified by current legislation (Sexual Offences Act, 1993). Historically this paradigm shared a resonance of Catholic corporatism and a hybrid neoliberal ideology (Skehill, 1999, 2010). This is
confirmed through how women have been viewed throughout Irish history to the present day; a notion of a moralistic relationship between service and service user. Furthermore, support only became available when a fear of sexually transmitted infections emerged, especially the fear of HIV that had led to opening the Women’s Health Project by the Health Service Executive (HSE), targeting prostitutes that were perceived at risk for HIV infection (Asthana, Oostvogels, 2001; O’Connor, 1996). Until now, the focus has remained on sexual health with the assumption that prostitution remains primarily in Dublin city, amongst drug using street prostitution. It is also clear from the literature, and indeed, the findings presented in the research that the prostitution profile has changed significantly, permeating all pockets of the country with a large demographic of migrant women. Yet, an analysis of their health needs has not come to fruition. It is also clear from the literature that the reports and research on health and prostitution are dated and hold little relevance to current health phenomenon.

Ecological theory sets the scene to understanding the psychosocial experiences of women involved in prostitution both while in prostitution and their experiences and life events which occurred prior to prostitution. Health promotion as a discipline seeks a preventative approach rather than cure, as the biomedical model pertains. Ecological theory adapts the principle set down by McKinley (1979), and the analogy of ‘focusing upstream’. To do this, it is imperative to hear the whole story, the lived experiences of the women. Ecological theory allows this as the micro, meso, exo and macro environment impact on the women’s life course which has shaped and moulded their outcomes. This research is not interested in the physical health needs alone of the women, but rather understanding these health needs in the context of their psychosocial experiences.

The findings provided enough evidence to draw a pattern in which to build from. In the case of the micro systems of the women, this centred on family breakdown and migration. The use of examining the micro system allowed the researcher to identify the need for earlier interventions for families when crises arise. Such health promotion targets may arise in the form of family support or adequate care needs for young women at risk or who have already left home. These risk factors have the potential to introduce women into street culture and prostitution. In the case of global migration, this is a concern for women entering the country, separated from family
Chapter Five: Discussion

and the burden of the financial responsibilities of sustaining their families back home.

As ecological theory allowed the researcher to consider the scope to build on the women’s environments. It becomes clear how the micro system interacted with all the other systems and how this impacted on the individual’s psychosocial health. The meso system for the women centred on clients, pimps and organisers of prostitution and support services; it was evident from the findings that these contacts were negative and isolating. Women primarily worked indoors without contact with others not involved in prostitution. They stated unanimously that they lived in fear constantly of theft, abuse, rape and of course being identified by the Gardai either due to working in prostitution and as their status to remain in the country was ambiguous creating uncertainty. For these reasons the women on the whole stated they were less likely to avail of support outside of the Women’s Health Project. Irrespective of this it is important to note that specific services meeting the needs of women involved in prostitution did not exist throughout the country. Overall, their meso environments remained unconducive to positive psychosocial health experiences.

The exo environments were greatly influenced by poverty, migration and politics. It was clear that the women had little influence over their exo environments but were rather subjects of gendered inequality. The findings confirmed that the women were involved in prostitution for financial reasons. The women who stated this were without an education, came primarily from low income countries or found themselves homeless due to family breakdown or addiction. Women and poverty is a health concern and again a determining factor of prostitution. Although some women clearly confirmed that they were happy and content with their work in prostitution, it must be clarified that these women held third level qualifications, owned their own properties, maintained familiar regular clients and had social networks and supports outside of prostitution. These women are in the minority.

In view of the macro environmental perspective, it was evident from the findings that services are shaped and presented in the context of neo-classic economic healthcare influenced by a biomedical framework of care (Healy, 2005). Local agencies talked about budget constraints, limited knowledge of prostitution and were ill-equipped to
meet the health needs of this group. National agencies sought change in legislation yet were not equipped or in a position to claim expert knowledge on the true nature of their psychosocial health. They assumed the question referred to their physical health and quoted outdated literature here in Ireland to answer this question. They did, nevertheless, identify prostitution as wholly harmful to the women involved and argued that a law enforcement approach as in existence in Sweden was the answer to positive change. However, what seemed to be missing within the discussion with the agencies was that if an ecological framework as opposed to just a revamp of legislation. Yet this could make governments and policies alike become accountable for addressing change, a social and health policy approach to change and service development. Ireland can learn from the Swedish model in terms of their gendered approach to social policy, however, their law enforcement approach does not work suitably for migrant women and cannot be used in Ireland without the issue of migration laws and globalisation being addressed first. The Swedish model certainly provides tools but without an ecological approach to the discussion, Ireland remains in a moralistic neoliberal vacuum approach to health care supports for women involved in prostitution.

5.7 Prostitution and ecofeminism

Fox (2008) discussed ecofeminism as a framework for an expanded ecological practise. If we consider an ecological – ecofeminist approach to health promotion, then the principles of enable, mediate and advocate (Ottawa Charter, 1986) maintain a holistic gendered appropriate interpretation. This research confirmed that `family `and `policies` at best are designed to facilitate gender oppression and oppression of those existing outside of expected social norms such as women involved in prostitution. This has been decided upon by the examination of the sub systems specifically in relation to women. While ecological theory focused on personal or adaptive processes, ecofeminism argued that within this model alone, the responsibility appeared to remain with the individual to adapt to a changing environment. `Such environments are inherently conservative socio-political orientations which focus on narrowly defined domains of environmental transactions` (Besthorn, 2003, 2008). The research supported the suggestions that the environment is directed by neoclassic economics and conservative to the landscape.
the women involved in prostitution exist in and they hold little power or influence to shape such ideologies. As Saleeby et al (2008) noted, the realities of power, conflict and oppression, and violence, are central to the survival of many groups (prostitution), then ecological theory alone needs to be adapted using a feminist critique. The ecological model alone, escaped a place where an individual before adaptation is an entity in their own right.

5.8 Limitations of an ecological/eco-feminist framework

As the research draws to its conclusion, it is important to add that an eco-feminist perspective was considered early on in the research in keeping with a feminist standpoint epistemological underpinning to the research and to maintain the women’s voices as central to the research. In doing so, it could be decided that this may be at the expense of further developing the ecological framework itself to include the ‘Chrono’ system’. The Chrono system lends itself to the patterning of environmental events and transitions over the life course (Santrock, 2007). By excluding this perspective from the research, it would appear that to understand the impact, for example of family breakdown and prostitution, it would be necessary to learn when in fact this occurred during the life course to determine a more comprehensive understanding of this link. Furthermore, disciplines such as health promotion, social care and social work are concerned with the life course and life course theory, so to explore the Chrono system within the research would have supported professional practice and education. It is the view of the researcher the Chrono system should be part of the theoretical framework chosen. As a recommendation for future research in this area, this layer has an important place as does the life course of individuals within their environment. The Ecology of Human Development has had widespread influence on the way health promoters and the social approach the study of human beings and their environments. These environments from the family to economic and political structures have come to be viewed as part of the life course from childhood through adulthood (Santrock, 2007).

5.9 Limitations of the study

The limitations to the study are as follows:

Methodology
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The philosophical underpinning of the research, feminist standpoint epistemology determined a feminist methodology. This became qualitative biographical narrative interviewing format alongside a Voice Centred Relational Model of analysis. Such an approach provided a voice for each participant and was in keeping with the principles of the research. However, to fully comply with using the Voice Centred Relational Model of analysis, the researcher would have to revisit the interviewees more than once which was not manageable as the women could not be located or asked to follow this path of enquiry. Furthermore, due to time constraints, the analyses employed the original features of VCRM, by using the four readings, thereafter thematic analyses was used. Thus, it is more correct to acknowledge at this point, a hybrid VCRM was adapted. As noted earlier, the population was extremely difficult to access with the researcher remaining in the field for more than twelve months, thus fifteen voices were eventually represented which is a useful departure point.

The Findings

The women in the study were more willing to talk despite their illegal status and uncertainty around being permitted to remain in the country. A smaller sample of street women was represented due, in part, to their chaotic lifestyles of homelessness and addiction and their difficulty of access. However, this limited sample, whilst not generalisable, does represent the multifaceted issues within prostitution in Ireland today.

5.10 Recommendations

The starting point of this research was to examine the psychosocial experiences of women involved in prostitution and the current nature of prostitution in Ireland. This study provided a platform for the women to share their stories and for the researcher to interpret these stories to make recommendations. The recommendations aim to represent the voices of the women. This study identified some of the barriers that exist and that prevent women involved in prostitution from accessing healthcare. The women in the study shared their stories not as victims but rather as women, mothers, sisters and friends. Although their stories shared experiences of abuse, fear, and loss, they maintained a strong desire to advocate on behalf of themselves and other
women in the industry, thus showing resilience, compassion and a sense of their own self-worth. This study has important implications for future research in the field of Irish prostitution that will inform practice and broaden the policy debate on prostitution.

- Lack of voice was one of the main findings from the study. Women participating in this study reported that their voice is not heard and that there are no avenues for them to express their voice, especially in relation to services. Involving these women in planning services that are designed to meet their needs will result in services that are more appropriate and relevant for women in the sex industry and will enable the women to have a more active role in voicing their needs and preferences.

- It is evident from the findings that health care practitioners require further training and skills to identify the health needs of women involved in prostitution. Local agencies in particular spoke about being ill-equipped and ill-informed about the needs of women involved in prostitution. Effective training should be informed by the needs of service users, and include the involvement of women in prostitution as peer leaders that would both assist in identifying the needs of service users and advocating for the services among their peers. Training for health care practitioners will also need to be culturally appropriate in order to address the experiences of foreign national women involved in prostitution.

- Currently, only one HSE facility, situated in the capital, is available to women involved in prostitution. Findings from the study indicate that prostitution in Ireland is mobile in nature, thus there is a need for outreach or mobile services that would accommodate women that are travelling around the country.

- The current service was established as a sexual health facility in the early nineties to address HIV prevention amongst Irish drug using women involved in street prostitution. However, the findings from this study suggest that at least some of the women are both proactive and well informed on their sexual
health, and that more holistic services are required to address the physical, mental and social health needs of women involved in prostitution.

- The women in the study felt that current legislation deters women in prostitution from reporting criminal acts of theft, rape and abuse. The women discussed their fear of the Gardai and fear of services revealing their identity, resulting in dealing with violence and rape alone and unsupported. Changes in legislation need to be introduced to protect women in prostitution from all types of crimes, providing them with the same protection that is available to all members of society.

- The 'Swedish model’ was advocated for by the national agencies in the study, however, this model does not address the needs of foreign national women, who are largely represented in this study. There is insufficient evidence to suggest that this model will work for this particular group. It would be useful to examine this model and adjust it to the current nature of prostitution in Ireland using a participatory approach to policy making.
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Violence Against Women Act 1999, Sweden:


Dear Manager,

I am a PhD student at the National University of Ireland Galway, within the discipline of Health Promotion. I would greatly appreciate your involvement as an agency in a collaborative context to support my research which seeks to examine the experiences of women in prostitution specific to their health requirements and specific needs throughout Ireland. I would appreciate your support in the recruiting of participants who wish to contribute to this research. Ethical approval for this study has been granted from the ‘Research Ethics Committee’, NUI Galway. The following criteria for participants are as follows;

1. All participants must be actively or have been recently active in prostitution in the West of Ireland, or of a transient population who may work in Galway at intervals during the year.
2. All participants must be 18 years and over.
3. All participants must have a good standard of English, as all interviews will be conducted in English and no interpreter will be present.
4. All participants must voluntarily agree to participate in the interview process and informed consent is required.

5. Each participant will be asked to invite a friend to also take part in the interview process, should they know anyone who would be interested.

There is a need to change attitudes that create barriers which impact on those seeking supports from our health care service. As we address the changing nature of Irish society as multicultural and the changing shift of prostitution and the sex industry, the health service to date has not researched national health care objectives specific to this group’s needs.

This study aims to identify barriers that impede or prevent women in prostitution from availing of health services. It seeks to examine the experiences of women engaged in this area and in addition to explore the attitudes and policies of agencies providing these services. An estimated total of 20 women involved in prostitution will partake in an open biographical in depth-interview. Subject to this, interviews with experts in the field of working with and advocating for women in prostitution will be carried out, to identify concerns, attitudes and need.

Following completion of the study, information packs will be put together to distribute findings at training groups for healthcare professionals of both statutory and voluntary sectors alike, nationally. The target groups will comprise also of academics, which design and deliver teaching modules for Health Promotion, Social Work, Women’s studies and related healthcare modules. This study will be reviewed in peer journals and delivered at national conferences and forums promoting women’s health. This study hopes to be delivered at International conferences relating to women’s health. The overall objective should represent a model for good practice.

Thank you so much for taking the time to read this letter. In the interest of this research and more significantly in the interest of this service using population, please consider your agency’s involvement in recruiting appropriate participants. Please talk to any of the women you work with who you feel would be interested in partaking in this interview process. Should you require any further information, please do not hesitate to contact me. I am more than happy to meet with your agency in person to discuss this research and your involvement in greater detail. My aim is
to do roughly 20 interviews between Sept. 2011 and December 2011. Interviews will be held in a familiar safe environment such as your agency. Please note that my background is ‘medical social worker’, which provides me with the necessary skills to undertake this research. No expense or unnecessary inconvenience will be incurred for the participants involved. Consent forms are also attached.

Kind Regards,

Leigh-Ann Sweeney
Project Title: the psychosocial experiences of women involved in prostitution: an exploratory study

Introduction

You have agreed for your agency to take part in an exploratory study of women involved in prostitutions’ psychosocial experiences of the Irish healthcare service as part of the PhD research study of student Leigh-Ann Sweeney. This study will be conducted within the Department of Health Promotion, National University of Ireland Galway, under the supervision of Dr. Saoirse Nic Gabhainn, Director of the Health Promotion Research Centre and Dr. Michal Molcho, Lecturer in Health Promotion.

Invitation to take part in the study

I would like to invite your agency to take part in supporting this research process.

Your participation is voluntary, and you are free to withdraw from the research at any time.

Everyone taking part will be given an ID number and no names will be used when the findings of the study are reported. All the information collected during the research will be kept strictly confidential and will be stored in a way that protects identities. Only the researcher of the research will have access to the information.

Purpose of the study

This study aims to identify barriers that impede or prevent women in prostitution from availing of health services. It seeks to examine the experiences of women engaged in this area and in addition to explore the attitudes and policies of agencies providing these services. This study aspires to contribute to knowledge about these groups experiences of the health services, and to consider the implications for and inform the development of a holistic, multidisciplinary healthcare service for women engaged in prostitution. It seeks to examine the gaps between the current socio-
political realities of prostitution and the Irish health services ability to provide services to women, to adapt and to report rapidly changing circumstances.

An estimated total of 10 women involved in prostitution will partake in semi-structured in-depth interviews.

This study will capture the experiences of women in prostitution accessing generic health services. How they are received by practitioners? Are their needs being met holistically? What are the gaps in the health system? These questions will be answered by meeting with women engaging in prostitution and finding out what their needs are and asking them about their concerns. These questions will direct the research to identify gaps in the service and how to incorporate an ecological approach to practice.

Taking part-what it involves.

**Do I have to take part?**

It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. If you decide not to take part this decision will be respected.

**What does taking part involve?**

Taking part will involve recruiting 10 women involved in prostitution who you feel would be interested in taking part in this study and meeting with me for an interview. The following criteria for participants are as follows;

1. All participants must be actively or have been recently active in prostitution in the west of Ireland, or of a transient population who may work in Galway at intervals during the year.
2. All participants must be 18 years and over.
3. All participants must have a good standard of English, as all interviews will be conducted in English and no interpreter will be present.
4. All participants must voluntarily agree to participate in the interview process and informed consent is required.

Each participant will be asked to recommend a friend who they think might also be interested in meeting with me. My aim is to do the 10 interviews between
January 2011 and March 2011. I will travel to where the participants are living such as Dublin and the interviews will be held in a familiar safe environment such as your agency. No expense or unnecessary inconvenience will be incurred for the participants.

What are the possible benefits in taking part?

The benefits to taking part in the research are to learn more about the health needs and experiences of women engaging in prostitution throughout the country. Ideally this research will inform policy and progress service development in the future.

What are the possible disadvantages of taking part?

There are no foreseeable risks attached to taking part in this study.

What happens at the end of the study?

Following completion of the study, information packs will be put together to distribute findings at training groups for healthcare professionals of both statutory and voluntary sectors alike, nationally. The target groups will comprise also of, academics who design and deliver teaching modules for Health Promotion, Social work, Women’s studies and related healthcare modules.

This study will be reviewed in peer journals and delivered at national conferences and forums promoting women’s health. This study hopes to be delivered at international conferences relating to Women’s health. The overall objective should represent a model for good practice.

What happens if I change my mind during the study?

You are entitled to change your mind about participation at any time during the course of the study without disadvantage or penalty.

What if I have a complaint during my participation in the study?

If you have any complaints in relation to the research process you may refer these to the Director of the Health Promotion Research Centre: Dr. Saoirse Nic Gabhainn, Health Promotion Research Centre, NUI Galway.

Tel: 091- 493092. Email: saoirse.niegabhainn@nuigalway.ie
Each complaint will be dealt with as quickly as possible and in a confidential manner.

*If you have any concerns about this study and wish to contact someone independent and in confidence, you may contact ‘the Chairperson’ of the NUI Galway Research Ethics Committee, c/o Office of the Vice President for Research, NUI Galway, ethics@nuigalway.ie.*
Participant, stakeholders and facilitators consent form

Centre Number:
Study Number:
Participant Identification Number

CONSENT FORM

( Agency )

Title of Project: the psychosocial experiences of women involved in prostitution: an exploratory study

Name of Researcher: Leigh-Ann Sweeney

Please initial box

1. I confirm that I have read the information sheet for the above study and have had the opportunity to ask questions.

☐

2. I am satisfied that I understand the information provided and have had enough time to consider the information.

☐

3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

☐

4. I agree to take part in the above study.

☐

Name of Participant Date Signature
<table>
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<tr>
<th>Name of Person taking consent</th>
<th>Date</th>
<th>Signature (if different from researcher)</th>
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</thead>
<tbody>
<tr>
<td>Researcher</td>
<td>Date</td>
<td>Signature</td>
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1 for participant; 1 for researcher; 1 to be kept with research notes
Appendix II

Participant information pack

Date: 14th December 2010

Dear Participant

I invite you to take part in a discussion with myself, to share your experiences, so I can listen to your stories about your experiences of prostitution and what health supports you need. My work is about understanding what health needs you have and how to make this better for you. Your health is important and I would like to find out more about this. I am a student at University Galway in the Department of Health Promotion and my research title is; an explorative study of women involved in prostitution and their psychosocial experiences of the Irish healthcare service. I would like to know if you can get the help you need in your area where you live or were you work.

The interview will remain anonymous and confidential; no names and personal details of yours will be released. If you would like to meet with me for a discussion, please sign the consent form provided. If you have a friend who is also involved in prostitution and would like to meet with me also, I would be delighted. I look forward to the pleasure of meeting with you and having the opportunity to learn from your knowledge and expertise that you can have.

Kind Regards,

Leigh-Ann Sweeney

PhD Student

Department of Health Promotion
Participant Information Sheet (Participant)

**Project Title:** the psychosocial experiences of women involved in prostitution: an exploratory study

**Introduction**

You have agreed to take part in a study of women involved in prostitution: their experiences of the healthcare service. I am a student of the Health Promotion Department at the National University of Ireland, Galway. In order to do this study, you will be invited to meet with me to discuss your experiences of the health support you have or the health support you need. Your experiences will help me to find out what you need and to help make that happen.

**Invitation to take part in the study**

We would like to invite you to take part in a discussion with me.

Your participation is up to you, it is voluntary, and you are free to withdraw from the study at any time. If you would like to ask a friend who you think would also like to meet with me, I would be delighted.

Everyone taking part will be given an ID number and no names will be used when the findings of the study are reported. All the information collected during the research will be kept strictly confidential and will be stored in a way that protects your identity. Only members of the research team will have access to the information.

**Purpose of the study**

The study is designed to find out what it is like to be involved in prostitution. What supports do you feel you need? Can you get these supports? How do you think we could help? Your health needs are important and this study would like to know what they are?
Taking part—what it involves.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. If you decide not to take part in the study, that is ok.

What does taking part involve?

Everyone who agrees to participate will be asked to meet with me for a discussion about your experiences and your health needs. This discussion will take about an hour and will not be a lot of questions, but more like a chat to hear your views and opinions in more depth.

What are the possible benefits in taking part?

Taking part in the study will help the researchers to understand what your needs are and how best to support those needs. You have the benefit to have your say and give your opinion.

What are the possible disadvantages of taking part?

There are no foreseeable risks attached to taking part in this study.

What happens at the end of the study?

At the end of the study, the information or data will be analysed and a document will be written. This document will be used to show what the health supports are for women involved in prostitution in Ireland. No individual will be identified in the document.

What happens if I change my mind during the study?

You are entitled to change your mind about participation at any time during the course of the study without disadvantage or penalty.

What if I have a complaint during my participation in the study?

If you have any complaints in relation to the research process you may refer these to the Director of the Health Promotion Research Centre at NUI Galway:

Dr. Saoirse Nic Gabhainn
Each complaint will be dealt with as quickly as possible and in a confidential manner.

*If you have any concerns about this study and wish to contact someone independent and in confidence, you may contact ‘the Chairperson’ of the NUI Galway Research Ethics Committee, c/co Office of the Vice President for Research, NUI Galway, ethics@nuigalway.ie.*
Participant, stakeholders and facilitators consent form

Centre Number:

Participant Identification Number:

CONSENT FORM

(Participants)

Title of Project: the psychosocial experiences of women involved in prostitution: an exploratory study

Name of Researcher: Leigh-Ann Sweeney

Please tick the box

1. I have read the information sheet for the study of women involved in prostitution and their experiences of the healthcare service and have had the opportunity to ask questions.

☐

2. I understand the information I was given and have had enough time to think about it.

☐

3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without any of my rights being affected.

☐

4. I agree to take part in the above study.

☐

Name of Participant Date Signature
Name of Person taking consent                  Date
Signature

(If different from researcher)

Researcher                  Date                  Signature

Copies: 1 for participant; 1 for researcher; 1 to be kept with research notes
Appendix III

Agencies’ information pack

Date:

Leigh-Ann Sweeney
Department of Health Promotion
National University of Ireland Galway
L.SWEENEY1@NUIGALWAY.IE
0879108685

Project title: the psychosocial experience of women involved in prostitution: an exploratory study

Dear,

I am a PhD student at the National University of Ireland Galway, within the discipline of Health Promotion. I would appreciate your time to meet with me for an interview to hear your views and expertise on the issues of prostitution in Ireland, more specifically; to focus on the health needs of this population and access to healthcare.

As we address the changing nature of Irish society as multicultural and the changing shift of the sex industry, this study aims to indentify barriers that impede or prevent women in prostitution from availing of health services. It seeks to examine the experiences of women engaged in this area and in addition to explore the attitudes and policies of agencies providing these services.

Following completion of the study, information packs will be put together to distribute findings at training groups for healthcare professionals of both statutory and voluntary sectors alike, nationally. The target groups will comprise also of academics, which design and deliver teaching modules for Health Promotion, Social
Work, Women’s studies and related healthcare modules. This study will be reviewed in peer journals and delivered at national conferences and forums promoting women’s health. The overall objective should represent a model for good practice.

Thank you so much for taking the time to read this letter. In the interest of this research and more significantly in the interest of this service using population I look forward to meeting with you shortly.

No expense or unnecessary inconvenience will be incurred for the participants involved. Consent forms are also attached.

Kind Regards,

Leigh-Ann Sweeney
(Agencies)

Date:

Consent Form

Centre Number:
Study Number:
Participant Identification Number:

Project title: the psychosocial experience of women involved in prostitution: an exploratory study

Leigh-Ann Sweeney
Department of Health Promotion
National University of Ireland Galway
L.SWEENEY1@NUIGALWAY.IE
0879108685

Please initial box

1. I confirm that I have read the information sheet dated for the above study and have had the opportunity to ask questions. □

2. I am satisfied that I understand the information provided and have had enough time to consider the information. □

3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. □

4. I agree to take part in the above study. □
Name of Participant: Date:
Signature:

Name of Person taking consent: Date:
Signature:

Researcher: Date:
Signature:

1 for participant; 1 for researcher; 1 to be kept with research notes
Information Sheet (Agencies)

Project Title; an explorative study of women involved in prostitutions` psychosocial experiences of the Irish healthcare service.

Introduction

You have agreed to take part in a study of women involved in prostitutions` experiences of the healthcare service. I am a student of the Health Promotion Department at the National University of Ireland, Galway. In order to do this study, you will be invited partake in an interview with myself which has been informed in response to interviews which have recently occurred between myself and with women involved in prostitution.

Invitation to take part in the study

I would like to invite you to take part in a semi structured interview.

Your participation is up to you, it is voluntary, and you are free to withdraw from the study at any time.

Everyone taking part will be given an ID number and no names will be used when the findings of the study are reported. All the information collected during the research will be kept strictly confidential and will be stored in a way that protects your identity. Only members of the research team will have access to the information.

Purpose of the study

The study is sets out to identify barriers that impede and prevent women in prostitution from availing of health services.

Taking part-what it involves.

Do I have to take part?
It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. If you decide not to take part in the study, that is ok.

**What does taking part involve?**

Everyone who agrees to participate will be involved in an interview of roughly 20 minutes.

**What are the possible benefits in taking part?**

Taking part in the study will help the researchers to understand and identify barriers that impede and prevent women in prostitution from availing of health services. You have the benefit to have your say and give your opinion.

**What are the possible disadvantages of taking part?**

There are no foreseeable risks attached to taking part in this study.

**What happens at the end of the study?**

At the end of the study, the information or data will be analyzed and a document will be written. This document will be used to show what the health supports are for women involved in prostitution in Ireland. No individual will be identified in the document.

**What happens if I change my mind during the study?**

You are entitled to change your mind about participation at any time during the course of the study without disadvantage or penalty.

**What if I have a complaint during my participation in the study?**

If you have any complaints in relation to the research process you may refer these to the Director of the Health Promotion Research Centre at NUI Galway:

Dr Saoirse Nic Gabhainn

Tel: 091-493092. Email: saoirse.nicgabhainn@nuigalway.ie

Each complaint will be dealt with as quickly as possible and in a confidential manner.
If you have any concerns about this study and wish to contact someone independent and in confidence, you may contact ‘the Chairperson’ of the NUI Galway Research Ethics Committee, c/o Office of the Vice President for Research, NUI Galway, ethics@nuigalway.ie.
Local Agencies- Interview questions

Date:

Centre Number:
Study Number:
Participant Identification Number:

Project title: the psychosocial experiences of women involved in prostitution: an exploratory study

Leigh-Ann Sweeney
Department of Health Promotion
National University of Ireland Galway
L.SWEENEY1@NUIGALWAY.IE
0879108685

1. What service do you provide?
2. What are the key health factors/risks that are a concern for your population?
3. Do you think women that access your services can be at risk of prostitution?
4. Have you had direct contact with a woman/women involved in prostitution?
5. Have you had suspicions that women/woman you have worked with may be involved in prostitution?
6. If so, how do you attempt to address their health needs?
7. Do you feel equipped to address the needs specifically of women involved in prostitution within your service?
8. Is prostitution policy incorporated into your service policy?
9. Do you feel additional training in prostitution policy and care would benefit your service?
10. Would you like to see women involved in prostitution being provided a service within the West of Ireland?
Interview question- national Agencies

Date:

Centre Number:
Study Number:
Participant Identification Number:

**Project title:** the psychosocial experiences of women involved in prostitution: an exploratory study

Leigh-Ann Sweeney
Department of Health Promotion
National University of Ireland Galway
L.SWEENEY1@NUIGALWAY.IE
0879108685

1. How do you view the current situation for women involved in prostitution in Ireland today?
2. What are the issues in your opinion?
3. What are the key determinants of health for women involved in prostitution in Ireland today?
4. What are the psychosocial experiences of women involved in prostitution throughout the country?
5. Do you feel these health factors are being addressed by our current healthcare service nationally?
6. What are the underlying issues that prevent/support women in prostitution from accessing appropriate healthcare?
7. In your view, what are the answers to change?
8. Can you comment (if you have not already done so) on the legal framework of prostitution in Ireland?
9. Can you add further to this interview; anything that needs to be explored or addressed which has not been discussed here, in your expert opinion?
1. Can you discuss the current legal framework of prostitution in Sweden today?
2. How has this impacted on prostitution in Sweden?
3. What is the current situation for women involved in prostitution in Sweden today?
4. What are the key determinants of health for women involved in prostitution in Sweden today?
5. How are these health factors being addressed by the current healthcare service in Sweden?
6. Is there a role of healthcare providers in meeting the needs of women involved in prostitution in Sweden?
7. Do you think this model of Intervention is supportive of women involved in prostitution? Why?
8. Can you discuss any pros or cons of this model?
9. What can Ireland’s healthcare service learn from this approach?
10. Can you add further to this interview; anything that needs to be explored or addressed which has not been discussed here, in your expert opinion?