

"Two pairs of gloves"

**Sex Workers Experiences of
Stigma and Discrimination in
Healthcare Settings
in Europe**



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Contributions

Jules James was responsible for the conceptualisation of research, as well as design and implementation of survey methodology. Charlie Dominic provided review and refinement of methodology, including design of survey and guidance for data analysis. Marin Scarlett provided support for circulation and communication of the survey, as well as design and dissemination of the final report. Hanna Nyman conducted the systematic review which summarised the evidence-base relative to the research. Elizabeth Mc Guinness was responsible for data analysis, data visualisation, and co-facilitation of the data validation workshop, as well as synthesis of results and writing of the report. Julian Hows supported facilitation of the validation workshop, as part of the Red Umbrella Academy 2.0.. Luca Stevenson, Jules James and Sabrina Sanchez were responsible for securing funding associated with the research, co-facilitating the data validation workshop, as part of Red Umbrella Academy 2.0, and providing strategic oversight and guidance throughout the research process.

Abbreviations

ESWA

European Sex Workers' Rights Alliance

ECDC

European Centre for Disease Control

HIV

Human immunodeficiency virus

LGBTQI+

Lesbian, gay, bisexual, transgender, queer, intersex, plus.

PrEP

Pre-Exposure Prophylaxis

SRH

Sexual and reproductive health

WHO

World Health Organisation

Introduction

Sex workers¹ face higher rates of physical and mental health conditions, compared to non-sex working² populations. (1, 2, 3) Evidence shows that physical and mental health conditions among sex workers are influenced by the high rates of physical, sexual, psychological, and economic violence, as well as stigma and discrimination faced by sex workers in social services, education, housing, healthcare, and employment, and finance, among others areas. (2, 4, 5, 6, 7, 8, 9) Studies also suggest that sex workers experience greater unmet health needs compared to the general population, which in turn, influence their overall health.(10, 11, 12)³

For sex workers, access to healthcare is influenced by a variety of factors which may either support workers to access services (facilitators) or get in their way (barriers). (13) One of the major barriers shown to influence sex workers' access health care is stigma. (14, 15, 16, 17) For example, sex workers that disclose their occupation to health care providers may experience discrimination, including denial of care, disrespectful and abusive language and treatment, confidentiality breaches and a lower quality of care. (18, 19, 20) This may in turn impact whether workers feel comfortable following treatments and seeking healthcare in future. (21)

It is important to acknowledge sex workers as a diverse community. Sex workers have varying health needs, which are influenced by the structural, economic, social, and legal context where workers live and work.(14) Furthermore, the setting or type of sex work plays a significant role in shaping the risks and health outcomes associated with it.(22, 23) For example, street-based sex work is subject to a higher risk of violence when compared with indoor sex work. (24) Among workers who are also at higher risk of violence, and therefore negative health outcomes, are lesbian, gay, bisexual, transgender, queer, and/or intersex (LGBTQI+) sex

¹ Sex workers, as defined by the World Health Organization (WHO), are adults of all genders who receive money or goods in exchange for sexual services. Not all those who engage in sex work identify as sex workers (Sawicki et al., 2019). The term 'sex workers' reflects the immense diversity within the sex worker community including but not limited to: female, male and transgender sex workers; lesbian, gay and bi-sexual sex workers; male sex workers who identify as heterosexual; sex workers living with HIV; sex workers who use drugs; young adult sex workers (between the ages of 18 and 29 years old); documented and undocumented migrant sex workers, as well as displaced persons and refugees; sex workers living in both urban and rural areas; disabled sex workers; and sex workers who have been detained or incarcerated."

² 'Sex work' refers to the provision of sexual services for money or goods between consenting adults. The term sex work frames sex work as a legitimate form of labour and aims to normalise sex work as an occupation (Benoit et al., 2018; McMillan et al., 2018; Sawicki et al., 2019). Furthermore, it may be used to refer to an array of sexual services that may or may not involve direct physical contact, or exchange of 'full-service' (Benoit et al., 2018; McMillan et al., 2018).

³ For example, a study of sex workers in five census metropolitan areas of Canada found that sex workers experienced nearly three times as high unmet health care needs compared to the general population (Benoit et al., 2016).

workers, sex workers who are incarcerated or living in institutions, sex workers who use substances, racialised sex workers, sex workers living with the human immunodeficiency virus (HIV), and sex workers who are migrants (particularly those with undocumented status), refugees, or asylum seekers.(25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35) Parent sex workers have also been evidenced to face distinct forms of stigma and discrimination related to parenting, and particularly, custody of children.(36)

Current understandings of stigma shift focus away from stigma as individual trait and emphasise its structural nature.(37) Stigma is thus understood as a social process that operates on multiple levels of society in a cyclical manner.(38) It is dependent on power and hierarchical social structures, such as capitalism, colonialism, race, gender, and class.(39, 40) The sources of sex work stigma can be traced back to such socio-power structures as well as institutions, communities and individuals that operate to enforce social norms and structures.(15) While sex work stigma is present in all legal contexts, the criminalisation of sex work is argued to perpetuate it. Furthermore, stigmatisation of sex workers occurs through institutions such as the health care and legal systems, communities as well as individuals such as family and friends, partners, and clients.(15) The stigmatisation of sex workers creates an environment which normalises the dehumanising treatment of sex workers and leads to discourses that guide the development of laws, policies and practices which criminalise sex work and continue the cycle of stigmatisation.(19)

As part of background to this research, ESWA supported development of a systemic review, examining evidence of sex workers experiences of stigma and discrimination in healthcare settings in high-income countries.(41) The findings of this review suggest that sex workers' interactions with health care professionals are especially important in shaping their experiences of stigma in health services. Experiences of stigma in health services may have long-lasting effects on access to care as sex workers may internalise stigmatising beliefs and learn to anticipate stigmatising experiences.(16, 42, 43, 44, 45, 46)

This review was limited however, in that the studies within were mainly conducted in Canada, the United States and Australia.(41) As these countries represent different health care systems and legal frameworks surrounding sex work in comparison to Europe, the results may not be transferrable to European contexts in which ESWA works.

Therefore, one of the objectives of this research was to facilitate deeper understanding of sex workers' experiences of stigma and discrimination in healthcare settings in Europe. The research also aimed to inform future interventions to combat stigma and discrimination against sex workers in healthcare settings, thus improve sex workers' access to appropriate and quality healthcare.

Methods

Sex workers experiences of stigma⁴ and discrimination⁵ in healthcare settings⁶ were inquired about via an online survey, containing both closed and open-ended questions. The survey was prepared and cross-checked by ESWA staff. The survey was circulated online via ESWA's social media platforms, list-servs as well as by member associations. The survey platform Shout was used to maximise privacy and safeguard data of participants. To be eligible, respondents were required to be current or former sex workers based in Europe. Prior to beginning of the survey, an explanation of the research was offered to potential respondents. Respondents were asked whether they consent to use of quotations, and if so, to the level of description attributed to their quote (i.e. country, identity). Respondents had the option of remaining anonymous, as they were not required to disclose any personally identifying information. They could however chose to provide an email address where they could be contacted to provide further information and to be kept in the loop of findings.

The survey was offered in English, French, Spanish, and Russian. Data was translated by sex worker rights activists with the necessary language capabilities and via an online translation app. Where in doubt about slang regarding sex work, this was checked with community members who spoke the relevant language.

Data arising from the survey contained a mixture of closed and open-ended (text) responses. Closed-ended responses were analysed using Microsoft Excel. This included generation of descriptive statistics, as well as data visualisations. Text based responses were analysed using NVivo 14. Qualitative data analysis combined Thematic Analysis with Framework Analysis (47, 48). This allowed for both bottom-up, and top-down coding. An updated framework of Meyer's 2003 theory of Minority Stress was chosen as the framework through which to organise qualitative findings. (49, 50) "Minority stress"⁷ (Meyer, 2003) was developed as a framework to understand why sexual minorities face higher levels of physical and mental conditions, without reinforcing pathologisation. (50) Minority-stress offers a framework for examination of factors which shape health outcomes at distal (external) and proximal (internal) levels. External stressors may arise from discriminatory laws and policies, institutions, experiences of violence, or simply from negative attitudes resulting in microaggressions.

⁴ The term stigma refers to "a set of negative and often unfair beliefs that a society or group of people have about someone," (Definition from The Britannica) for example, being a sex worker. The survey also stated that any definition participants might have about stigma and discrimination also applies.

⁵ Discrimination, was referred to as any behaviour expressing stigma.

⁶ The survey provided the following explanation of healthcare settings: Healthcare settings referred to various services and places where healthcare occurs. It is a broad term, and can refer to public or private healthcare, general healthcare (such as doctors or general practitioners), hospitals, specialised healthcare outside hospitals, sexual and reproductive healthcare (related to HIV, contraception, abortion, etc.), mental healthcare and other healthcare providers (dentist, endocrinologist...).

Internal stressors relate to identity concealment, internalisation of stigma, and coming to expect rejection. The framework of Minority Stress was chosen due to calls from sex worker' rights scholars and activists, as well as based on accessibility for policymakers, and relevance for designing of interventions. (51)

Data was coded line-by-line and according to steps of Thematic Analysis, as outlined by Braun and Clarke.(47) Themes were sorted into categories of the relevant framework in iterative fashion. A data validation workshop was hosted among representative of sex worker rights associations and sex workers from across Europe, to triangulate findings. These included two contexts not represented within survey responses (namely Armenia and Austria). Participants were asked to discuss perceptions of stigma and discrimination against sex workers, in their country contexts, and feedback in front of the whole group, prior to presentation of survey findings. This was done to avoid biasing responses.

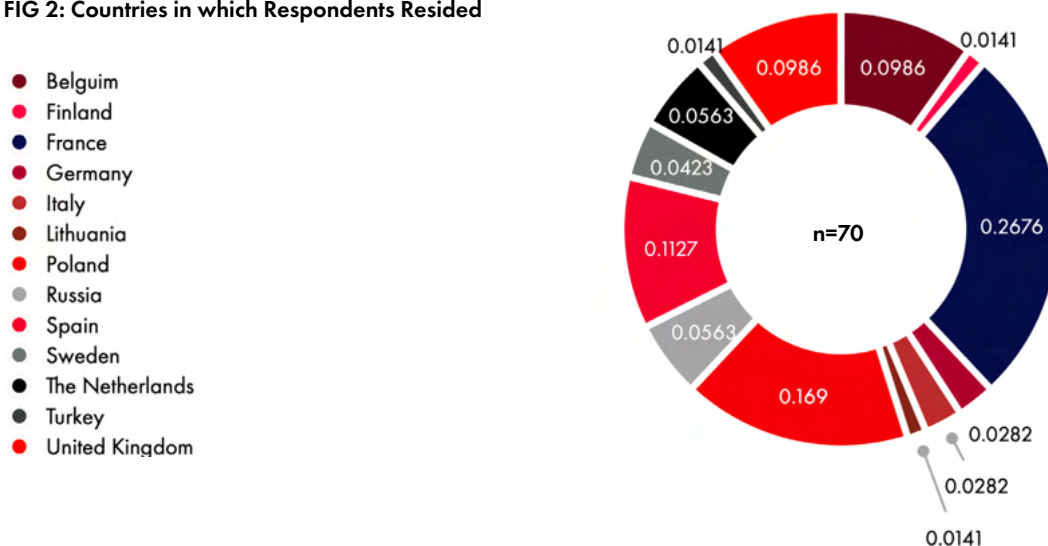
⁷ As described by Meyer: "Minority stress is distinguished from general stress—stress that all people may experience—by its origin in prejudice and stigma. Thus, a stressor, such as losing one's job, could be a general stressor or a minority stressor depending on whether it was motivated by prejudice as opposed to, for example, economic downturns that impact all people. Collectively, these minority stressors constitute the excess stress burden that places sexual and gender minority people at greater risk for negative health outcomes compared with cisgender straight people. Against these stressors, there are individual- and group-level coping mechanisms that can reduce the negative impact of minority stress. Thus, the overall health impact in the minority stress model is determined by the negative impact of stressful experiences and the ameliorative impact of coping, social support, and resilience."

Results

Who responded to our survey and in which countries are they based?

A total of seventy-one current or former sex workers responded to the survey. Thirty-eight participants responded in English, twenty-two in French, seven in Spanish, and four in Russian. One set of responses were removed, due to being outside of Europe. This brought the total sample to seventy. Respondents represented a range of countries across Europe. The ages of respondents ranged from 19-66, with a median of 27 years.

FIG 2: Countries in which Respondents Resided



Respondents self-reported doing a range of forms of sex work, including direct contact with clients and digitalised forms of sex work, such as camming. These included 64% of respondents who mentioned escorting (45), 6% full-service (4), 33% BDSM or fetish services (23), 24% camming, porn or content creation (17), 3% burlesque (2), 6% stripping (4), 3% selling items online (2), 3% providing girlfriend experience (GFE) (2), 3% erotic massage (2), 1% phone sex-operation (1), and 1% sexual accompaniment for clients with disabilities (1).⁸

Five respondents were currently or formerly street-based, while eighteen received clients at their homes, and five in unspecified other in-call locations. Nine respondents mentioned outcalls, four of which listed using hotels or holiday rentals. Fourteen respondents mentioned working online or camming. Finally, two respondents mentioned working within brothels or private houses, and one as being window-based. Three participants mentioned working independently, and two

⁸ Forms of sex work reported by respondents overlapped. For example, GFE, escorting and full-service, may all refer to full service sex work.

with an agency. The range of time doing sex work among the sample was from six months to 34 years. Participants reported a cumulative total of 508 years in sex work.

Of participants who self-reported their gender identity and sex characteristic (n=59), 41% (24) were cis-women, 39% (23) non-binary, 10% (6) as trans-women, 7% (4) as trans-men, and 3% (2) as intersex. No cis-gender men responded to the survey. Of the 55 respondents who reported their sexual orientation, 46% identified as queer, 40% as bisexual, and 7% as gay and lesbian. One participant specified their sexual orientation as asexual, and another as pansexual.

FIG 3: Legal Framework Concerning Sex Work Within Countries of Respondents

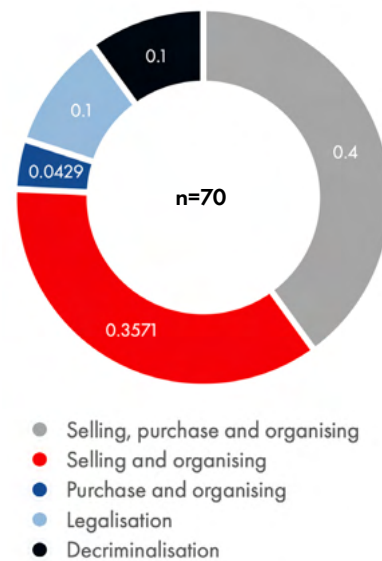


FIG 4: Gender Identity and Sex Characteristics Among Respondents

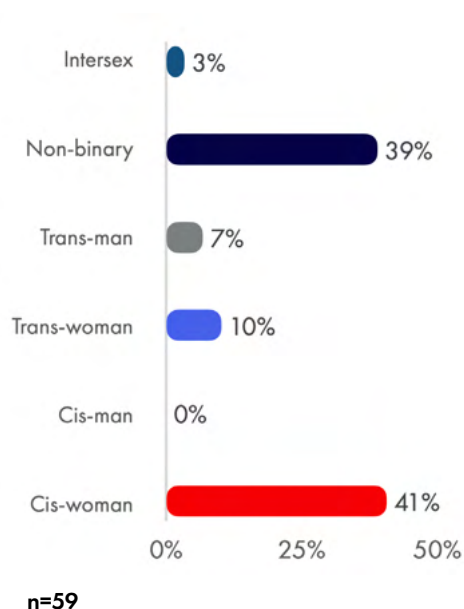


FIG 5: Sexual Orientation Among Respondents

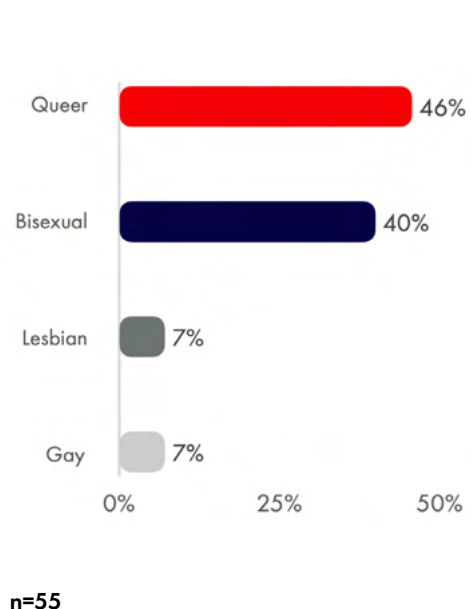


FIG 6: Minority Identities Among Respondents

n=70

Eight participants identified as racialised. Eleven participants were migrants with residency status, and one with another kind of migration status, which was not further explained. No currently undocumented migrants completed the survey, or chose to disclose. Twenty respondents identified as persons who use drugs, and one as a former drug user. Five respondents disclosed being HIV+. Thirty-three percent (23) of participants identified as disabled. Of those who explained further, one person identified as physically disabled, two as having ADHD, one as neurodiverse, and one as having a mental health condition. Two additional respondents disclosed neurodivergence but did not identify as disabled. Eleven percent (n=8) of participants were parents. Of the six participants who listed other identities, three reported either current or past engagement with child protection systems.

What are sex workers' own definitions of stigma and discrimination?

We asked participants about their personal definitions of stigma and discrimination. Here's what they had to say: Stigma is:

"The way in which people assume and form an idea of my life, or experiences in terms of my association to what I do for work."

Gay, non-binary, sex worker, the Netherlands

"Structural othering."

Queer, non-binary, disabled, sex worker, Germany

'Social exile.'

Queer, non-binary, sex worker, Belgium

"Preconceived notions that people have about us, that we're unreasonable, irresponsible, as if we were putting ourselves in danger or mutilating ourselves by our choice of work, that it's the hidden cause of our "somatic" health problems, that we're alienated, that we're accomplices in the exploitation of women, that we need to be saved."

Bisexual, disabled, migrant, sex worker, France

"Rejection and contempt due to being at odds with societal norms."

Queer, non-binary, racialised, disabled, trans-man, sex worker, France

"Politics of lower expectations."

Bisexual, non-binary, sex worker, Belgium

"Being blamed for systems beyond our control."

Bisexual, non-binary, Belgium

"Preconceptions from others that don't align with your own sense of self."

Queer, non-binary, sex worker, Belgium

What are the overall trends in sex workers experiences of stigma and discrimination in healthcare settings?

Overall, 87% of respondents had experienced either stigma, or discrimination in healthcare settings, or both. Those who were unsure mentioned confusion in understanding the motives of healthcare staff (i.e. whether certain actions were routine, or attempts to belittle respondents). Of respondents who identified as either racialised, migrants, or living with HIV (n=5), 100% reported either experiencing stigma or discrimination in healthcare settings, or both. Of respondents who identified as trans or gender-diverse (n=36), 92% reported either experiencing stigma or discrimination, in healthcare settings, or both. Finally, 91% of respondents who identified as disabled (n=23) reported either experiencing stigma or discrimination, or both.

FIG 7: Have you ever experienced stigma and discrimination in healthcare settings?

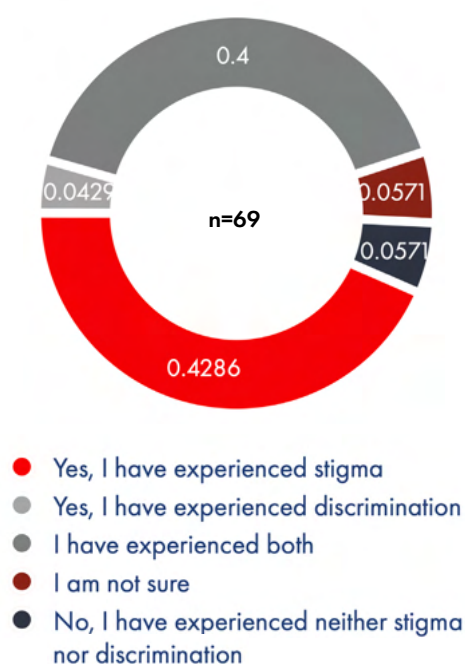
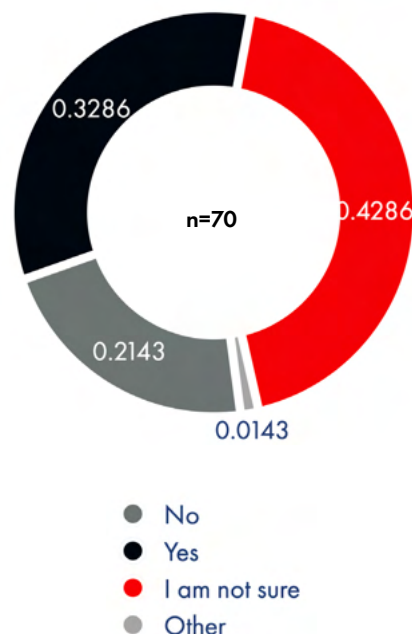


FIG 8: Has stigma and discrimination you face in healthcare settings increased since you started sex work?

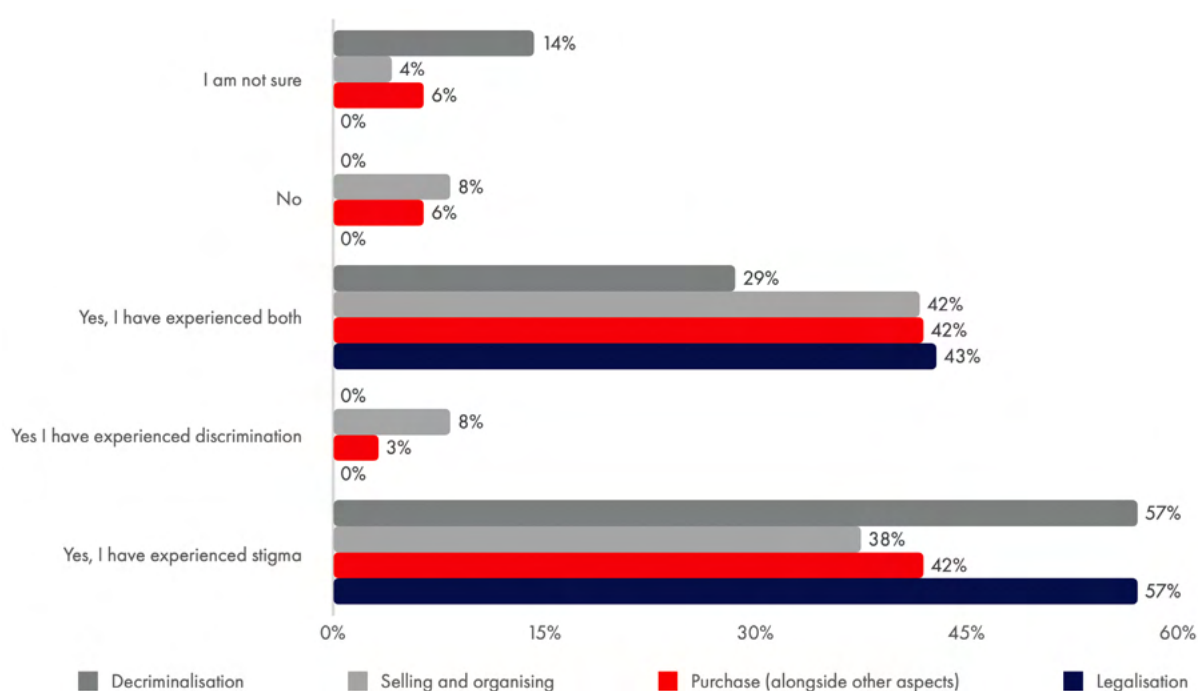


When asked about the number of times experiencing stigma, and discrimination in healthcare settings, those who responded numerically cited 667 collective instances of stigma and discrimination. Others were unable to place a number on their experiences, instead referring to the nature of stigma as a constant.

The frequency of reported stigma and discrimination among individual participants ranged from once to over a hundred times. When asked whether stigma and discrimination in healthcare

settings had increased, since beginning sex work, the response was mixed. For example, some respondents found it hard to distinguish between whether negative experiences had net increased, or whether this was because they were now more likely to be open about their sex work. Others mentioned that negative treatment related to their sex work was just a continuum of the abuse they experienced in healthcare settings as abusive throughout their lives. Others found it difficult to discern sex work related stigma and discrimination from ageist treatment.

FIG 6: Experiences of stigma and discrimination by legal framework surrounding sex work

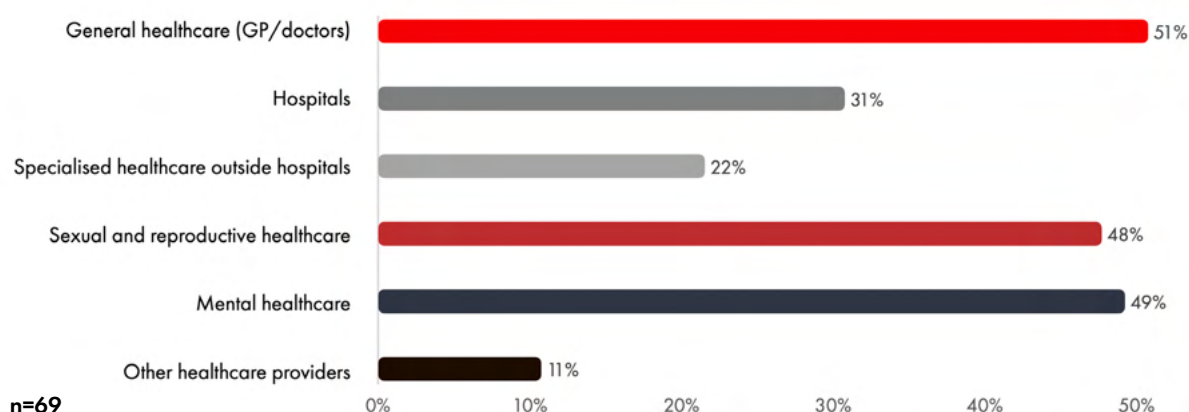


There was no major differences between experiences of stigma and discrimination in healthcare settings, and the legal framework regarding sex work in discrete answers. However, one sex worker in Belgium discussed a positive evolution in stigma, which they attributed to the recent decriminalisation of sex work, whose implementation is currently underway, and gains in the movement towards realisation of sex workers' rights since Covid19. The relevance of the legal framework surrounding workers' experiences is discussed further within Environmental Circumstances.

In which health care settings do sex workers experience stigma and discrimination?

General healthcare settings (such as general practitioners) was the most commonly cited setting in which stigma and discrimination was reported (with 51% of participants citing experiences). This may be due to the fact that it is also the most commonly accessed form of healthcare, and not necessarily mean that stigma and discrimination occurs at higher rates within. This was followed by 49% of respondents and 48% disclosing having experienced stigma and discrimination in mental healthcare and sexual and reproductive healthcare (SRH) respectively. Other healthcare providers which respondents mentioned experiences of stigma and discrimination in, included staff providing homecare to patients with disabilities, community healthcare centres, and blood donation centres.

FIG 10: Within which healthcare provider(s) have you experienced stigma and discrimination?



Sex workers living with HIV (n=5) reported most stigma in general healthcare and hospital settings. Whereas those who were racialised (n=8) reported most stigma and discrimination in general healthcare, hospital settings, and mental healthcare, with 75% in each. Disabled sex workers (n=22) reported experiencing most stigma or discrimination in mental healthcare settings (81%), followed by general care (63%). Migrants (n=11) reported most stigma and discrimination in general healthcare and SRH care, 63% in each. Of the 34 sex workers reporting stigma or discrimination in mental health care, 53% identified as disabled, 50% as queer, and 44% as non-binary. Of 31 sex workers reporting stigma and discrimination in SRH care, 45% identified as queer, 35% as non-binary and 35% as disabled.

Below, Meyer's framework of minority stress, on which the data analysis and reporting is based, is presented. As the Sex Worker Outreach Project USA stated: "as sex workers do not conform to societal sexual norms, applying the minority stress framework to those engaged in sex work is useful for understanding this lived experience." For example, internal stressors applied to sex workers can look like: "passing as non-sex worker, concealing job from friends, family, internalization of whorephobia, believing sex work is not "real" work etc., and

anticipating rejection which may result in fewer close bonds, difficulty making new friends, isolation, being frequently guarded or defensive, etc.”(51)

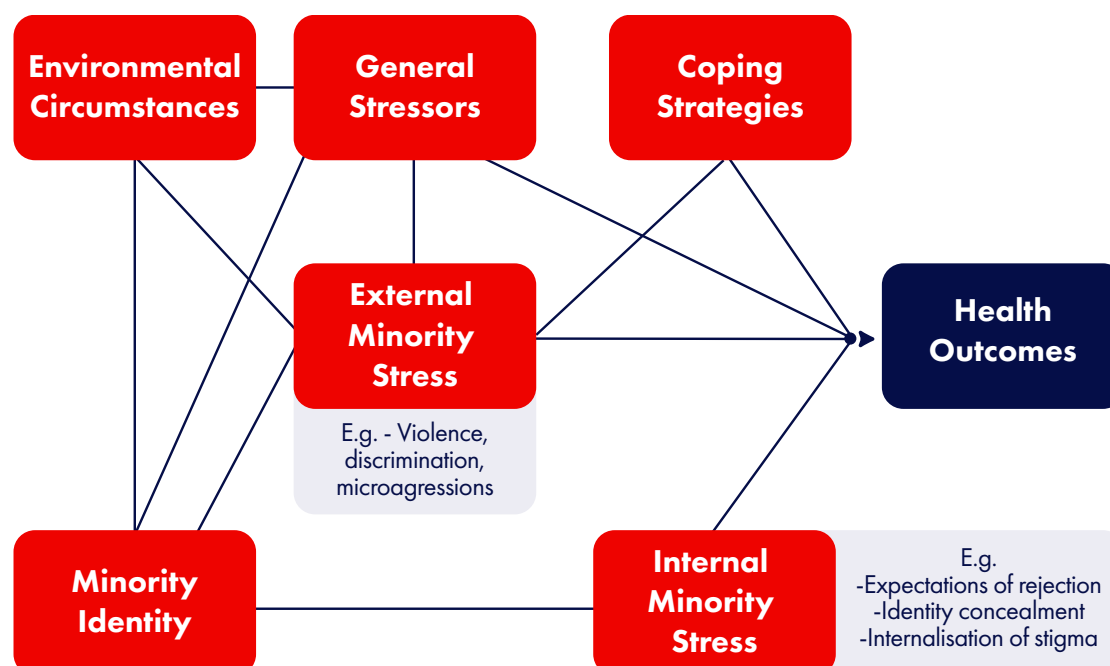


FIG. 1: ADAPTED FROM: Frost DM, Meyer IH. Minority stress theory: Application, critique, and continued relevance. *Current Opinion in Psychology*. 2023;51:101579.

What forms of external stigma and discrimination do sex workers' experience in healthcare settings?

A range of forms of external stigma and discrimination were reported by participants in healthcare settings. The most frequently reported behaviour encountered was being asked inappropriate questions (67%):

"I called my appointments with my therapist, "the tribunal." Non-binary, lesbian, disabled, parent, sex worker, Belgium

"They asked me how I can look at myself in the mirror." Bisexual, non-binary, sex worker, Poland.

In some cases, sex workers mentioned that questioning seemed to be mandatory, but that staff were ill-prepared to deal with outcomes:

"questions [about violence exposure] seemed to come from a checklist that they then didn't seem to know what to do with afterwards." Queer, disabled, sex worker, U.K.

Invasive questioning, for example being asked about income or rates, was linked to several themes arising within data, including voyeurism and fetishization of sex work: "since working I have to basically get ready for questions like

"how many clients daily do you have?" Bisexual, non-binary, sex worker, Poland

"Questions about my work would often come especially from male interns (they don't need that knowledge to help me with a common cold)." Disabled, non-binary, lesbian, sex worker, Poland

Fetishization of sex workers, contributed to a reported sense of entitlement to sex workers' bodies, and seeing sex workers as "public property:"

"The people in the ambulance asked me invasive questions about my intimate piercings." *Queer, neurodivergent sex worker, Poland.*

"There was this entitlement that I would be willing to have sex with the person talking, at any time, because of my line of work" *Bisexual, racialised, disabled, trans woman, Poland.*

Even where questioning was perceived as non-threatening, this contributed to a sense of othering, or exoticisation:

"Kind of an attitude like "wow, it's not every day we get to meet a prostitute." *Cis-woman, sex worker, France*

This led to reported feelings of alienation among respondents, as well as disruptions to care:

"A nurse spent so much time asking questions (she had never met a sex worker before), the tourniquet failed, we could not take any blood that day." *Cis-woman, sex worker, U.K.*

Similarly, even where healthcare staff's reactions were recognised as well-intended, overly positive attitudes or "affirmations" of empowerment in relation to sex-work, contributed to feelings of alienation:

"the comments are meant to be supportive, but they just make me feel isolated (like "if you enjoy it and you're making loads of money then good for you.")." *Queer, non-binary, disabled, sex worker, U.K.*

The second highest cited behaviour among participants was being advised to stop sex work (54%). Unsolicited advice was one manifestation of broader themes of paternalism and infantilisation discussed by participants:

"They don't listen to me when I say I don't want help quitting sex work." *Queer, cis-woman, parent, sex worker, Sweden*

Sex workers mentioned a perceived double standard surrounding sexual versus other forms of labour:

"Other jobs can be dangerous too. I think being soldier is more dangerous than being an escort. So why aren't doctors constantly telling them to stop doing that for a living." *Non-binary, bisexual, sex worker, Poland.*

Respondents also spoke of a double standard in being consistently advised to stop sex work while not being offered, or referred for, material assistance by healthcare providers. Even when material assistance for stopping sex work was requested, one respondent mentioned that staff were not equipped to respond. Respondents felt this is a good illustration of the ways in which sex work is often divorced from the external, namely economic, contexts:

"I was stressed because I had to earn a certain amount of money before a travelling. The gyn interpreted it as though I was pressuring myself to sell sex." *Bisexual, cis-woman, parent, sex worker, Sweden.*

Respondents felt that healthcare staff were either insensitive to or uninformed of the multitude of reasons why people use sex work as a form of income generation. Particularly, they lacked understanding that for many, sex work is often the best of limited options, when considering flexibility, time-resources, including linked to caring responsibilities, access-needs, and access to formal job markets.

This led to advice, which was not only unsolicited, but generally unhelpful, or unrealistic. Unsolicited advice came both in the form of being told to cease sex work, but so too in being advised to change certain behaviours, or ways of working, within. Again, such advice was seen as misplaced, as healthcare providers generally did not understand nuances of practices, or forms of sex work, including the often-necessary compromises workers may make, for example to increase earning potential:

"The doctor refused to refer me to physio [for chronic leg pain], because "just stop wearing heels." " Queer, non-binary, disabled, sex worker, U.K.

In several instance, a respondent reported receiving unsolicited advice linked to heteronormative understandings of cis-gender women's (or others assigned female at birth)'s perceived role in society (i.e. as mothers):

"I was advised to get pregnant and have a baby, by quite a few doctors of various specialities, both for making my hormones stable, quitting job, being heteronormative, even for depression."

Non-binary, disabled, lesbian sex worker, Poland.

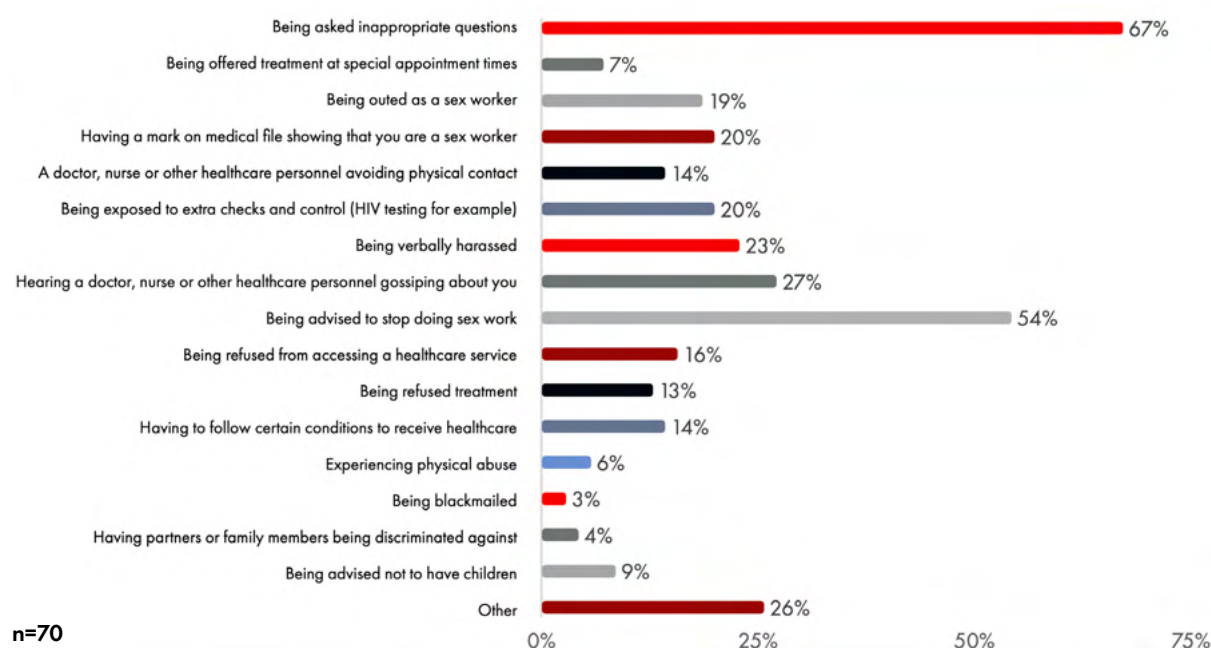
"One gyno told me one that I have "beautiful and healthy uterus and wasting it in this way." Non-binary, bisexual, sex worker, Poland.

Conversely however, participants also reported being advised not to parent

"better not to reproduce." Queer, non-binary, disabled, sex worker, Germany

Indeed 9% of sex workers responding to the survey disclosed being told by a healthcare professional not to have children. This illustrates the ways in which norms surrounding reproduction are weaponised against those who transgress dominant sexual norms, including sex workers. Reproduction is positioned both as the cure to deviance, but so too as undesirable in resisting its spread. Unsolicited advice was unanimously viewed by respondents as an overstepping of health providers' roles.

FIG 11: What type(s) of stigma and discrimination have you encountered in healthcare settings?



In addition to unsolicited advice, respondents also cited receiving unsolicited commentary, again evident of overarching attitudes of paternalism and infantilisation. Unsolicited commentary was perceived as either uninformed, ignorant, or condescending in nature, by workers. Sex workers felt that comments often related to assumptions of risk, or were voyeuristic, in undertone. Unsolicited commentary was also reported to take on a moralising stance:

"They tell me how bad I must feel when doing this to myself and how bad it is for my self-worth and so on." Bisexual, cis-woman, parent, sex worker, Sweden.

"I came here for a HIV test, not moral advice." Sex worker, U.K.

Linked to notions of morality, healthcare providers were reported to weaponize either spirituality or notions of honour and shame, in their treatment of sex workers responding to the survey:

"[I've had] remarks about "selling my body" made during therapy." Queer, non-binary, disabled, sex worker, U.K.

"One gynaecologist said that I should think of what I do to my soul." Queer, cis-woman, parent, sex worker, Sweden.

Moralising was linked to overall judgement, another theme arising within the data. For example, respondents encountered judgement relating not only to engaging in sex work generally, but related to discussion of their practices within, such as provision of oral sex or penetration without condoms.

Several respondents cited judgement or attempts to influence their relationships with those around them, particularly where it was known to providers that they were parents (See minority identity). This manifested, for example, in scepticism by healthcare providers of sex worker's capacity to form and maintain healthy relationships:

"you cannot have "real" relationships." Queer, non-binary, disabled, sex worker, Germany

In instances, providers were reported to have made comments referring to the inevitable abandonment of sex workers by their partners, given perceived difficulties in accepting their profession. In other cases, comments related to heteronormative and cis-sexist stereotypes surrounding purity and worth, as linked to sexual activity:

"my gynaecologist said that "nobody will want to marry that much of a used wh*re." Non-binary, bisexual, sex worker, Poland.

This included implicating notions of "family honour." This expanded to the idea that sex work and parenting were incompatible:

"Do you realize that if we insult your children as "un fils du pute," it will be true?"

Several sex workers reported receipt of slut-shaming remarks and perpetuation of myths surrounding vaginal 'looseness':

"Once a gynaecologist said, "with a body like yours, you must have had lots of clients." Non-binary, lesbian, disabled, parent, Belgium.

Judgement appeared to stem from assumptions and attributions healthcare workers held surrounding sex work, or those who engage within it, another theme apart within data. For example, assumptions reported were commonly linked to victimhood, intelligence, work-

practices, and sexual orientation or attraction: "you're too smart for sex work." Queer, disabled, migrant, sex worker, Spain.

Assumptions reported were also based around racial, gendered, ableist or other stereotypes (see Minority Identity). For example, it was reported that healthcare providers had trouble understanding that there may not necessarily be an overlap between a patient's sexual orientation and how this is enacted at work with clients. This was the case reported by one sex worker who identified as a lesbian, but frequently saw cis-gender male clients at work.

Assumptions surrounding perceived victimhood of sex workers were seen to be held in place by narratives which conflate sex work to trafficking. This was seen to be reflected within healthcare providers' use of language concerning sex work, namely insistence on using the term "prostitution." Sex workers felt this mirrored the broader control of language, upheld by pro-criminalisation "feminists," within the mainstream political and societal realms. These assumptions frequently resulted in excessive questioning of sex worker's agency: "always asking if I'm being forced." Queer, disabled, sex worker, U.K.

Parallel to assumptions evident within healthcare workers' practices and beliefs, sex workers reported being attributed at risk of harm (or as already harmed), or as themselves constituting a risk to be managed. Concerning the former, workers were treated as at risk of a range of harms to physical and mental health, including what in medical terms constitutes "negative coping mechanisms," such as substance use, even where no indication was made to providers that this was the case:

"they want me to start to talk to a therapist about my sex work and the danger I expose myself to." Bisexual, cis-woman, parent, sex worker, Sweden.

"Questions about drugs only happen after I mention sex work." Cis-woman, sex worker, Sweden.

Meanwhile, attributions perceiving sex workers themselves as 'risks,' manifested for example, in excessive focus on STIs, and insistence on screenings:

"whenever disclosed/implied, the most frequent responses are about sexually transmitted diseases." Bisexual, racialised, disabled, trans-woman, Poland.

"They always book an hour for testing to first have a "talk"." Bisexual, cis-woman, parent, sex worker, Sweden.

Several sex workers responding to the survey, also cited restrictions on blood donation, which they felt reflected narratives linked to sexual 'promiscuity' as a vector of disease.

In instances these attributes combined to re-enforce the perception that sex work, and by extension sex workers' health care needs, were so complex, they could not be attended to in 'generalised settings:

"I've been refused therapy in past because doing sex work means I have 'complex needs.'" Queer, non-binary, disabled, sex worker, England.

This is one instance illustrating the ways in which care is deferred for sex workers. Even when participants were referred to sex worker only services, this caused them delays in attending to health care needs, as well as loss of time and money. Deferring care was seen to be uphold

by narratives which pathologise both sex work and sex workers themselves. Attempts to defer care is one manifestation of being refused from a healthcare service, an occurrence which 16% of sex workers cited. Similarly, 9% of respondents reported being offered treatment at special appointment times.

Assumptions were related to two interlinked, and overarching themes: sex work as a totalising identity, and sex workers as homogeneous. The latter was seen to result in presumption among healthcare providers that all sex workers provide the same services, and that sex work is limited to in-person, full-service work:

"When I talk about my job, I also have to talk about STIs even if I'm talking about being a camgirl/ or doing solo content. They tell me that I have too many sex partners even if I'm not meeting IRL with clients and I'm in a stable monogamous relationship." **Non-binary, disabled, lesbian, Poland.**

Viewing sex workers as homogeneous was also reported to lead to the exclusion or erasure of specific identities within sex work. For example, one trans-male sex worker encountered transphobia at a clinic specifically oriented toward gay, male sex workers, which they reported experiencing as particularly disappointing.

Relatedly, viewing sex work as a totalising identity served to overshadow and erase all other facets of workers' lives and identities:

"They only see the sex worker in me." **Sex worker, Russia.**

"Above all, they gave me the feeling of being nothing else, as soon as I talk about my job all the exchanges revolve around it." **Queer, cis-woman, parent, sex worker, Belgium.**

Respondents detailed how once having disclosed that

"all problems linked back to or were attributed to sex work." **Queer, cis-woman, parent, sex worker, Belgium.**

Excessive focus on sex work was perceived as a by-product of pathologisation, another prominent theme within data. Pathologisation was evident not only of those who engage in sex work, but so too of sex work itself. Regarding the former, this manifested in the assumptions among healthcare providers, particularly in mental health care, that engaging in sex work was unequivocally related to adverse experiences in workers' pasts:

"In mental health care, everything was always reduced to the fact that I'm a prostitute, no recognition that it can be a job, no more nor less, and not necessarily "the manifestation of my childhood traumas" or whatever." **Queer, sex worker, France**

Relatedly, sex work was viewed as a conduit to, as well as a manifestation of poor mental health or general psychological distress: "A psychiatrist looked straight in my eyes and said "sex workers are always addicted to something." **Bisexual, non-binary, sex worker, Poland.** " "They said that my sex work was the thing that made me feel bad about myself." **Cis-woman, sex-worker, Sweden.** "The gyno said I was hurting myself with my behaviour and that I would stack up my traumas and deal with them later in life." **Bisexual, parent, sex worker, Sweden.**

Finally, the theme of pathologisation also arose in relation to workers who engaged in sexual practices seen as outside the norm:

"My ex-psychologist told me that sex work is always running away from something and that BDSM is never healthy." Bisexual, cis-woman, Poland.

Paternalism, attributions of risk, and Pathologisation (among other factors) were seen to contribute to gatekeeping of treatment, including by placing excessive hurdles to meet care needs. Indeed, 14% of sex workers reported having to follow specific conditions to receive care: "They prescribed me condoms (even though I'm allergic to the only brand that is reimbursed). I told them I didn't want them, because I already have a brand adapted to me at home, but I was obliged to collect them from the pharmacy and bring them to the next consultation, otherwise, I could no longer be followed-up there." Queer, non-binary, trans-man, sex worker, France.

Mandating of additional STI checks was one manifestation of gatekeeping and was experienced by 20% of sex workers responding to the survey:

"When I showed up to the emergency room with bleeding, a gynaecologist requested STI testing, even though I told her I'd been tested a couple of days ago. She refused to further investigate without running the tests again first." Bisexual, inter-sex, sex worker, Belgium.

Being exposed to excessive controls led to feelings of "being socially monitored" among respondents. Queer, non-binary, sex worker, Belgium.

In some cases, sex workers reported feeling pushed to accept specific treatments by healthcare providers:

"The doctor kept aggressively encouraging me to take PrEP." Queer, disabled, sex-worker, U.K.

At other times, outright refusal of treatment was experienced by respondents, namely by 13%:

"The nurses refused me pain meds, I honestly think they wanted me in pain." Queer, non-binary, sex worker, Poland.

"I was once refused treatment even when I was in anaphylactic shock." Queer, racialised, disabled, sex worker, Spain.

"They didn't want to treat me, they didn't want me there." Bisexual, non-binary, sex worker, Poland.

Insistence on following specific treatments or requiring sex workers to undergo additional tests, even where indicated that they were not at risk (or had tested recently), reflected the overall theme of dismissal. This could manifest in dismissal of patient preferences, concerns, or requests for specific tests or courses of treatment: "I thought I would feel safe disclosing to a therapist, but she made me feel so uncomfortable and would not listen to me when I said, "I'd prefer we don't talk about my work right now."" Gay, non-binary, sex worker, Netherlands

However, dismissal also extended to disbelief or negation of patient's lived experiences and knowledge of their own bodies and symptoms:

"I'm regularly told I'm exaggerating." Queer, non-binary, disabled, sex worker, U.K.

Dismissal was seen as closely interlinked with medical ableism, particularly surrounding invisible disabilities, and cis-sexism. Respondents reported doctors to be quick to negate both experiences which patients found harmful in sex-work, as well as those they found positive:

"I was told that when a client raped me, I only needed contraceptive care." Disabled, migrant, sex worker, Spain.

"They can't get that it is enjoyable for me to have sex with strangers who pay me." Queer, cis-

woman, parent, sex worker, Sweden.

Finally, participants viewed refusal to accept sex work as a form of work as an extension of dismissal: “sex work, is it a real profession..?” Non-binary, disabled, parent, lesbian, sex worker, Belgium.

Lack of concern for patient confidentiality was widely reported by participants. This is reflected by the 19% of sex workers who cite being outed as a sex worker: Breaching of patient confidentiality was seen to occur both intentionally on behalf of healthcare providers (i.e., gossiping), and non-intentionally, related to service protocols:

“my practice now rotates patients between doctors, thus it seems to have spread through them.” Queer, disabled, non-binary, sex worker, U.K.

Service protocols sometimes meant that workers were obliged to out themselves, for example in reception areas, to access treatment. On the other hand, at sex worker friendly locations, respondents mentioned having personal information, such as legal names revealed:

“Don’t call out my legal name in a waiting room.” Queer, non-binary, disabled, sex worker, U.K.

Intentional breaches of confidentiality were reflected by the 27% of sex workers who reported hearing healthcare staff gossiping about them. One sex worker reported being

“Made fun of by nurses right outside my hospital room.” Queer, non-binary, disabled, sex worker, U.K.

Labelling patients as sex workers on their medical files, an occurrence which 20% of respondents cited, was also seen to jeopardise confidentiality, and create fear of repercussions:

“They started to write down on my file that I was a sex worker. I had to insist that this was not written down.” Queer, disabled, sex worker, U.K.

Several respondents spoke of attitude shifts among healthcare providers following disclosure of sex work. This included general senses of discomfort, non-verbal disapproval (such as looks of disgust), and in some cases, physical distancing: “an orthodontist physically recoiled in her seat when I told her what I do for work.” Cis-woman, parent, sex-worker, Belgium. Doctors, nurses, or other healthcare providers were reported to avoid engaging in physical contact by 14% of sex workers:

“they did not want to touch me, the physician used two pairs of gloves.” Sex worker, Russia.

“In the 80s, you were seen as a pest. There was no way they would touch you.” Trans woman, migrant, living with HIV, sex worker, France.

Avoiding physical contact was perceived as being linked to a “fear of transmission,” upheld by both stereotypes surrounding sex worker’s sexual health, and misinformation surrounding transmission of infections:

“I don’t have HIV, but the doctor and pharmacist assumed that I did, because I’m on PrEP.” Cis-woman, parent, sex worker, Belgium.

Indeed, several respondents reported receiving out of date, biased, or inadequate information surrounding sexual health. This was reported in particular in relation to PrEP. Workers were also subject to stereotyping surrounding their sexual health status: “When I told them I wasn’t HIV+, the counsellor said, “this is surprising” because he assumed that as a sex worker I would have HIV.” Queer, cis-woman, parent, sex worker, Sweden.

Avoiding of physical contact was also linked to the theme of dehumanisation, prominent within data:

"The physician did not speak a word during the visit. I was less than human to her." **Sex worker, Russia.**

Dehumanisation of sex workers played into hierarchies of perceived 'deservedness' of care among healthcare providers:

"Psych ward staff told me that the hospital is wasting space and money on me." **Bisexual, non-binary, sex worker, Poland.**

Dehumanisation was also seen to play into instances where standards of care were diminished, exposing patients to danger: "They wanted to use a speculum on me that had just fallen to the ground, and when I asked for a clean instrument to be used, they laughed in my face, saying that my vagina was far from sterile anyway." **Racialised, cis-woman, sex worker, France.**

Dehumanisation was also evident in the physical separation of sex workers from other patients:

"My bed and all belongings stayed in the hallway [of the psychiatric hospital] for the entire duration of the stay." **Bisexual, racialised, disabled, trans-woman, Poland**

Verbal harassment, similar to the above was reported by up to 23% of sex workers responding to the survey:

"They belittled me and verbally abused me for the entirety of my stay. One of them [nurses] said "you're good for nothing but a brothel." **Queer, non-binary, sex worker, Poland.**

In instances, gossip was also perceived as a means of belittling or humiliation:

"they would gossip as I leave, but not waiting for me to actually leave to start talking." **Queer, non-binary, sex worker, Italy.**

Blackmail within healthcare settings was reported by 3% of sex workers, although details were not elaborated upon. Sex workers also reported experiencing gaslighting:

"whatever I said out loud, they twisted it, applied their view and threw it back on me." **Bisexual, cis-woman, parent, sex worker, Sweden.**

Several respondents reported victim blaming attitudes in response to experiences of violence at work:

"they said rape was an "occupational hazard."" **Disabled, migrant, sex worker, Spain.**

Healthcare providers were also reported to disregard need for informed consent, particularly during physical examinations: "They have always touched me without my consent or explaining what they are doing." **Queer, non-binary, neurodivergent, sex worker, Poland.**

Finally, while the survey focused on stigma and discrimination, several participants shared experiences of physical abuse (alongside generally rough physical treatment), as well as sexual harassment, although few details were given:

"Hearing a doctor tell me I need a man with a good d**k for "treatment" was something else." **Disabled, non-binary, lesbian, sex worker, Poland.**

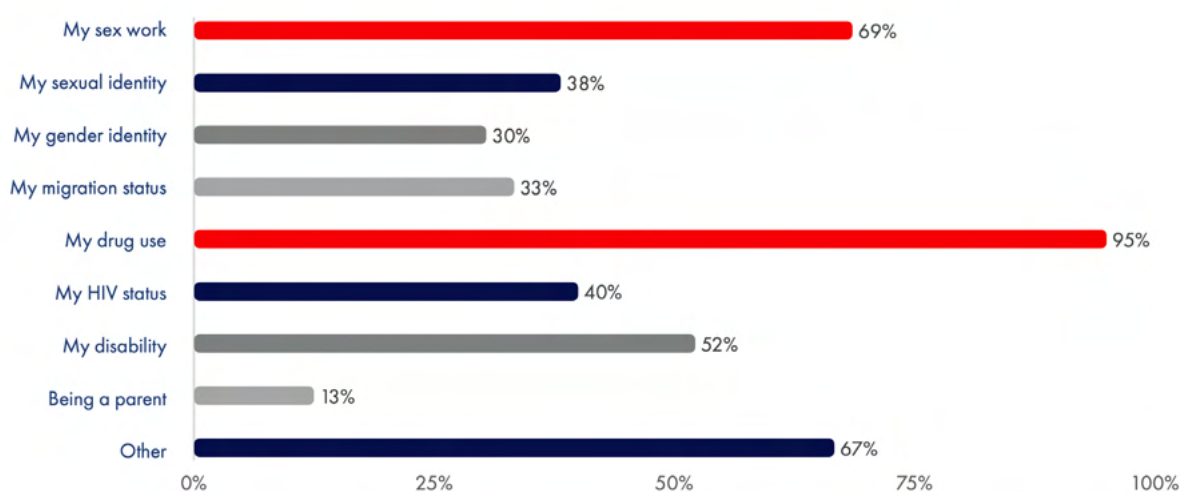
What forms of internalised stigma and discrimination do sex workers' experience in healthcare settings?

Overarching themes in relation to internal minority stress include expectations of rejection, identity concealment, and internalisation of stigma. Expectations of rejection were based both on prior negative experiences, including second-hand experiences, as well as general perceptions of stigma and discrimination concerning sex work in society: "a lot of my friends were stigmatized and discriminated by healthcare workers so I'm avoiding that subject." Queer, non-binary, disabled, sex worker, Poland. Some workers chose to deliberately disclose as a tactic to resist stigma:

"I generally talk about any topic that affects me, preparing for the negative consequences." Queer, non-binary, disabled, sex worker, France

Consistently expecting rejection, led sex workers to feel "on-edge" i.e. hypervigilant. Hypervigilance was exacerbated where workers felt pressure to stay on top of previous lies told told healthcare staff to avoid outing themselves. It was felt that over time, this become increasingly unmanageable.

FIG 12: When possible, I decided not to disclose:



n=70 n=55 n=46 n=11 n=20 n=5 n=23 n=8 n=6

The extent to which sex workers felt obliged to conceal their identities, is reflected by the 69% of respondents who stated that, when possible, they preferred not to disclose their sex work:

"My psychiatrist and therapist don't know what I do for living, I had to straight up lie that I have 'regular' job." Bisexual, non-binary, sex worker, Poland.

"I told him [the doctor] I was a synchronised swimmer, because I didn't want to say." Cis woman, sex worker, Poland.

Decriminalisation was the only legal framework within which sex workers reported greater comfort in disclosing (57%), than in hiding their sex work (21%). However, as changes to the legal framework were introduced as recently as 2022, implementation is still in progress, and therefore the extent to which results can be interpreted as indicative of a fully decriminalised setting are limited.

Identity concealment did not appear to greatly shift relative to legal frameworks regarding sex work. Instead, thought processes and choices around disclosure were dynamic, and shifted depending on various factors:

"When I'm in doubt, I don't out myself." *Sex worker, Europe*

This included past negative experiences following disclosure:

"Therapists refused to treat me after I was admitting to my job. Now I just hide that information."

Bisexual, non-binary, disabled, sex worker, Poland

Factors which hindered disclosure also related to fear of consequences. The most frequently cited fears among sex workers related to confidentiality, removal of children, ramifications on migrant status, loss of housing, or intervention of youth services (where respondents were still themselves engaged with child protective services):

"I don't share the fact I started [sex work] underage unless it's critical, because I'm afraid of safeguarding referrals being made about me and putting me in danger of eviction." *Queer, non-binary, disabled, sex worker, U.K.*

These fears were exacerbated in settings of criminalisation:

"Sex work is illegal here, so I can't say I'm doing it," *Queer, non-binary, disabled, sex worker, Lithuania*, as well as where respondents lived in smaller, rural areas.

Fear caused sex workers avoid engaging in aspects of examination: "I'm careful not to let them touch on personal ground." *Queer, disabled, trans-woman, sex worker, France.*

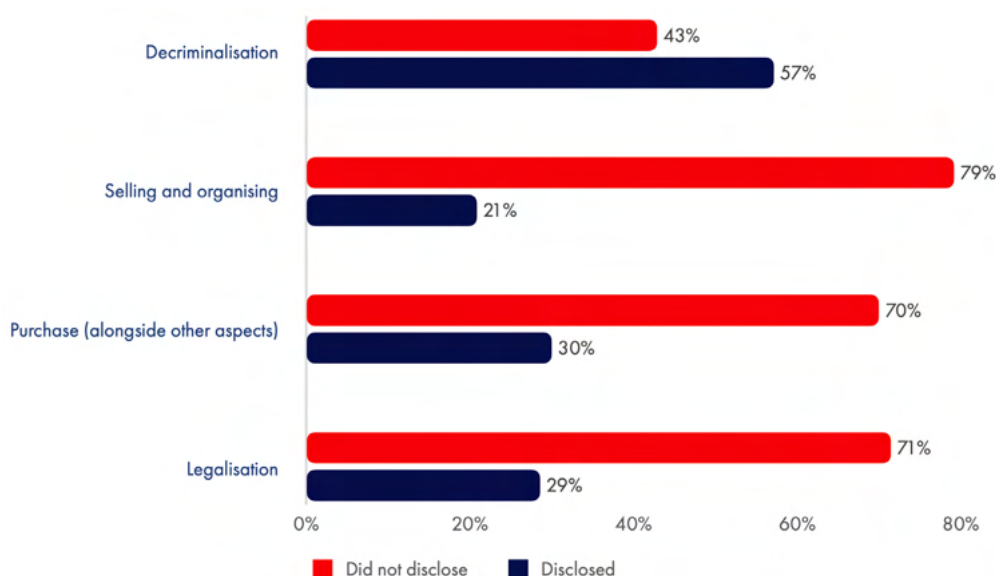
"I can't let the health care see me naked because I don't want to see my c-section scar." *Queer, cis-woman, parent, sex-worker, Sweden.*

Feeling pressure to hide their sex work caused respondents to miss-out on or delay care:

"I couldn't do STI tests because I was afraid to tell one old, male doctor about my job, so he told that there is no need to do the tests."

"I felt robbed of a right to feel more secure in my practice. To feel safe with doctors and to ask them for what I need." *Bisexual, racialised, cis-woman, sex worker, France.*

FIG 13: Disclosure of sex work in healthcare settings by legal framework



Disclosure thus emerged as selective, with workers making strategic choices about when, and crucially how much to share:

"I rarely tell the whole truth." Disabled, migrant, sex worker, Spain.

The trade-offs between outness and receipt of stigma versus accessing appropriate care were widely acknowledged:

"I have to hide this fact [that I am a sex worker] in therapy, which is making it pointless." Bisexual, non-binary, sex worker, Poland.

"How can a sex worker go through rehabilitation for Long COVID, when they can't speak about how working conditions impact their condition?" Queer, disabled, non-binary, sex worker, Germany.

Although sex workers were adept at finding compromises to meet their needs, including through partial disclosure, this incurred fatigue:

"I learned to find better ways to hide but still get what I need. It's a hassle and extra mental labour" Queer, non-binary, disabled, sex worker, Lithuania.

Overall, feeling pressure to conceal sex work was experienced as an extension of discrimination:

"I consider that not revealing this information to healthcare professionals for fear of being stigmatized and therefore not receiving advice or care adapted to my situation is an indirect form of discrimination." Racialised, cis-woman, sex worker, France.

Factors facilitating disclosure included confidence in healthcare providers, and prior knowledge of providers or locations as sex worker friendly:

"I avoid outing myself to medical personnel if I don't know they are sex work friendly." Bisexual, non-binary, disabled, sex worker, Poland.

"Putting up a pro-sex worker poster or flyer in the waiting room or listing the health facility in a "safe" directory, can be small details that will encourage those concerned to consult and disclose their activity." Disabled, racialised, cis-woman, sex worker, France.

One respondent felt that sensitive, clinical inquiry on sex work would support workers to disclose:

"In my experience, I've never been given the opportunity to talk openly about it, so I've never dared to do so. It would be much easier to provide practitioners with this information if the question were approached in a neutral, routine way." Disabled, racialised, cis-woman, sex worker, France.

Overall, having confidence to disclose and speak openly about sex work, made respondents feel comfortable to precise their needs and receive more tailored support.

For some sex workers, negative experiences in healthcare settings resulted in the internalisation of stigma:

"it made me doubt my self-worth and who I am." Bisexual, cis-woman, parent, sex worker, Sweden.

In other instances, workers referenced self-blame surrounding their responses to stigmatising events:

"It felt unfair and scary to understand I internalise and accept quicker than I speak up." Queer, sex worker, Belgium.

"I felt powerless and like I had let them cross my boundaries and step on me." Bisexual, cis-woman, parent, sex worker, Sweden.

Nevertheless respondents often critically reflected upon and respond emphatically where dissatisfied with their initial reactions:

“you are in such a vulnerable situation when you receive healthcare and I didn’t have my guard up.” Bisexual, cis-woman, parent, sex worker, Sweden.

What factors in the environment influence sex workers’ experiences of stigma and discrimination in healthcare settings?

Several environmental factors were perceived as influencing sex workers exposure to stigma and discrimination in healthcare settings. These included: the structure of health systems the legal framework surrounding sex work, migration, and LGBTQI+ rights, and access to information. Whether or not health systems were patient centred and evidence informed, as well as degree to which providers were aware of the inherent power differences between themselves and patients were perceived to influence exposure to stigma and discrimination. The inherent power imbalance in data collection in healthcare settings was mentioned as an explicit example of this. Similarly, general lack of access and availability of services (particularly in rural areas) influenced the extent to which sex workers could choose where to seek care. Finally, resource allocation in healthcare services, including distinctions between public and private care were perceived to influence negative treatment. Meanwhile, access to information and formal education influenced how comfortable sex workers felt advocating for themselves during consultations.

Laws criminalising sex work were perceived as licences to discriminate:

“Their point of view on sex work is printed in the law.” Bisexual, cis-woman, parent, sex worker, Sweden.

Criminalisation also created greater fear to disclose activities to healthcare providers, for fear of legal consequences. Several respondents made comparisons across countries featuring different frameworks in which they had previously worked:

“I’ve had better experiences in Australia than UK. I suspect this is due to a less criminalised environment and better funding for public health services.” Queer, disabled, sex worker, U.K.

Finally, while criminalisation exacerbated circumstances, decriminalisation was not automatically seen as a silver bullet towards ending stigma and discrimination¹⁰:

“Since decriminalization, we’ve been considered workers. What would be nice now is for the government to make things easier for us by helping us to become independent without being judged by the authorities.” Cis-woman, sex worker, Belgium.

¹⁰ Forms of sex work reported by respondents overlapped. For example, GFE, escorting and full-service, may all refer to full service sex work.

How do intersecting systems of oppression shape sex workers' experiences of stigma and discrimination in healthcare settings?

Sex workers' experiences of stigma and discrimination in health care setting were exacerbated by intersecting systems of oppression, such as ableism, classism, racism, cis-sexism, homophobia, transphobia, fatphobia, and xenophobia. Sex workers who were multiply marginalised cited an overall lack of understanding of cycles of exclusion among healthcare providers:

"Understand we aren't just marginalised for doing sex work, we were already marginalised before and that's why we are doing sex work." *Queer, non-binary, disabled, sex worker, U.K.*

Alongside concealment and selective disclosure of sex work, respondents also exercised caution surrounding disclosure of other (concealable) minoritized identities:

"I don't bother telling health services I'm non-binary because I don't think they'll respect it." *Queer, non-binary, disabled, sex worker, U.K.*

For example, 38% of lesbian, gay, bisexual, and queer sex workers chose to hide their sexual orientation in healthcare settings, and 30% of trans, non-binary and intersex sex workers hide their gender identity and sex characteristics.

Disclosure of concealable identities was often seen as an either/or i.e. discussing sex work or other aspects of identity:

"I'm always going to avoid saying that I'm a sex worker AND that I use cannabis, if I say one, I won't say the other." *Cis-woman, sex worker, France.*

This was done strategically to minimise potential harms:

"in my country in general being LGBTQIA+ brings shame, so being a sex worker too, is a big shame combo." *Queer, non-binary, disabled, sex worker, Poland.*

Some sex workers who are parents were concerned about the ramifications of disclosing their parental status on custody of children:

"I cannot tell them that I have kids, it would be devastating and they could convince other authorities that I can't be a good mother due to my sex work." *Queer, cis-woman, parent, sex worker, Sweden.*

13% of parent sex workers chose not to disclosure in healthcare settings. However, balancing disclosure of identities often came at the cost of forgoing healthcare needs:

"They refused to run certain tests because I'm a lesbian, and hadn't outed myself as a sex-worker" *Non-binary, lesbian, migrant, sex worker, France.*

This demonstrates the ways in which stigma and discrimination associated with sex work not only overlaps with other forms of stigma and discrimination, but combines with it to exacerbate impacts. For example, sex workers who use drugs were often hesitant to raise this with healthcare providers, for fear of both worsening stereotypes, as well as being subjected to them:

"Ah well you see, all us whores use drugs because you understand, we live such horrible realities that we are obliged to take drugs to get away from them." *Cis-woman, sex worker, France.*

"Just another drug addict," said the doctor while prescribing PrEP." **Queer, non-binary, racialised, disabled, trans man, sex worker, France.**

Workers who discussed drug use were also subject to gatekeeping of treatment, as well as labelling on medical files. This occurred even where drug use was in the past, or recreational in nature:

"My file states I had a cocaine addiction even though I said I'd only done it a handful of times at parties and was never addicted. I was refused mental health treatment as a result as they said I needed to do a substance abuse programme first." **Queer, non-binary, sex worker, U.K.**

"Despite being clean for many years, I was still repeatedly asked "Have you ever used drugs, have you ever injected drugs". Both were added to my file." **Cis-woman, sex worker, U.K.**

Revealing drug-use also subjected sex workers to discriminatory beliefs surrounding "deservedness" of healthcare: "They told me all drug users deserve to die. That time should not be wasted on the likes of me." **Bisexual, sex worker living with HIV, Russia.**

Of respondents who stated they use drugs, 95% reported hiding their drug use from healthcare providers.

Ableism was a large concern among sex workers with disabilities in health care settings, particularly for those with invisible disabilities, including neurodivergence and mental health issues. Of sex workers who identified as disabled, 52% hid their disability in healthcare settings. Sex workers with disabilities cited confronting of stereotypes surrounding sexuality and disability:

"There's this assumption that disabled people don't have a sexual life." **Queer, non-binary, racialized, disabled, trans-man, sex-worker, France**

"You can't be a sex worker if you are autistic." **Queer, Migrant, Disabled, Autistic, Sex-worker, Spain**

Stereotypes related not only to assumptions of persons with disabilities as asexual, or "undesirable," but so too about perceptions of productivity or capacity to work:

"As disabled, I'm expected to provide more proof that I can be a good worker." **Queer, non-binary, intersex, disabled, sex worker, France.**

Sex workers with chronic physical disabilities were frequently dismissed due to pathologisation:

"They blocked me from accessing care for my pain for one year because they thought it was somatic due to my work." **Queer, cis-woman, disabled, migrant, sex worker, France.**

"When they knew what I do for work, I would get questions like "Are you sure, that this is really an issue of corporal health?" **Queer, non-binary, disabled, sex worker, Germany.**

Dismissal was also attributed to ableist, cis-sexist and misogynist stereotypes:

"A&E staff consistently believe I am exaggerating or making things up when experiencing genuine pain and emergencies as I am a woman and "melodramatic."" **Queer, non-binary, disabled, sex worker, U.K.**

This included stereotypes surrounding disability (including mental health conditions) as a means of "attention seeking" or to "get-ahead:

"they said that it's just made up, that it's manipulation," **Queer, disabled, sex worker, Poland.**

"They said I use disability "as an excuse."" **Queer, non-binary, disabled, sex worker, Germany.**

Respondents felt that this kind of dismissal/disbelief was an extension on that they received

when disclosing sex work. It was felt that healthcare providers perceived them as doubly incapable of knowing their own bodies/need, due to being both a sex worker, and “mentally ill.” This was perceived as an overall lack of awareness surrounding both mental and chronic physical health conditions among healthcare providers:

“instead of recognizing a panic attack, they assumed it was somehow malicious.” Queer, non-binary, neurodivergent, sex worker, Poland.

Sex workers with disabilities also cited a lack of consideration for accommodating access needs in healthcare settings:

“I was refused help when I was not understanding what was happening because of processing problems.” Queer, racialised, disabled, migrant, sex worker, Spain.

“ADHD makes it hard for me to retain verbal info but when I ask for info in writing by email or text it’s often refused.” Queer, non-binary, disabled, sex worker, U.K.

This created additional barriers for sex workers with disabilities either in accessing healthcare for following treatment. Lack of accessibility also led to worse physical health:

“on the website the clinic said it’s accessible, but when I arrived, the lift was broken. I had to struggle up and down 4 flights of stairs cause I knew if I asked to move the appointment, it would be another 4 months of waiting.” Queer, non-binary, disabled, sex worker, U.K.

Racism also manifested within verbal harassment of black sex workers by healthcare providers as well through Islamophobic assumptions surrounding sexuality and culture:

“Your father must be ashamed of you, no?” This was a comment made by my former GP, because I’m of Moroccan and Muslim origin.” Queer, non-binary, racialized, disabled, trans-man, sex-worker, France

Two sex workers detailed playing with notions of ‘respectability’ in healthcare settings to be taken seriously, with favorable treatment reported due to being either white, middle-class, or ‘citizen’ passing. One racialised sex worker also encountered healthcare providers who believed racist misconceptions surrounding differences in pain processing (i.e. that black people feel less pain compared to white people). This led healthcare providers to take their pain less seriously, and provide less pain relief.

Migrant sex workers cited past fear surrounding documentation, as well as instances of xenophobia in healthcare settings:

“The doctors talked about me and not to me, as if I didn’t understand them.” Queer, racialised, disabled, migrant, sex worker, Spain.

One migrant sex worker also encountered stereotypes surrounding use of sex work as a form of “gold digging” i.e. to secure citizenship. 33% of migrant sex workers reported hiding their migration status in healthcare.

Cis-sexism, heteronormative attitudes, and bi-erasure were further illustrated through assumptions surrounding penis in vagina sex by healthcare providers where respondents were perceived as cis-gender women.:

“when asked if I’m pregnant, they ask how I’m so sure.” Queer, non-binary, disabled, sex worker, U.K.

This occurred alongside more obvious forms of homophobia:

“My dentist once told me that she can’t stand those LGBT+ people and theirs protest and prides.

She doesn't know that I'm LGBT+. It was stressful." **Bisexual, cis-woman, sex worker, Poland.**

Transphobia was also an issue in healthcare setting. However, exposure to discrimination based on gender identity/expression related to trans or non-binary sex workers ability to "pass":

"I prefer to keep what I can to myself."

"These [humiliating comments] mostly happened when I dressed as a woman." **Trans-woman, migrant, sex worker, France.**

Legal gender markers on identity documents (where incompatible with respondent's gender identity or expression) were also emphasised as both a barrier to healthcare, and source of anxiety due to outing. Deadnaming¹¹, including in crowded receptions, was reported. This was sometimes perceived as deliberate attempts to humiliate trans or non-binary respondents. Trans and non-binary sex workers cited heightened fetishisation and voyeurism, again resulting in invasive questioning:

"questions like how I masturbate, how often etc, which were not needed for the diagnosis." **Queer, trans-masc, disabled, sex worker, Poland.**

Trans and non-binary respondents cited feeling pressure to comply with providers requests or questions, particularly when they presented a blockage to hormone replacement therapy.

Finally, sex workers living with HIV disclosed stigma and discrimination based on their serological status:

"They told me that I was infectious, even though I take ARVs, and that I should not have children because I have HIV." **Bisexual, disabled, parent, sex worker living with HIV.**

"I was once refused treatment by a dentist" **Queer, trans-woman, sex worker, living with HIV, France**

40% of sex workers living with HIV reported hiding their status from healthcare providers.

As demonstrated in this section, many factors impact sex work experiences of stigma and discrimination in healthcare settings. The next section analyses how involvement in sex work and other social determinants impact on how sex workers cope and respond to negative experiences in healthcare settings etc.

What strategies do sex workers use to cope and respond to stigma and discrimination in healthcare settings?

Sex workers used a range of strategies to cope with and respond to stigma and discrimination experienced in healthcare settings. These include both external as well as internal strategies.

Only 44% of sex workers felt comfortable to take external action following stigma and discrimination in healthcare. Sex workers in Belgium, in which sex work was decriminalised in 2022 reported being between 40-44% more likely to take action challenging stigma than in settings of criminalisation, or legalisation. External actions which sex workers took to confront stigma and discrimination included, educating healthcare providers, engaging in complaints

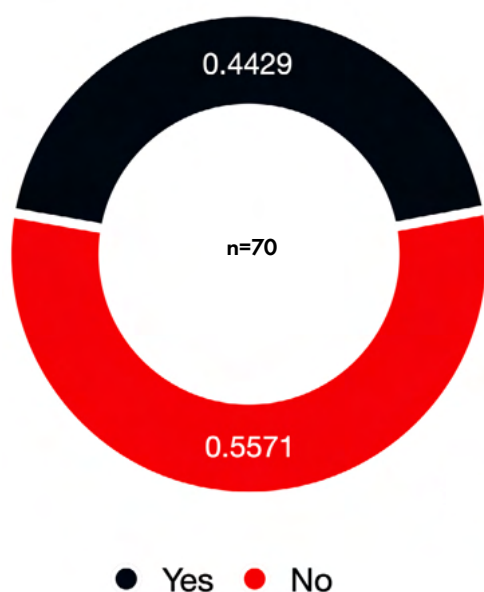
¹¹ Deadnaming refers to the act of calling a trans or gender-non conforming person by a name they used before transitioning. This can be done either unintentionally, or deliberately to cause harm.

processes (10%), changing healthcare providers, engaging in activism, using community-referral networks, drawing on community knowledge or community resources, engaging in informal dialogue with healthcare providers, asserting their needs in healthcare, or being vocal about their dissatisfaction, requesting to switch staff members, and bringing community advocates or other trusted friends and family to future appointments. Some sex workers also reported that one way they deal with stigma and discrimination was to give-in, or compromise with to healthcare providers:

"I just try to please them in any way they want." Bisexual, parent, cis-woman, sex worker, Sweden.

Others mentioned making strategic use of stereotypes, to meet their healthcare needs. For example, one sex worker receiving healthcare from a centre linked to the anti-trafficking movement in their country, chose not to argue against stereotypes regarding sex work and victimhood, due to concern they could be kicked out of the service (i.e. due not being a "real victim.")

FIG 14: When you experienced stigma and discrimination, did you take action to challenge it?



Many sex workers spoke of the importance of being able to rely on sex worker, or other communities. Communities provided both social (e.g. accompaniment to appointments, creation of care-networks) and logistical support (e.g. sharing referral networks):

"We pass around the details of providers (particularly therapists or gynos)" we found to be not too terrible amongst ourselves." Cis-woman, sex worker, France.

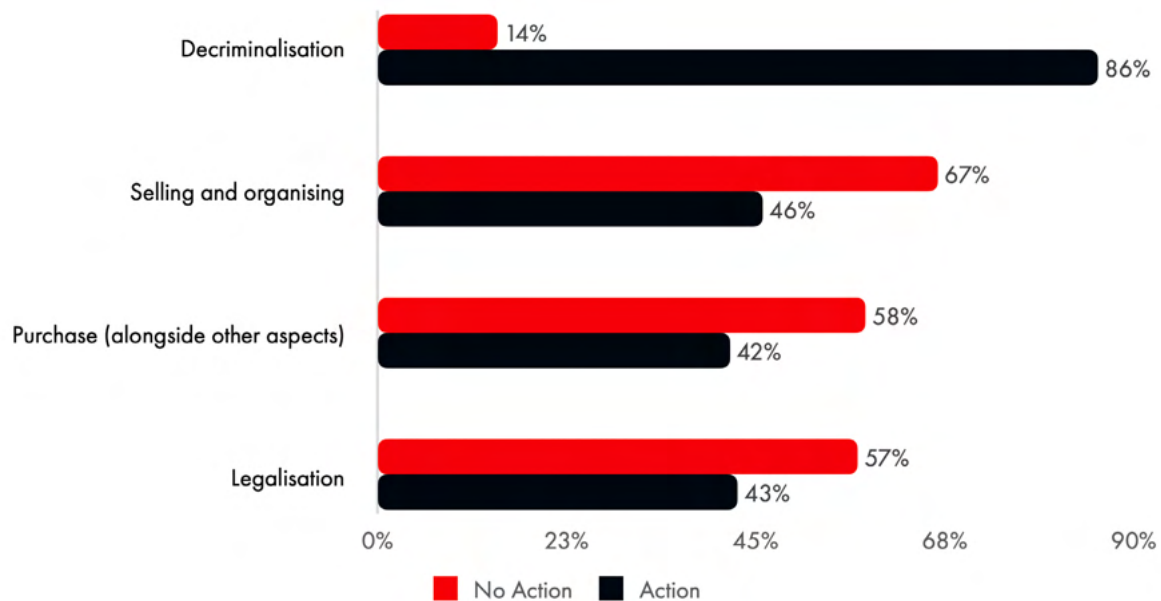
"Now my partner comes with me every time, otherwise, I don't feel capable of going to appointments." Queer, non-binary, racialised, disabled, trans-man, sex worker, France.

In one case, a sex worker spoke about drawing on professional knowledge among her community to substitute for formal healthcare visits:

"I didn't consult a doctor, just got an MRI and EEG. I interpreted the results myself with a help of friends who are med students." Bisexual, non-binary, neurodivergent, sex worker, Poland. This helped sex workers to feel able to make informed decisions about their health, while not further exposing themselves to harmful attitudes:

"I still suffer from migraines but as I know my condition is not life threatening, I'm still not going to see the doctor." Bisexual, non-binary, neurodivergent, sex worker, Poland.

FIG 15: Actions to challenge stigma and discrimination in healthcare settings by legal framework surrounding sex work



Many respondents mentioned educating healthcare providers when exposed to harmful attitudes:

“When asked if being forced I explained the forces of capitalism.” *Queer, disabled, sex-worker, U.K.*

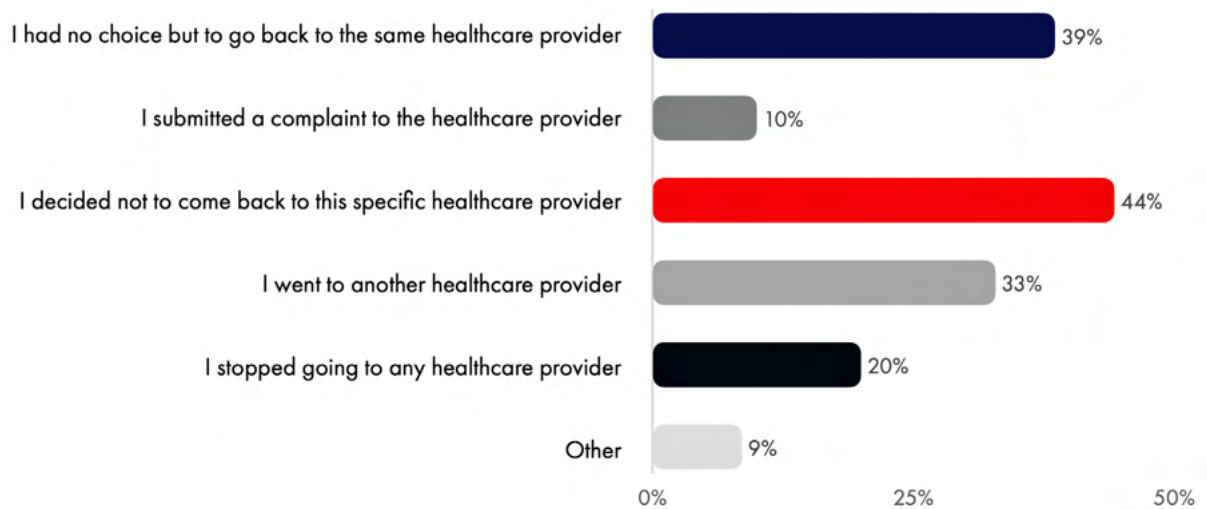
Others stated they found comfort in engaging in activism. Education was viewed as both an opportunity and a burden. Sex workers often felt obliged to do this in healthcare settings and suffered from a sense of education fatigue. Several sex workers who reported themselves to be in positions of privilege (e.g. white, cis-gender, documented sex workers), mentioned that educating providers was a means to protect other community members who may be unable to fight back due to greater consequences (i.e. risking parental custody, migration status, employment, housing, employment, etc.) Overall, it was felt that the efforts of sex workers and community led organisations had led to positive attitude shifts within healthcare settings. Several sex workers described positive changes in practice, or attitudes, following informal dialogues with staff. However, sex workers also felt that the education they provided was another instance of uncompensated labour, which is often expected of marginalised communities. This was the case in both informal education (i.e. provided by sex workers after a negative experience), and formal education, which was conducted by sex worker rights organisations. While respondents were happy that sex workers were finally being recognised as experts, many also expressed the desire for their labour to be appropriately recognised and compensated:

“I want to be paid for it, I’m sick of big institutions expecting sex workers to do voluntary work.”

Cis-woman, sex worker, France.

While 33% of sex workers chose to change healthcare providers, switching providers was emphasised as a privilege not all could afford financially. This led to trade-offs in managing increased financial pressure for example for access to private healthcare versus experiencing

FIG 15: Actions to challenge stigma and discrimination in healthcare settings by legal framework surrounding sex work



harm from existing providers. However, 39% of sex workers reported having no choice but to remain at the same provider in which stigma and discrimination was experienced. Lack of capacity to switch providers was also linked to insurance status, and healthcare systems. Where possible, many sex workers reported preferences for sex worker specific healthcare centres, although as mentioned this was not a silver bullet.

Barriers to engaging in formal complaint mechanisms included accessibility, awareness, perceptions of success, self-dismissal, and fear of retaliation or further harms. For example, 38% of those who did not formally complain did not know it was possible to do so, while 33% felt the process was in-accessible:

“Too much administration and too much time to devote to the process. As I had to choose between this and my disability benefits process, I preferred to have my benefits.” *Queer, non-binary, racialised, migrant, disabled, trans man, sex worker, France.*

In 8% of cases, inaccessibility was due to language barriers. In some instances, sex workers also reported being blocked from submitting complaints from healthcare providers:

“the personnel made it as hard as possible for me e.g. not giving me names, records, ... saying they can’t legally tell me who was working last shift.” *Queer, non-binary, disabled, sex worker, Poland.*

The perceptions of whether the complaint process would be a success was discussed as greatly influencing decisions to move forward. For example, 40% of those who did not complain believed there would be no follow up. This was related to overall power-dynamics, as well as feelings of whether sex workers would be believed, particularly without paper trails:

“it’s my word against theirs.” *Queer, cis-woman, disabled, migrant, sex worker, France.*

In some cases, sex workers self-dismissed their experiences as not meeting the criteria of seriousness needed to bring forth a formal complaint or minimised their impact:

“It seemed too indirect to be taken seriously.” *Queer, cis-woman, disabled, migrant, sex worker, France.*

“I felt like it wasn’t worth it because they didn’t “hurt me that much”?” *Queer, non-binary, sex worker, Italy.*

FIG 17: If you did not submit a complaint to the healthcare provider, was it because..?

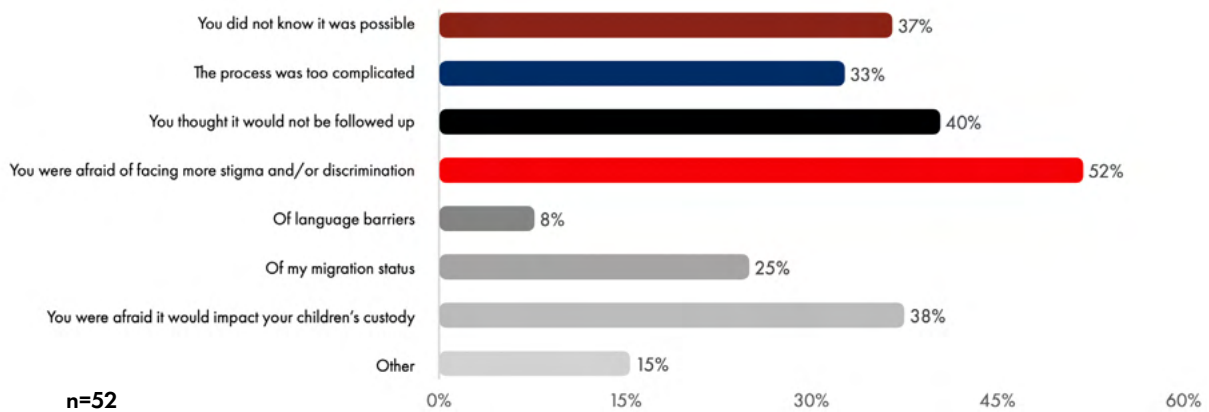
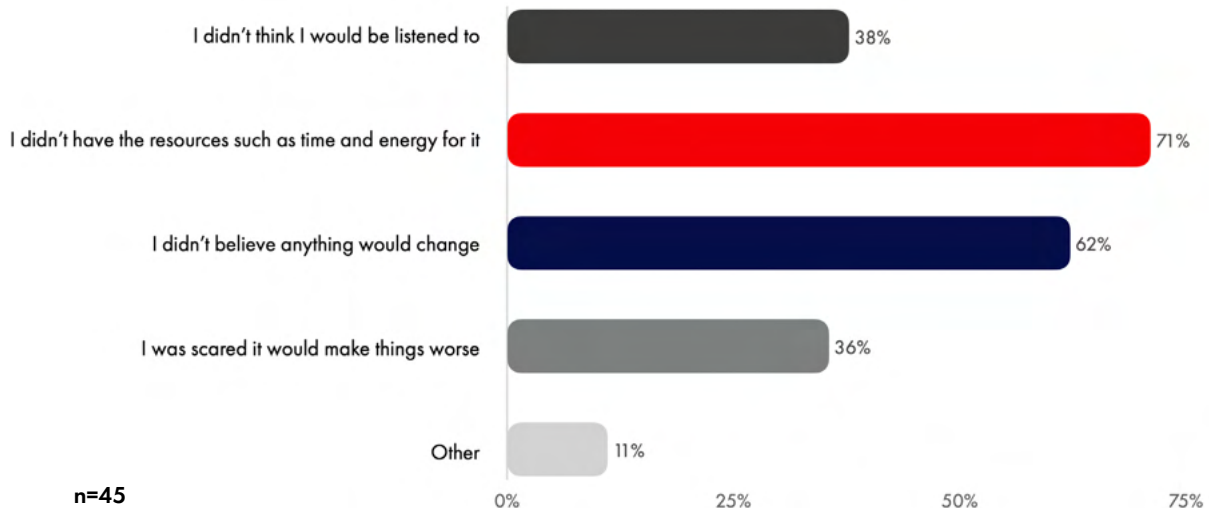


FIG 20: If you did not take action, why not?



Fear of retaliation also featured high among sex workers reasons for not submitting a formal complaint. For example, 27% of migrant sex workers were afraid that involving themselves in a complaints process would impact their migration status, and 38% of parent sex workers, custody of their children. Respondents were also afraid of the potential for outing or breaches of confidentiality among the wider healthcare service:

"How many escort patients they have daily? what if somebody is "not so friendly " and will look up my address or something?" *Queer, non-binary, sex worker, Poland.*

Fear for impact on current or future care, related to power-dynamics, also prevented sex workers from bringing complaints:

"I was hospitalized and depended on them to live, even to eat or go to the bathroom." *Trans woman, sex worker, Germany.*

Of sex workers who submitted complaints, 72% of these were not followed up, and only 20% of sex workers who submitted complaints were satisfied with the outcomes:

FIG 18: If you submitted a complaint to the healthcare provider, was it followed up?

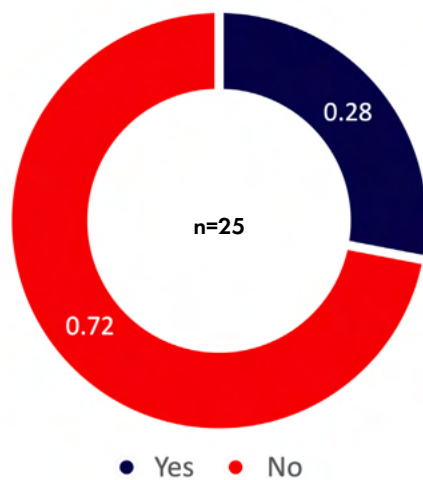
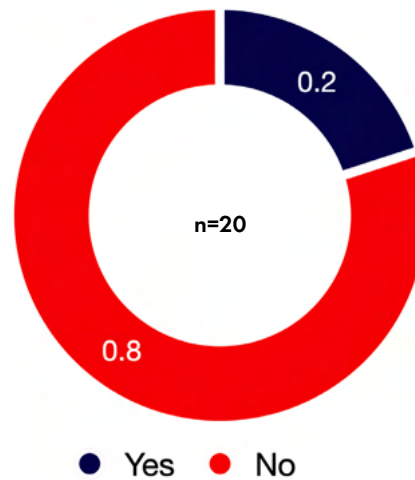


FIG 19: If you submitted a complaint to the healthcare provider, were you satisfied with the result?



"it was followed up by saying I invented the situation." *Queer, racialised, disabled, sex worker, Spain.*
One respondent found it difficult to judge whether the outcome of their complaint had made a difference due to the staff-rotation and turnover in the service (i.e. being unable to judge whether particular staff had changed attitudes):

"it just happened again with a new hire." *Cis-woman, sex worker, U.K.*

Dissatisfaction with results was experienced, in some cases, as an extension of the harm or dismissal which resulted in the complaint in the first place. Indeed, over half of sex workers who did not submit formal complaints, did so as afraid of experiencing further harm.

Internal strategies which sex workers took to deal with stigma and discrimination included: reclaiming sex worker identities, delaying seeking help for health issues, stopping to seek healthcare (20%), minimising the number of visits to healthcare providers, rationing use of medication, detaching emotionally, forgetting, choosing how to manage time and energy, expressing empathy for healthcare staff, and imagining what better care could look like.

Sex workers reclaimed their sex worker identities by being deliberately outspoken about their sex work or choosing to come out to bring awareness to sex work, as well as through affirming positive or unique attributes of sex work:

"It can be a beautiful profession, few people can say they give love as their profession." *Cis-woman, sex worker, Belgium.*

Many respondents discussed choosing how to manage time and energy as a coping strategy. Indeed, 71 % of sex workers felt they did not have the internal resources to act. This included making deliberate choices not to engage in complaint mechanisms, or discussion with healthcare providers, as this was seen to conserve internal resources or shield themselves from further harm. Disengaging from health services, or minimising visits, as also seen as a means of shielding from harm. Several respondents described delaying help-seeking based on energy and capacity to cope with potential harm:

Sex workers also reported a range of negative consequences to both their physical and mental health. Negative mental health consequences reported by sex workers included: diminished self-worth, diminished confidence and capacity to self-advocate, anxiety, complex-post-traumatic stress-disorder, and suicidal ideation:

"Actually my appointments at [PROVIDER] are worse for my mental health than any of my clients ever have been. Some of these talks really triggered me and I think they were a bit traumatic for me."

"I felt like I had let them cross my boundaries and step on me." **Bisexual, cis-woman, parent, sex worker, Sweden.**

"I had a panic attack each time I left." **Queer, non-binary, racialised, disabled, trans man, sex worker, France**

Sex workers also reported dwelling on negative experiences:

Sex workers with existing fears linked to medical settings, and those who have prior experiences of victimisation, discussed their experiences as creating secondary distress:

"I have a lot of trauma from childhood so they making me feel that way again when I was adult was something really sad." **Queer, non-binary, sex worker, Poland.**

Stereotyping surrounding (i.e. that sex workers cannot be victims of sexual violence), also led to lack of adequate treatment of mental health concerns:

"I did not access rape trauma counselling because the healthcare providers I saw when it happened were only concerned with whether I was using birth control." **Disabled, migrant, sex worker, Spain.**

FIG 22: If you changed your healthcare provider, did you change the way you behaved in that setting or the information you disclosed to avoid stigma and discrimination?

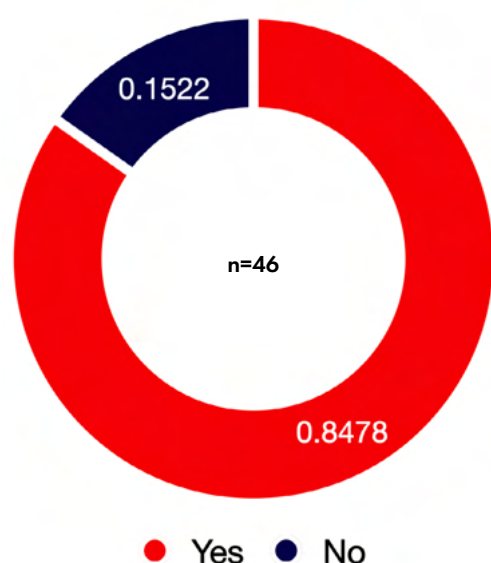
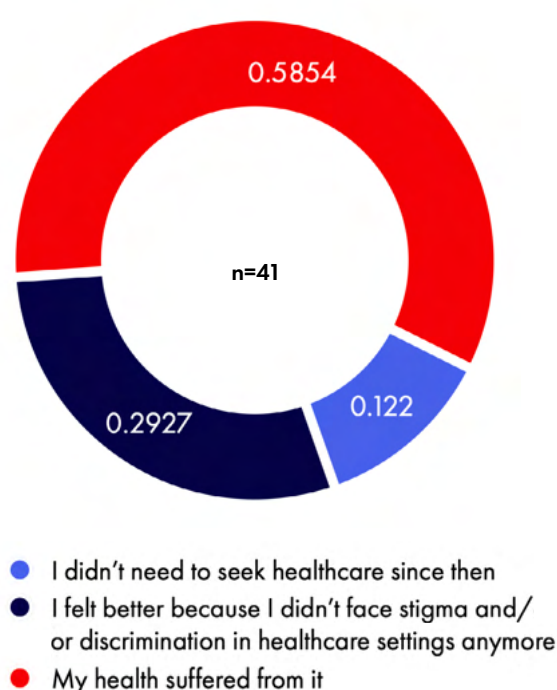


FIG 23: If you stopped going to any healthcare provider, how did it impact your health?



Physical health consequences came about due to dismissal of sex workers' concerns by healthcare providers. This led to lack of adequate care:

"I didn't receive proper check-up and echo for vaginal complaints. Instead got antibiotics, without knowing the cause - leaving me with a menstrual cup stuck inside for 3 months. This resulted in an infection on my right ovary and 3 months of uncomfortable, untreated symptoms." **Queer, non-binary, sex worker, Belgium.**

Negative health outcomes also appeared to relate to sex workers being prevented from making informed decisions regarding treatment or health concerns. This was because they often felt unable to ask questions related to their concerns and due to having to conceal their sex work, alongside other identities.

Negative physical health outcomes were also discussed in relation to delays in accessing care. Delays were brought on both by reluctance of sex workers to seek help, and deferral or refusal to treat by healthcare providers:

"My phobia [of medical settings] wasn't that big before starting doing sex work. I feared needles mainly, but I would regularly do something if something was wrong. Now it has to make me unable to work for me to take care of it in doctor's office. I have a lot off issues with breathing, with low energy, I have a lot of issues with teeth. I'm going only on blood check ups as I've said (HIV etc blood tests) and to my psychiatrist because I need medication for my bipolar disorder, but I don't go to any other doctors." **Queer, non-binary, sex worker, Poland.**

"In some cases I went elsewhere. In other cases, I just didn't get any further care." **Disabled, migrant, sex worker, Spain.**

"It stopped me from having another consultation for years, despite my gynaecological problems." **Racialised, cis-woman, sex worker, France.**

This caused either delays or lack of coherence in treatment. For example, 59% of sex workers who stopped going to health care providers said that it negatively impacted their health. In some cases, sex workers felt obliged to ration medication usage to avoid harm. Finally, general confusion surrounding sex worker's health care needs led to provision of care that was not adequately adapted:

"I have never been asked about working during my menstrual cycle or offered sponges without asking for them, the alternative is that sex workers use things like make up sponges and scourers, we have no idea of the harm this is causing us in the long run." **Queer, non-binary, disabled, sex worker, U.K.**

Discussion

How do our findings relate to other research on stigma and discrimination against sex workers in healthcare settings?

Our findings highlight the pervasive negative attitudes towards both sex work, and sex workers, among healthcare providers, and across healthcare settings, in Europe. Our findings compliment research pointing to the role of the healthcare system in stigmatising sex workers. (46, 52) They also align with evidence showing that sex workers' experiences of stigma in health services act as a barrier to access to health services. (13, 19) For example, a systematic review found that poor attitudes and treatment from health care providers as well as privacy and confidentiality concerns acted as barriers to access to care among sex workers. (13) Furthermore, sex workers perceived health services to be inadequate to meet their health care needs and reported that services were often inconvenient to access due to issues related to opening hours, locations, waiting times and appointment systems. Sex workers were also resistant towards seeking health care due to social stigma associated with sex work, HIV or STIs and drug use. (53, 54) These barriers are compatible with those identified through this research.

Our findings also reinforce existing evidence surrounding the impact of identity concealment and expectations of rejection among sex workers in healthcare settings. (16, 18, 46) Namely, expectations of rejection are shown to limit sex workers' access to health care, as fears of judgement dissuade workers from accessing services. Similarly, where sex workers are hesitant to disclose their occupations to health care providers, this has been found to limit opportunities to meet their healthcare needs. (10) Our findings build understanding of sex workers' decision-making processes surrounding disclosure in healthcare settings, including pointing to factors which may support workers to feel comfortable discussing their occupations with providers. (55)

Evidence shows that laws governing sex work shape sex workers' living and working conditions, in turn influencing their health. (56) Repressive policing of sex work is associated with increased risk of sexual/physical violence from clients or other parties, as well as increased burden of mental and physical health conditions among sex workers. (56) There is growing evidence to suggest that, despite claims of protecting sex workers, the criminalisation of clients, such as via the Swedish Model, results in the escalation of the risks associated with sex work and increases sex workers' exposure to violence. (57, 58, 59, 60, 61, 62) Similarly, the legalisation of sex work allows for the legal sale of sex under certain conditions, e.g. relating to immigration status, registration, or sexual health screening, and criminalises sex workers who fail to meet these conditions. Consequently, legalisation of sex work has been shown to create a two-tiered system where some sex workers may experience benefits while others experience increased vulnerabilities, depending on the extent to which they meet the conditions imposed by the state. (14, 63, 64, 65, 66)

On the other hand, recognising sex work as a legitimate occupation allows for application

of occupational health and safety standards and the prioritises of sex workers' health and rights.(67, 68, 69, 70) For example, a scoping review examining evidence from decriminalised contexts found improvements in sex workers' health and overall well-being as well as decreases in exploitative work conditions after the decriminalisation of sex work in New Zealand and the Australian state of New South Wales. (67)

One of the ways in which laws surrounding sex work influence sex workers' health is through impact on sex workers' access to health care.(56, 67) Contexts wherein sex work is criminalised are thought to limit sex workers access to appropriate, timely, healthcare. This is supported by the finding that sex workers' access to health services in New Zealand and the Australian state of New South Wales improved after the decriminalisation of sex work.(67, 71, 72) This was largely attributed to the development of peer-based outreach and access to healthcare, as well as other services, that the decriminalisation of sex work has enabled. (67, 73) (71)

Interestingly, no major difference was noted in sex workers experiences of stigma and discrimination across different legal contexts represented by the research. However, sex workers facing criminalisation referred to the legal framework as a deterrent to disclosure of their occupations, thereby hindering them from receiving adequate care. In settings of legalisation, workers reported 1% more experiences of both stigma and discrimination, and 15% more experiences of stigma alone than in settings of criminalisation. This may be attributed to the persistence of measures which separate sex work from other forms of labour, thus demarcating sex workers as "other," under frameworks of legalisation.(65) Only one context, Belgium, represented a setting in which sex work was de-criminalised, however changes to the legal framework were introduced as recently as 2022, and implementation is still in progress. (74) One explanation may be that stigma surrounding sex work pervades, even in settings of decriminalisation. This would align with evidence that de-criminalisation alone is insufficient to end stigma and discrimination faced by sex workers in healthcare settings and must be supplemented other measures.(75) Alternatively, it may have been that changes were too recent to see impacts upon attitudes of healthcare workers, as well as the fact that workers reported experiences in healthcare prior to the decriminalisation of sex work.

Belgium was also the only context in which sex workers reported feeling more comfortable than not, both disclosing their sex-work, and acting to challenge following experiencing stigma and discrimination in healthcare settings.

This may point to the role of decriminalisation in increasing confidence of sex workers to disclosure their occupations health settings, and challenge with potential stigma. The latter may be because workers live in less fear of legal and other consequences in settings of decriminalisation. Although this should be interpreted with caution, given that the new legislation has not yet taken full effect.

An alternative explanation may relate to the wide range of state funded community organisations, offering a variety of services in both Dutch, Flemish, and English, and catering to a variety of sex workers. These organisations have built up strong trust among the community over decades of work and were crucial in pushing progress in decriminalisation. More research is needed into the impacts of legislative changes on sex workers in Belgium following full implementation.

Our findings build the evidence surrounding negative experiences of sex workers who are multiply marginalised within healthcare, and other settings, an area currently under researched. (76, 77, 78, 79, 80, 81) Namely, sex workers who are racialised, migrant sex workers, parent sex workers, LGBTQI+ sex workers, sex workers living with HIV, sex workers who use drugs, and disabled sex workers face heightened and unique forms of overlapping stigma and discrimination in healthcare settings in Europe. For example, as found within a study conducted by the European Centre for Disease Control (ECDC) across fifty-four countries in EU and Central Asia, which used the ‘The People living with HIV Stigma Index,’ one quarter of participants had fears about being treated negatively by healthcare staff, while 14% avoided healthcare settings altogether due to these fears.(82) Results of the ECDC study surrounding internalised stigma among those living with HIV, were compatible with sex workers reports within this research. Namely, nearly one third of person’s living with HIV reported being either ashamed of their HIV status, or having poor self-esteem because of it. (82)

Further research is necessary to understand the experiences of sex workers who face marginalisation and multiple intersections and respond to their needs. Additionally, the identification of strategies which sex workers use to cope with stigma and discrimination in healthcare settings can contribute to design of interventions to support workers in access to healthcare and management of treatment.(83) Our findings also reinforce the importance of the role of sex worker rights’ organisations in addressing health inequalities faced by sex worker communities, including in acting as liaisons, providing comprehensive, up-to-date, information, and training healthcare providers.(84, 85, 86, 87, 88, 89, 90, 91) While sex worker rights associations are key toward promoting sex workers’ health and well-being, their efforts must stand alongside those of healthcare systems, local and national governments, as well as the inter-regional mechanisms within Europe, and the wider international community.

What are the strenghts of this research?

This research was sex worker led, putting into practice one of the core principles among sex worker’ rights movements “nothing about us, without us.” It is possible that sex workers felt more comfortable to discuss experiences, given both the option to remain anonymous when filling out the online survey, and due to trust of ESWA, and its members who circulated the survey. This may have reduced bias. Additionally, several respondents mentioned that the survey was one of few opportunities they have had to discuss negative experiences in health care settings. This highlights the need to create more avenues for sex workers to share feedback in settings where they are treated as experts in their own experiences. Respondents lived in countries with a variety of legal frameworks surrounding sex work and reported doing a

range of forms of sex work itself. This increases our capacity to generalise findings across legal frameworks, and diverse forms of sex work (i.e., that stigma and discrimination is experienced across forms of sex work practiced). Similarly, this research sought to embed an intersectional lens, examining the ways in which various systems of oppression intersect with whorephobia. Sex workers are a diverse community, with those most marginalised (namely, migrants and trans communities) known to be overrepresented within, due to structural exclusion. An intersectional lens is therefore necessary to fully understand and combat stigma and discrimination against sex workers. It is hoped that this may be replicated within research both within and outside of traditional academic settings. This was one of the first pieces of research, known to the authors, which examined the strategies that sex workers use to cope with and address stigma and discrimination, including sex workers' engagement with complaint mechanisms in healthcare settings. A workshop to validate the findings was conducted with representatives from ESWA and ESWA members across seven countries.

What are the weaknesses of this research?

As completion of the survey was uncompensated, this may have biased results towards those in less precarious positions i.e., those who can volunteer their time and expertise for free. This was reflected in breakdown of identities of respondents, of whom the majority were white, and disclosed working indoors. Only 11% of the sample identified as racialised/BIPOC, limiting the ability to develop a deeper understanding of how racism intersects with stigma and discrimination impacting sex workers in healthcare settings. Similarly, only 7% of the sample disclosed being currently, or formerly street based. This limits our ability to generalise findings to street-based workers who are known to face greater risks in terms of violence, stigma and discrimination, and negative health outcomes. Additionally, the fact that data was collected only through an online survey, with only four language options, means only those with access to internet, internet literacy, and writing/reading knowledge of English, Spanish, French, or Russian could respond. This may have limited participation from sex workers facing extreme precariousness, such as un-housed sex workers, or those with low formal education. No respondents disclosed an undocumented migrant status, although may have been due to fear of consequences. This limits our ability to understand how insecure migration status plays into experiences of stigma and discrimination against migrant sex-workers in healthcare settings. Most respondents (75%) lived in Western European countries. By contrast, 25% of respondents lived in Eastern Europe. Although one additional Central Asian country was present within the validation workshop, this limits our capacity to generalise survey findings to sex workers in Central Asia. Findings may nevertheless have relevance for high-income countries outside of the region. The small sample size prevented statistical analysis to explore associations between stigma and discrimination and various factors, such as race, age, gender identity, sexual orientation, migration status, or legal frameworks surrounding sex work. Finally, although Belgium voted to decriminalise sex work in March 2022, implementation is still in progress. Therefore, results related to decriminalised should be interpreted with caution. For example, it is uncertain whether the partial implementation to date has yet to impact on attitudes of healthcare providers.

Recommendations

What recommendations do sex workers make to combat stigma and discrimination in healthcare settings?¹²

“Hire us. We are talented & skilled, and we understand the culture and sex work more than you ever will learn from training – [services] are missing out by not recognising this.

Recognise the value of our labour and pay us.

There will never be a simple one size fits all approach because we are a diverse group and you can’t get a good understanding from one person with lived experience - you need to listen to and recruit street workers, indoor workers, content creators, brothel workers, migrant workers, men and trans workers, black workers, brown workers, to improve your services.”

Queer, non-binary, disabled, sex worker, U.K.

¹² The following recommendations align with findings from two systematic reviews examining effectiveness of interventions on sex workers’ physical and mental well-being (Johnson et. al., 2023), (Kevin et. al., 2022). One review found that interventions which were co-designed and co-delivered by sex workers, and which focused on providing education and empowerment were effective toward improved health and determinants of health among sex workers (Johnson et. al., 2023). This review also found multi-component interventions (i.e. addressing a variety of health-issues at once), as well as use of outreach to show promise for improving sex workers’ health. The other reinforced importance of peer-delivery for psychological interventions for sex workers well-being (Kevin et. al., 2022).

Recommendations to combat stigma and discrimination against sex workers in healthcare settings

Actors	Recommendation
Healthcare Providers	<ul style="list-style-type: none"> • Commit to undertake continuing professional development, from a variety of different sources, connect with other professionals, attend community events and conferences where sex workers are represented to learn about sex work, legal frameworks, stigma, issues impacting sex workers and be informed of sex workers potential healthcare needs. • Commit to learning about evolving concepts in gender, sexuality (including kink), relationship structures and practices (including non-monogamy), so as to better understand patients experiences and needs, and practice non-judgement. • Commit to practicing inclusion by learning about racism, ableism, xenophobia, transphobia, homophobia and other structural forms of discrimination and understanding their impacts upon health, how these manifest in healthcare settings, and how they can be challenged.
Health Service Managers	<ul style="list-style-type: none"> • Ensure flexible timings of appointments and drop-in hours, and if possible, allow for a range of scheduling options (e.g. online, telephone etc.) to support different access requirements. • Ensure accessibility information (e.g. lifts, wheelchair access, including accessible bathrooms, availability of sign-language interpretation) for a service is available and up-to-date on websites, and other information streams. • Hire and train sex workers to become embedded within healthcare delivery, including addition of outreach components. • Ensure where new programmes are developed this is done in tandem with sex worker rights associations. Programmes should be multi-component (i.e. addressing a variety of health issues at once), and seek to include an educational, as well as empowerment focus (i.e. promoting sex workers autonomy, decision-making, and capacities to cope with problems) in line with evidence.

- Engage sex worker rights associations to deliver training for health care providers on working with sex workers, as well as other trainings for understanding impacts of systems of oppression on health outcomes, and on working with marginalised groups i.e. anti-bias training. Trainings should be delivered to all staff working within a health-setting, including receptionists or other administrators etc.
- Prioritise embedding of person-centred care, according to the WHO Framework on integrated people-centred health services (IPCHS).
- Centres providing sexual and reproductive healthcare or materials should ensure that essential materials, such as a variety of lubes (e.g. water-based, silicone), male condoms, female condoms, (both in a variety of different sizes, and colours, and including latex and non-latex condoms), menstrual sponges, are available to service users, without request (e.g. open-service in hallway spaces, so as not overly visible to reception/ waiting rooms).
- Placing materials which indicate that providers are supportive of sex workers (such as a red umbrella, signs affirming sex work as work etc.) may support sex workers to feel comfortable disclosing. However, this should be done only if known that providers are competent in working with sex workers.
- Centres catering to sex workers should consider introducing 'membership cards' for sex workers, which they can show at reception/ to providers, to access necessary tests, treatments etc. in place of having to specifically disclose. This card should be provided based on self-declaration and should not be linked to medical files, and identity documents.
- For locations providing STI testing, consider options for self-testing, and home-testing.
- Ensure integration of mental healthcare into relevant services i.e. counselling for HIV, STIs, sexual and reproductive health, violence, substance use etc.
- Commit to adopting non-coercive responses to service users in mental health crises i.e. do not involve police or take measures which may lead to involuntary admittance, prioritise de-escalation techniques and community response channels.

Health Service Managers

- Decriminalise sex work. This includes sex workers in all sectors as well as migrant sex workers, clients and third parties. Acknowledge sex work as work, support the self-organisation and unionisation of sex workers, and regulate sex work according to labour laws. Ensure sex workers can access national social security mechanisms, including unemployment and disability benefits.
- Always consult with and involve sex workers' organisations and communities in the development of any laws and policy that directly or disproportionately impacts them. This includes within national (mental) health policies or plans.
- Introduce anti-discrimination laws for sex workers and ensure their successful application. Eliminate the unjust application of laws, sanctions and regulations used against sex workers. Sex workers should access health care services without fear of possible consequences such as being outed, being fired from other jobs, or losing the custody of their children.
- Ensure availability of universal healthcare, including comprehensive mental healthcare, gender-affirming care, and broader sexual and reproductive healthcare, in line with international human rights standards, and review and remove barriers to healthcare access across regions.
- Remove barriers to access to PEP, PrEP, ARVs, and expand national roll-out plans to include all sex workers (whether trans, cis, non-binary, MSM etc.) where not already accounted for.
- Repeal punitive laws and policies that criminalise and disproportionately impact upon people living with HIV, including those necessitating mandated partner notification.
- Ensure trans and gender diverse individuals have access to gender affirming care without necessity to undergo sterilisation or being subject to other forms of pathologisation, including in relation to mental health care.
- Commit to transformation of mental health services, in line with a human rights-based approach, in line with guidance of the WHO and OHCHR.
- Incentivise programmes and training opportunities for sex workers

who wish to become health care practitioners, outreach workers, community-health liaisons, health administrators etc.

- Implement regularisation mechanisms for all undocumented migrants in the EU, as recommended by PICUM (2022).
- Develop or implement anti-racism policies in the areas of housing, employment, and healthcare.
- Allocate funding directly to sex worker rights associations and support development of community-based health care programmes which are multi-component, integrate empowerment and education, and are co-designed and co-delivered by sex workers. Involvement of sex workers in design and peer-delivery should be appropriately remunerated.
- Liaise with sex worker rights associations to embed training surrounding sex work for healthcare providers within health systems, including within universities and other continuing professional development.
- Where sex workers receive healthcare through anti-trafficking organisations supported by government funding, ensure services are provided without sex workers having to identify as survivors of violence, or placing conditions upon care (for example, stopping sex work, or testifying).
- Repeal laws and policies imposing a ban on the donation of blood by persons in sex work, and update these in line with current evidence.

European Legislators and Policymakers

- Adopt a pro-decriminalisation stance towards sex work that includes the decriminalisation of migrant sex work and encourage the Member States to enact full decriminalisation sex work policy.
- Implement regularisation mechanisms for all undocumented migrants in the EU, as recommended by PICUM (2022)
- Include sex worker-led organisations and networks in policymaking and consultations in all policy areas affecting sex workers, for example within the European Commission's comprehensive approach to mental health initiative.
- Fund sex worker-led and other key population-led organisations at national and regional levels.

Sex Worker' Rights Organisations

- Consider developing a digital directory of 'sex worker friendly healthcare providers,' which can be filtered by specialisation, locality, languages spoken, gender-of providers etc. as well as other factors such as provider-initiated sign-up for sex worker recommendation. Providers can have the option of self-sign up, however they need to agree to principles for supporting of sex workers' well-being. Options for users to provide feedback, as well as a monitoring mechanism should be integrated within the platform.
- Consider training sex workers, if possible, those fluent in multiple languages, as health-advocates who can accompany sex workers to appointments upon request.

Academics Institutions

- Conduct rigorous, mixed-methods, community-led research into the impacts of criminalisation and decriminalisation of sex work upon sex workers, adapting an intersectional approach.
- Partner with sex worker rights associations or networks, such as the European Sex Work Research Network (ESWORN) and commit to support sex worker led research to enhance the relevance of research for sex work communities.
- Look out for and align with resources on good practice in research developed by sex-workers, such as ESWORN's upcoming "Gold Standards for Researching Sex Work."
- Ensure where sex workers are engaged as peer researchers, or interviewees, they are appropriately remunerated, and information is returned. Include peer-researchers in future projects and training opportunities.
- Commit to appointing researchers with lived experience in sex work within Ethical Review Boards.
- Conduct research surrounding healthcare providers beliefs and attitudes, as well as design, pilot, and test the effectiveness of training packages aimed at supporting healthcare providers to develop their capacities to work with sex workers.
- Ensure the dissemination of the research findings in partnership with sex worker-led organisations and beyond academic circles.

Funders

- Commit to make available multi-year, flexible funding directly to sex worker rights' organisations to establish peer-run health services and advocacy.
- Fund community-led research about sex work and health outcomes, recognising sex workers as experts.(92)

Tip sheet for engaging with sex workers for healthcare providers

What kind of treatment do sex workers want?

Sex workers want sex work to be normalised. We want healthcare providers to understand nuances surrounding sex work. We want providers to understand that the negative aspects sex work are not unlike those in other forms of work, especially precarious work, but are exacerbated due to stigma and punitive legal frameworks. Sex workers no longer want to feel responsible for educating providers.

Sex workers want to stop being pathologised. We want to stop being seen as either victims or "happy hookers."

We want to be viewed as complete human beings, as opposed to only in reference to our livelihoods.

Sex workers want to be believed, listened to, and trusted by healthcare providers. We often feel isolated due to criminalisation and stigmatisation: just listening can go a long way. Sex workers want providers to recognise the diversity of our identities, experiences, and practices. Sex workers want to feel confident to fully engage in care, so we can ensure our needs are met.

* Providers should strive for awareness of knowledge surrounding the legal framework on sex work, as well as the risks this presents to workers, where they operate.

* First and foremost, listen to service users, understand their needs, avoid making assumptions, believe them, affirm their agency, and treat them as the rightful experts in their own experiences, symptoms, priorities, goals, and needs.

* Do not ask questions without a valid medical basis; explain why you are asking questions so that service users can participate in the consultation, and better understand motives. Let users know it is okay to decline to answer questions.

"Don't assume I hate my job, but don't assume I like it either."

Queer, non-binary, disabled, sex worker, U.K.

"Saying I'm a sex worker should be treated as normally as saying 'I ate pasta last night.'"

Queer, non-binary, trans-man, racialised, disabled, sex workers, France.

* Uses terms advocated for by the sex worker community, adapted to national and local languages. E.g. in English "sex work" and "sex worker," as opposed to "prostitution" etc.

* Always practice informed consent for engaging in physical examinations; check-in with users during about their comfort levels during examinations, and help them to feel in control where possible.

"Trust that I am making the best decisions for myself already and unless I ask, I don't need advice."

Queer, non-binary, disabled, sex worker, U.K.

"I want to know I can be honest."

Queer, cis-woman, disabled, migrant, sex workers, France.

* If possible service users' preferences for gender of providers should be considered.

* Avoid marking that someone is a sex worker on their medical files. This information may place patients at risk.

- * Be aware that contact with police, for example reporting an incident of violence or exploitation, may place sex workers at risk. Never pressure a sex worker to report a negative incident that they may disclose.
- * Do not coerce or pressure sex workers to stop engaging in sex work. In fact, “stopping sex work” should not be raised at all, unless responding to a patient. If a patient has expressed that their goal is to stop sex work, or explore alternatives, providers may link them to livelihood support, vocational trainings etc.

“Realize sex workers are different people, there is no one possible way to do sex work. Some of us are single ladies who sell nudes, some are in loving relationship and have big family and are doing escort jobs, some are queers who do porn. Some lesbians are doing escort jobs with male clients. Sex workers are very diverse, from diverse backgrounds with diverse needs, like all human beings.”

Non-binary, lesbian, disabled, sex worker, Poland.

- * Be mindful of ‘outing’ someone as a sex-worker. Sex workers must frequently conceal their identities for fear of being “outed,” thereby facing negative consequences from friends, family, employers, social services etc. Never disclose someone’s status as a sex work (even if they are accompanied by a partner, family member etc). and treat this information confidentially, in the same way a provider should treat all medical information.

“We often feel kinda lonely with our experiences, so please be kind and listen to us, we are your family members, neighbours, cashiers, teachers, just regular people you meet in your life.”

Non-binary, lesbian, disabled, sex worker, Poland.

“I don’t need to be cured of my work.”

Queer, cis-woman, disabled, migrant, sex workers, France.

- * Sex workers often face a distinct form victim-blaming, linked to stigma and punitive laws. This manifests in views that sex workers cannot experience sexual violence. In reality, sex workers face higher burdens of sexual violence, which may take the form of covert-condom removal, ignoring boundaries etc.. Always believe survivors of violence, listen to their support (if they share them), validate their emotions, reactions, understand their needs, and support them to access appropriate services. (93)

"I'd like healthcare workers to bear in mind that many people go through, have gone through or will go through sex work at least once in their lives."

Racialised, cis-woman, sex worker, France.

"Respect the range of reasons we do this work, and also respect the anxieties and impact sex work can have."

Cis-woman, sex worker, U.K.

- * When communicating through a friend, family-member, interpreter, or other person accompanying the appointment, be sure to talk directly to the service user themselves.
- * Remember that not all disabilities are visible, never make assumptions surrounding someone's health, accessibility needs etc. always inquire about a service users' needs and support their full participation within consultations.
- * Avoiding making assumptions about someone's sexual orientation or gender identity, or about the kinds of sex someone is having in their personal and professional lives. Avoid reinforcing binary understanding of sexuality and gender when inquiring about sexual histories. Use gender-neutral pronouns when referring or asking about romantic and/or sexual partners.

"Treat me like a regular hot girl who uses Tinder a lot"

Queer, disabled, sex worker, U.K.

"Understand that I'm a whole human being."

Queer, disabled, migrant, cis-woman, sex worker, France

- * If unsure what pronouns someone uses, it may be appropriate to ask them. Using the correct pronouns can minimise feelings of gender dysphoria for people whose gender expressions may not match societal expectations associated with their gender identity. However, make sure not to make someone feel pressure to disclose their pronouns. Stating your own pronouns or displaying these openly in a consultation room may help people to feel safe disclosing their own.

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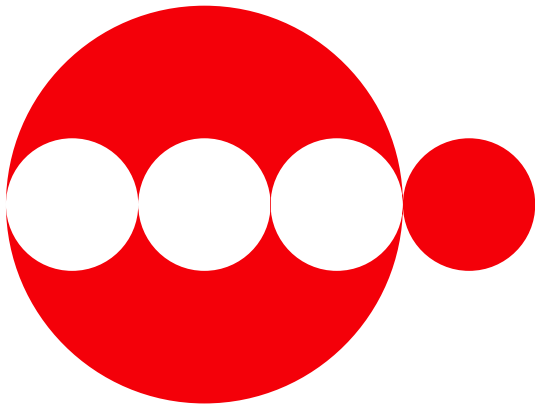
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