PERSPECTIVES OF OCCUPATIONAL STIGMA ON SEX WORKERS IN HEALTHCARE SETTINGS: A QUALITATIVE STUDY

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ABSTRACT: Those who are known to be involved in the sex trade are deeply impacted by occupational stigma and that has far reaching effects on their lives, extending even to their healthcare. Stigma has also has an impact on the research about those in the sex trade. The focus of these studies is sex workers' sexual and reproductive health. Reinforcing the idea that sex workers are only vectors of disease. There are very few studies about their general wellbeing and the healthcare they receive. From previous literature, we know that it is rare for sex workers to feel safe enough to disclose their work status for a variety of reasons including fear of arrest. We also know that when sex workers choose to disclose, they are often deeply shamed or even barred from returning to clinics and hospitals. How do those working in one of the most highly stigmatized professions experience interacting with the healthcare system? The narrative phenomenological approach of this study will provide vital perspectives from those living within the confines of occupational stigma and its impact on their ability to have their healthcare needs assessed and addressed. Studies exist that have measured how sex workers have previously interacted with the healthcare system through qualitative surveys. Very few studies exist that have put forth this type of data, making the proposed study invaluable to start creating room for sex workers within healthcare settings. However, when discussing studies to those who create policy numbers is not enough. Both qualitative and quantitative data is needed to paint a picture for policy makers to understand the lives of those who are impacted by the result of their policies.

Background and Introduction

Sex workers carry the burden of being in one of the most highly stigmatized professions worldwide. Historically and modern times sex work has been considered by society to be dirty, immoral, and sexually deviant. What is largely unknown is how occupational stigma creates and reinforces clinical repercussions for sex workers and trafficking victims in the healthcare settings where they seek help for their health. For decades, most academic studies about sex workers have focused on their sexual health, specifically their STI and HIV infection and transmission rates. These studies are essential for public health, but they neglect the rest of the sex workers' health. For example, with the current pandemic, a PubMed search of 'sex work' and 'COVID-19' returned zero results, highlighting how little information is available on significant health issues in this population. If the data does not exist, then we will create it ourselves.

Data from Lazarus et al. (2012) has shown that disclosing one's status as a sex worker can create an impossible barrier to accessing comprehensive care. The American Academy of Family Physicians (1980) defines as the "concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment." Creating healthcare provisions for sex workers

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includes creating a compassionate and friendly environment, ensuring case-worker support, and staff who are trained in sensitive, trauma-informed, and gender-affirmative care with flexibility in appointments. Continuity of care for sex workers with the same primary care providers and access to specialists, including ones who can help with dual diagnoses, unstable housing, and domestic violence, is essential (Potter et al., 2022). Continuity is a critical component of high-quality care that Fraser and Clarke (2023) say can reduce urgent care visits and preventable hospital admissions.

It is necessary to learn about sex workers' experiences with barriers to accessing healthcare and the quality of care they receive when health providers know their work status to help create a more welcoming and inclusive healthcare system that addresses their needs. Sex workers have unique health challenges that are compounded by a general lack of disclosure. Doctors and staff cannot offer the correct services and appropriate treatments without a complete picture of their patients' needs (Global Network of Sex Work Projects, 2017).

Sex Work

The stigmatization of sex work is even reflected in the derogatory terminology society often uses to address this marginalized community, which carries negative connotations and imagery. Worldwide, prostitution is a crime, though the definition varies by who is enforcing it. According to Rivera (2023), a queer, Jewish and Puerto Rican pleasure activist that co-founded Reframe Health and Justice, the best practices for the words 'prostitute' and 'prostitution' is to use them only when referring to laws and criminal proceedings. Therefore, in Rivera's opinion, the term "sex work" is more appropriate. In the 1970s, the idea of "sex work" and "sex workers" became new terms created by the late Carol Leigh, known worldwide as the Scarlot Harlot. As a sex industry and pleasure activist, Scarlot Harlot wanted to highlight that providing sexual services was a legitimate form of labor (Rivera, 2022). Sex work is an umbrella term for all forms of erotic services, such as stripping, phone sex, in-person services like trading sex, and more. For this proposal, sex work is defined as the commercial act of trading in-person sexual services and labor for money or other goods such as housing or food. Sex work is illegal in almost every country globally despite an abundance of studies that have shown the negative impact criminalization has on sex workers' access to critical health and other support services (Argento et al., 2020).

Sex trafficking

In 2000, the Trafficking Victims Protection Act defined sex trafficking as "... a commercial sex act that is induced by force, fraud, or coercion" (22 U.S. Code § 7102 - Definitions, 2013) . Despite being frequently conflated, sex work and sex trafficking are different, but they do not exist on a binary. Involvement in the sex trade occurs for a variety of reasons influenced by an ever-shifting spectrum of choice, circumstance, and coercion, otherwise known as the Three Cs of Sex Work (Rivera, 2022).

- Choice: The worker can leave anytime and have many other job options. They are fully autonomous in their work and control their earnings and spending. These workers will usually hold social and economic privileges.
- Circumstance: Most sex work likely occurs in this area. On the choice end of the circumstance spectrum, the person's involvement is practical; why not make more money "selling their body" via sex on their terms? On the coercion end of circumstances, economic issues typically drive the involvement in the sex industry. Workers would prefer to have a different job but are stuck for one reason or another.
- Coercion: There may be times when they may not have autonomy over their work or their income as someone is controlling them,

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but that does not automatically indicate that there is trafficking, nor does it mean the person being controlled is unhappy. These circumstances are not linear or permanent. Trafficking does involve coercion, and these are victims who want nothing to do with the industry.

It is important to note that there is infinitely more nuance to the sex worker versus trafficking victim discussion than is provided in this paper, but its importance cannot be understated. Trafficking victims are included in the papers' definition of the populations that deserve access to comprehensive healthcare that is in the sex trade, even if not explicitly stated elsewhere. For simplicity, in this proposal, sex workers are considered to have generally given consent to work. In contrast, sex trafficking victims do not consent to their involvement in the industry.

The Impact of Criminalization on Sex Workers' Health

Globally, prostitution is almost entirely criminalized, as it is in the US. Each state determines the legal status of prostitution, as well as the punishments for getting caught, which can have a lifetime impact. In 49 states, prostitution is illegal. In the 50th state – Nevada, there are six rural counties where prostitution is legal if done in a licensed brothel. Working under a government-controlled brothel has been described as the legal equivalent of being "pimped out" (Decriminalize Sex Work, 2023).

A unique exception to this almost uniform policy of criminalization comes from Rhode Island. In 1980, several factors led to changes in the state's prostitution laws that unwittingly omitted the law's section where prostitution was defined. While legislators cracked down on public soliciting, they unintentionally decriminalized indoor prostitution. The loophole went mainly unnoticed until 2003, when several massage and spa workplaces were raided, resulting in four arrests and charges of prostitution. Citing a previous Rhode Island Supreme Court Ruling that there is no law in the state against indoor prostitution, the charges were dropped. Indoor sex work in Rhode Island was recriminalized in 2009 (Decriminalize Sex Work, 2022) ("R.I. Looks to Close Prostitution Loophole," 2009).

This Rhode Island case study provides us with an opportunity to examine how criminalization can impact sex worker health and safety. For example, the National Bureau of Economic Research (2014) compared STI infection and rape rates of Rhode Island sex workers against people outside of the sex industry in the state from 2004-2009. Results showed a 31% decrease in reported rape cases; no other crimes showed the same pattern, removing the general possibility that policing or more extensive policies around public safety can be linked to the decline. Similar positive impacts on reproductive health and the spread of sexually transmitted infections have also been noted. During this brief period of decriminalization, a 40% decrease in cases of gonorrhea was also reported (Cunningham & Shah, 2014).

The results seen in Rhode Island are not unique. The World Health Organization (2024) says that modeling studies have suggested that decriminalizing sex work worldwide could decrease up to 46% of new HIV cases among sex workers in the following ten years. On the other hand, Lyons et al. (2020) found that the increasing criminalization of sex work across sub-Saharan Africa is positively associated with higher rates of HIV, even as global rates for HIV infections are falling for the rest of the world's population.

Stigma

Stigma is when one's reputation gets marked as a disgrace once associated with a distinct quality society disapproves of (Stigma, 2024). Scholars Toubiana and Ruebottom (2022) have suggested that those who enter the sex trade are

automatically burdened with three simultaneous stigmas: social stigma (associations with pariahs), physical stigma (proximity to perceived dirt), and moral stigma (unrighteous acts) simply due to the nature of their labor. For example, sex workers have long been stigmatized as 'vectors of sexual disease,' which wraps up all three types of the mentioned stigmas into one tidy stereotype as sexual diseases are often considered 'dirty,' sex with strangers outside of marriage for money is immoral, and sex work is not socially acceptable.

Unsurprisingly, society's stigmatization is reflected in the singular focus of medical and academic research on sexual and reproductive health in this population. As mentioned above, there are no published studies on how the COVID-19 pandemic has impacted this community. To illustrate this further, when we searched PubMed using the keywords 'sex worker' and 'healthcare access' together, approximately 70% of the results were directly related to the topics of 'HIV,' 'STIs,' and 'STDs.' Sex workers undeniably carry the burden of higher rates of STI infection and transmission when compared to those who do not engage in sex work. Still, workers also have much higher STI exposure rates, making it an unfair comparison. While HIV and other sexually transmitted infections are important to consider, so are other pressing health concerns like chronic disease. However, when PubMed was again queried to find studies on 'sex work' + 'diabetes,' there were zero results, and when 'sex work' + 'cancer' was combined, the overwhelming majority of results were about HPV and cervical cancer. The dearth of research on other important health topics, like chronic disease and mental health, reveals how all other aspects of this marginalized group's general health and well-being are wholly ignored in the research literature.

It is worth noting that infection and transmission of STIs among sex workers and trafficking victims would likely go down not only with decriminalization, as modeled in Rhode Island by Cunningham, S., & Shah, M. (2014), but consistent access to stigma-free healthcare may also be a key factor. When compared to the general public across five metropolitan cities in Canada, sex workers had nearly triple the prevalence of unmet healthcare needs (Benoit et al., 2016). A study at a free sex worker clinic in San Francisco found that 70% of almost 800 sex workers did not discuss their work status with healthcare providers, feeling embarrassed about being a sex worker or having experienced prior discrimination, such as being explicitly told not to return to a clinic (Cohan et al., 2006). There is a stigma cycle with sex work, stigma, and healthcare. Sex workers and trafficking victims fear what will happen if they disclose their work status to healthcare workers and professionals, knowing there may be repercussions. Still, if they reveal their job, they are often treated precisely as they had feared, decreasing the likelihood of future divulgence (Singer et al., 2021). To illustrate this point, consider this quote from the COYOTE Rhode Island (Call off Your Old Tired Ethics) anonymous survey of Rhode Island sex workers called "Policing Modern Day Slavery in RI 2014-2016."

"The hospital staff at the ER were very nice until the police showed up to take my report. Once they found out I was an escort, they told me that if I wanted to press charges against the man who raped me, that I would be arrested for prostitution. At this point, the hospital staff got cold, distant, and then some of them became downright rude to me" (coyotewebadmin, 2018).

Counting the Hidden

The criminalized, underground, and highly stigmatized nature of the industry makes properly quantifying the world's sex trade population an impossible task (Sawicki et al., 2019). There is no concrete data on the sex worker or trafficking population size, only speculations and estimates. Historically, studies

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on sex workers have recruited almost only cis women as participants, leaving out male and transgender sex workers. Today, there is still little data on these populations, and this proposed study allows all genders to be involved. The underrepresented quantitative data that does exist about these two populations has a narrow focus on HIV and lacks qualitative data to show the day-to-day lives of these participants, including how stigma about being a sex worker impacts their access to healthcare (Sawicki et al., 2019).

Nonetheless, a 2012 report by Fondation Scelles estimated that there were 40-42 million sex workers worldwide. There is no way to know if that estimate is high, low, or relatively accurate. Despite significant apparent bias in methodology and reporting as outlined below, this report has become one of the most widely used statistics in academia and the media when discussing the sex worker population. To start with, the Sexual Exploitation: Prostitution and Organized Crime Report (2012) does not distinguish between sex workers and trafficking victims—a necessary separation when studying population sizes, creating an immediate discrepancy in their data. Additionally, there is a significant conflict of interest as Fondation Scelles is a non-profit, sex work abolitionist group that wants to "build a world without prostitution" (Fondation Scelles, 2012). Their draconic agenda may bias their research design, data collection, analysis, and publication. Based on these flaws in the proposed methodology, the data from this sex work abolitionist group appears unreliable. Ultimately, between criminalization and the existence of groups with beliefs like such as this, it is likely that critical data like the population size and demographics of sex workers will stay unknown.

Research Question and Hypothesis

There are increased barriers and mistreatment that sex workers face when seeking healthcare due to occupational stigma. A Canadian study by Lazarus et al. (2012) found compelling evidence that regardless of a sex worker's demographics, the associated stigma hindered their ease of access to healthcare. Close to half of the 250 outdoor sex workers who participated in the Canadian study had encountered significant obstacles when seeking healthcare services within the previous six months. There are relatively few studies that have investigated the connections between the impact of the stigma of being a sex worker and their experiences in accessing and navigating their work status within healthcare settings. This proposed study seeks to answer the following question: how do sex workers experience the impact of occupational stigma on their ability to access healthcare settings, the quality of their medical treatment, and treatment from staff? Holding space for the personal narratives of sex workers will give crucial insight into how the phenomena of the occupational stigma of their work color their experiences with accessing healthcare services, how they are treated in healthcare settings, and the quality of care they receive.

Research Approach

Research Design

Studies thus far have shown that occupational stigma has wide-reaching impacts on sex workers, even in healthcare settings. Many studies have focused on quantitative results showing an association between stigma and healthcare when it comes to sexual and reproductive health. However, relatively few qualitative studies have been produced to capture the narratives of sex workers who have experienced the wide-reaching phenomenon of occupational stigma and healthcare. As such, we proffer a narrative phenomenological qualitative study offering the chance to capture and lift their voices.

Study Population and Sampling

As previously mentioned, the sex worker population can be challenging to reach due to their work being criminalized, underground, and highly stigmatized (Sawicki et al., 2019). This challenge also applies when recruiting the target population for this study. As such, snowball sampling is the best approach for reaching this population. Recruiting will start with distributing social media posts across Facebook, Twitter, Instagram, and TikTok to find potential participants. Emails with flyers will also be sent to local sex worker resources and potential community partners to request aid in recruitment. After each interview, participants will be asked if they know anyone interested in the study to try and increase the chances of finding a variety of participants. Given the discretion needed for recruitment and other study aspects, the snowball method offers the most privacy.

A. The goal is to recruit twenty participants. Study eligibility requirements are as follows.

B. someone of any gender who works in the sex industry who is

C. over the age of 18 who

D. lives in Pierce, King, or Snohomish County that has

E. has traded oral, anal, or vaginal sex for something of value at least five times in the last six months who

F. primarily works in King County that

G. understands and speaks English who is

H. mentally competent and is

I. able to give informed consent.

Operationalization

In this study, sex work is defined as the act of trading in-person sexual services for money or other goods such as housing or food. Sex workers are considered to have given consent to be involved in the sex trade, while sex trafficking victims do not consent. The occupational stigma associated with sex work is a profoundly discrediting social distinction that marks a person as a criminal pariah unworthy of being involved in society, potentially for a lifetime. Healthcare settings are any formal medical set-up where patients can seek medical and psychiatric help and have vision and dental care. Healthcare staff are anyone working in the above settings who interacts with patients. Barriers are anything that the participants view as reasons why they were not able to access healthcare settings.

Data Collection

Those interested in the study will email a specific address to answer questions about it, verify if they are eligible to participate and schedule an interview. Individual, semi-structured, in-depth interviews will be conducted via a secure connection on Zoom or in a private conference room at the local public library. The interview instrument will be designed with the help of current and former sex workers and allied shareholders in the community. Current sex work literature and previous related studies will also be used to build the interview questions. Interviewers will include current and retired sex workers trained to work in qualitative studies, as participants may feel more relaxed being interviewed by a peer. A predetermined set of open-ended questions to help guide each interview and allow room for additional probing when a topic arises organically. One example question might be, “If you have revealed your work status during a visit with your primary care provider, what was their initial response?” Followed by, “How were you treated after that revelation?” Each interview aims to create a space where the participants can share their stories and have it matter. As such, each participant is asked at the end of the interview to choose the top three things that they think need to be fixed to improve sex workers’ health

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outcomes. The answers will be used to create future interventions for those in the sex trade.

Data Analysis

The interviews are recorded, allowing each one to be transcribed and analyzed by AI. The transcription technology will allow for thematic and content analysis of the interviews, looking for themes and patterns as the words get coded. More importantly, it provides for interpretive phenomenological analysis (IPA), an essential element for this study. IPA allows for data analysis that helps create an understanding of the sex workers' lived experiences and how the sex workers assign significance to them. It is exceedingly likely that the results of the investigation will show that occupational stigma has a monumental impact on sex workers' interactions with healthcare, like facing difficulty accessing health services, receiving poor or no care, or being treated poorly by health staff.

Ethical Considerations

In consideration of their historical mistreatment by academia and society in general, this study must be for the benefit of sex workers and not just another arbitrary thought experiment. It is essential to include people with lived experience in creating and carrying out the study to develop a better environment of sensitivity and social awareness. Research in marginalized populations that is for them and by them is difficult to find. To ensure that the principles of ethical research, especially given this at-risk population, are respected, this study will first seek the approval of the Internal Review Board. After being approved and the interview instrument created, volunteers will be pursued to participate in the study. Incentivizing a study recruiting and studying marginalized populations is a tricky subject to navigate. However, given that sex workers are, by design, paid for their time, incentivization made sense.

The entire interview can be recorded and transcribed. At the beginning of each interview, the participants will consent to be recorded; then, they will review the informed consent form with the interviewer. If there are questions, all the time will be taken to answer them until the participant is satisfied. At this point, they will give their verbal consent to be involved in the study. During interviews, participants will be encouraged to share their experiences. With each new section of the interview instrument, participants will also be reminded that they can skip any questions, take a break if needed, stop recording, or stop the interview at any time if anything distresses them. They will also be reminded that dropping out of the study will not affect receiving the incentive.

Knowing the participants exist under criminalization, confidentiality in this study is critical. As another layer of safety, all communications with participants, whether voice, video, or emails, will be deleted within one year of the study's conclusion. No identifying information will be used in interviews - each interview will be assigned a number. All interviews, recordings, and transcripts will be double-backed in a password-protected cloud and physical hard drive. The research teams will do their utmost to protect the participants' identities.

Discussion

Significance

Sex worker's rights are human rights. "The right to the highest attainable standard of physical and mental health" was declared a human right by the United Nations (OHCHR, 1966) .

Due to the stigma of their career, most sex workers choose not to disclose their work status to their healthcare providers, which can lead to adverse health outcomes, including shortened life spans. Our interviews will allow sex workers to share their lived experiences and speak for themselves. We will lift their voices while creating abundant data to help develop

programs to reduce the stigma they face. A merit of the study includes gaining introspection into how stigma impacts workers uniquely and phenomenologically in healthcare settings. Studies can then be created around those two aspects of sex work stigma and healthcare.

Limitations

The choice of snowball recruiting can limit the participant demographics and can bias results. However, since marginalized and criminalized communities can be hard to find, it is often the easiest method to reach them. Participants may also drop out due to the sometimes transient nature of the job, fear of repercussions, lack of internet, or lack of privacy. If more people are eligible and interested in the interview, we can attempt to fill the empty interview spot until saturation. Another limitation is being unable to include the narratives of sex workers who did not speak English or those below a certain education level, given the further challenge of reaching them. Given the sensitive and personal nature of many of the questions in the interview and the many abuses sex workers face from the general public, we have ensured that the interviews will be conducted only by current or past sex workers. Recall bias is an essential consideration when asking about emotionally charged situations. Lastly, the study size is small and cannot be extrapolated.

Future Directions

It is possible to develop an easy-to-understand, culturally competent healthcare training curriculum for healthcare workers to lower bias against sex workers based on data from this study. Once that is created, its implementation must be measured quantitatively and qualitatively. Will it have an impact on healthcare workers' attitudes towards sex workers and sex worker patients? It has been shown that more sex workers than not choose not to disclose their work status in healthcare settings. This phenomenon deserves to be investigated further, especially qualitatively. Lastly, the three questions participants were asked at the end of the interviews – the top three things that they think needed to be fixed to improve sex workers' health outcomes should be given immediate attention for further analysis.

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