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Thematic article

"I've just schooled you, so you can't shame me". Stigma, Discrimination, and Healthcare Access among Sex Workers in Scotland, the Republic of Ireland, and Aotearoa/New Zealand

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Abstract

Drawing on interviews with 70 sex workers in Scotland, the Republic of Ireland, and New Zealand, in this paper we examine experiences accessing healthcare, in relation to stigma, discrimination, and laws governing sex work. Although laws in these countries were historically similar, they now differ considerably. While sex work was decriminalised in New Zealand in 2003 for permanent residents and citizens, the Republic of Ireland criminalised clients in 2017 ('the Nordic model'). In Scotland, where an archaic system of criminalisation remains, sex work laws have been subject to ongoing debate, with a subset of politicians and activists campaigning for the Nordic model. Focusing on experiences accessing health care services, in this paper we foreground the voices of sex workers, illustrating how laws impact people in tangible ways and make a case for a model of full decriminalisation, grounded in equality, rights, and social justice.

Keywords: decriminalisation, Nordic model, sex work, stigma, healthcare.

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1. Introduction

It is widely understood that sex work laws have tangible impacts on sex workers and their working conditions. Academic studies have long underscored the harms caused by the criminalisation of sex workers, particularly in relation to safety and access to justice (see for example Campbell and Kinnell, 2000; Sanders and Campbell, 2007; Kinnell, 2008). More recent research has demonstrated that even when sex workers are not directly subject to criminal penalties, laws which criminalise clients and other third parties have negative impacts on them. These impacts include impeding their safety strategies and increasing their vulnerability to violence, along with creating a discriminatory context in which sex workers have been evicted from their homes and workplaces (see, for example, Amnesty International, 2016; 2022; Ellison, Ní Dhónaill & Early, 2019; Levy & Jakobsson, 2014; McBride et al, 2020; Vuolajärvi, 2019).

A policy of full decriminalisation is widely considered the most impactful to support the health, safety and rights of sex workers (Abel, 2014 Armstrong, 2021; Macioti, Power, and Bourne, 2022). While the evidence strongly supports decriminalisation, this legislative approach remains rare. In the global context, sex work policy has largely not been led by evidence on what works to best support sex workers. Within this context, transnational studies which compare the experiences of sex workers in diverse legislative environments are particularly important.

Stigma is an issue that has been neglected by policy makers, despite advocates for sex workers rights and researchers having long called attention to its harms. Broadly, stigma refers to negative attitudes and beliefs held towards those with particular characteristics or attributes, which are based on stereotypes (Hannem, 2012). Understanding how stigma features in the lives of sex workers is important because it is widely acknowledged that stigma is harmful and contributes to social and health inequality (Addison, 2023; Hatzenbuehler, Phelan, and Link 2013; Tyler, 2020). An important area in which the impact of stigma on sex workers has been highlighted is on access to healthcare (European Sex Workers Alliance, 2023). Health is acknowledged as a fundamental human right, including an expectation that all people should have access to information and services in which they are treated fairly, respectfully, and without discrimination (Adhanom Ghebreyesus, 2017). It is therefore important to understand how sex workers experience healthcare, and how stigma may impact this under different legislative approaches. In this paper, we contribute to the evidence base on stigma and experiences accessing healthcare among sex workers, reporting on a transnational qualitative study undertaken with sex workers in New Zealand, Scotland, and The Republic of Ireland.

1.1. Stigma, access to healthcare, and the law

It is widely acknowledged that sex workers are subject to various forms of stigma. While past research has examined individual experiences of stigma, in more recent years researchers have increasingly examined how stigma manifests structurally impacting sex workers in a range of settings; for example, access to justice, financial services, and healthcare (Herrmann, 2022; Jobe, Stockdale and O'Neil, 2022; McCausland et al, 2022; Stardust et al, 2021). It has been frequently found that marginalised communities face barriers accessing healthcare due to stigma and discrimination, and often experience poorer health outcomes as a result (Baker, Adams, and Steel, 2022). The inaccurate framing of sex workers as vectors of disease, both historically and in the contemporary context, in many parts of the world has exacerbated barriers to accessing health services, and has also resulted in stigmatising policy approaches (Global Network of Sex Work Projects, 2021).

Researchers have examined how stigma has a detrimental impact on health among sex workers, and can create barriers to accessing healthcare services, and result in adverse experiences with healthcare providers (Benoit et al, 2016; Benoit et al, 2018; Ma and Loke, 2019; Singer et al., 2021). Fear of judgement from healthcare providers can mean that people do not disclose sex work experience, which researchers have acknowledged can lead to them receiving substandard care due to their identity not being holistically understood (Bungay et al., 2012; Ryan and McGarry, 2021). Furthermore, when sex workers do disclose their work, it has been found that they often experience judgement, poor quality care, and subsequently become reluctant to disclose their occupation in this context, or access healthcare at all (Benoit et al, 2016). A survey of 71 sex workers based in 13 countries in Europe found that 87 percent of participants had expressed stigma or discrimination when accessing healthcare. Experiences of stigma and discrimination were even higher among participants who were migrants, racialised, living with HIV, trans or gender diverse, or disabled (European Sex Workers Alliance, 2023). Most commonly in this study, experiences of stigma and discrimination occurred in general healthcare settings (such as while accessing General Practitioner (GP) services)[1], followed by mental health care and sexual and reproductive healthcare. Examples of stigma and discrimination included being asked inappropriate and invasive questions, being advised to stop doing sex work, and receiving unsolicited comments that were infantilising and moralising (European Sex Workers Alliance, 2023).

In participatory action research (PAR) with sex workers in the North East of England, Jobe, Stockdale and O'Neill (2022) found that while all participants were registered with a GP, none had disclosed their work to their GP and did not feel comfortable doing so. The researchers conclude that ideological constructions perpetuated by existing systems of governance served to

[1] A General Practitioner is a doctor that provides general medical care to people in the community, and may also be referred to as a family doctor or physician.

shape service provision, resulting in the adverse experiences that participants described. Researchers have also highlighted how some sex workers can experience additional barriers to accessing healthcare services, including street-based sex workers who are subject to particularly entrenched stigma (Potter, Horwood and Feder, 2022). It has also been acknowledged that sex workers face significant structural barriers accessing sexual and reproductive health services, which is compounded further for male and transgender sex workers due to homophobia, transphobia, and a failure to recognise the sexual and reproductive health needs of these communities (Global Network of Sex Work Projects, 2018).

A number of studies focused on the intersection between stigma and access to healthcare for sex workers have acknowledged the role that policies and laws in place can play in shaping these experiences and either helping to reduce stigma and barriers to access or further entrenching these. It is widely acknowledged that forms of criminalisation negatively impact the health of sex workers more broadly (Platt et al, 2018). However, clearly laws are not the only factor that shape access to healthcare, and even in decriminalised settings ongoing barriers and adverse experiences have been observed. Research undertaken in New Zealand in the years initially following the passing of the PRA indicated that overall participants were reluctant to disclose involvement in sex work to their GP due to ongoing stigma, with a survey of 772 sex workers finding that 46 percent did not disclose their occupation in this context. This compared to 52 percent who reported non-disclosure in this context in an earlier survey conducted in 1999, prior to the change in law. The authors concluded that it was important to examine the experiences of sex workers over time to determine any changes as decriminalisation became more embedded (Abel, 2014). More generally, it has been acknowledged that further research examining changes over time, considering the various social, political and cultural factors that may shape access to healthcare among sex workers is important (McCann, Crawford, and Hallett, 2021).

2. Contextual overview

The data that forms the basis of this paper were collected between 2020 and 2022 as part of a transnational study focused on stigma, discrimination, and the impacts of sex work laws in New Zealand, Scotland, and the Republic of Ireland (Armstrong et al., 2024). The research focused on these jurisdictions due to their laws being similar historically, but now differing substantially following legislative change. While a full overview is beyond the scope of this paper, it is essential to provide a brief contextual summary of the laws and policies in place.

Sex work was decriminalised in New Zealand in 2003 with the passing of the Prostitution Reform Act (PRA), following years of advocacy by sex workers, led by the New Zealand Prostitutes Collective (NZPC). The purpose of the legislation was to better support the occupational health and safety of sex workers, and clearly defined sex work as a form of labour. The decriminalisation of sex work meant that existing laws which criminalised sex workers were repealed and in place the PRA provided rights to sex workers.

In the Republic of Ireland, legislation was passed in 2017 in the form of Part 4 of the Criminal Law (Sexual Offenses Act) 2017, amending previous legislation relating to sexual offenses passed in 1993. The new legislation criminalised the purchase of sex, along with increasing existing penalties for living on the earnings of prostitution, and brothel keeping. Thus since 2017, Ireland has had a variant of the Nordic model in place. While sex workers in the Republic of Ireland opposed this law change and campaigned against it, it was adopted regardless. Concerns have been raised about the lack of consultation with sex workers, and since the law passed, research has indicated a multitude of negative impacts on sex workers, particularly in relation to their safety (see for example Mac and Smith 2020; Amnesty International 2022; Murphy 2022; Minescu et al, 2022).

In Scotland, laws in place mirror those that were in place in New Zealand and the Republic of Ireland prior to their respective law changes. While technically it is legal to sell sex, it is only possible to do so legally if working alone indoors (Smith 2015) A debate has been ongoing in Scotland for decades regarding how sex work laws could evolve. Specifically, there has been a sustained campaign by a subset of feminist activists and politicians to adopt legislation akin to that in place in the Republic of Ireland, with a focus on criminalising the clients of sex workers and other third parties. While such laws are not in place, the Scottish Government has officially adopted a position since 2006 that 'prostitution' (the Scottish Government does not use the term sex work) is a form of violence against women and girls (Morgan Thomas, 2009). Sex workers have steadfastly opposed this position and these policy proposals, instead calling for a system of full decriminalisation. However, their voices have been marginalised in these policy debates (SCOT-PEP, 2020).

All three countries have public health systems available, where residents can access primary health care such as GP services either for free or for a relatively low cost. New Zealand is the only country that has a sex worker-specific sexual health clinic that runs directly from a peer-led organisation[2]. While sexual health clinics for sex workers exist in Scotland and Ireland, there are no dedicated clinics that run out of peer-based organisations.

[2] The Aotearoa New Zealand Sex Worker's Collective (NZPC) provides free, confidential sexual and reproductive health clinics at community bases in three cities. The NZPC is a peer-led organisation, which means that it is run by sex workers, for sex workers (as distinct from organisations led by people who are not community members).

3. Methodology

The research involved in-depth interviews with 70 sex workers in New Zealand, Scotland, and Ireland between 2020 and 2022 as part of an international comparative study on stigma, discrimination, and sex work laws. While the focus of the project was on the intersection between stigma, discrimination, and sex work laws more broadly, this paper focuses on how sex workers experienced access to health services in each context. Specifically, it focuses on access to primary health care for physical health conditions.

This paper reports on the findings of in-depth interviews with 26 sex workers in New Zealand, 24 in Ireland, and 20 in Scotland. These participants included 48 cisgender women, 4 cisgender men, and 18 participants who are non-binary, transgender, and/or intersex. Participants were mainly citizens or residents of the country they were living in, but the sample also includes migrants from various parts of the world, including 14 who originated from various regions of Southeast Asia, Africa, Latin America, and Europe. Participants were all full-service sex workers or had worked as full-service workers in the past two years. While most participants worked independently indoors, a third of participants had also worked together indoors with other workers. Just over a quarter of participants also had experience working on the street and were either currently working in this context or had done so previously. Significantly, half of the participants reported that they were living with some form of disability or chronic illness and/or were neurodiverse. For several of these participants, sex work was a means of managing their ongoing health issues. Therefore, several participants had ongoing health needs and access to high quality, safe, and inclusive healthcare was particularly important.

Participants were recruited using personal networks, snowballing, through posters placed in the offices of sex worker organisations, services for women experiencing homelessness, and social media. Interviews were conducted either in person or on Zoom in accordance with the participant's preferences (and, in some cases, due to COVID-19 lockdowns). Interviews averaged 1.5 hours. All participants received €60 or local equivalent as a voucher or cash in recognition of their contribution to the research and the time taken to participate. Interviews were transcribed verbatim, and participants were offered the opportunity to read, comment on, and request edits to their transcript if they wished. While very few participants requested edits to their transcript, all requests that were made were fully respected. All names used in the research are pseudonyms. The interview transcripts were coded and analysed using reflexive thematic analysis, and our process was guided by Braun and Clarke (2021). A first read through of the transcripts enabled us to become familiar with them and to take initial notes about the content. Transcripts were coded on the second read through, and the coding was open, organic, and

guided by the narratives of individual participants. Our approach was both inductive and deductive since we were exploring the transcripts with an interest broadly in stigma, discrimination, and the law, but we remained curious about the data and interested in any broader issues that arose. Once the transcripts were coded, the coding was reviewed and revised and broad themes were developed.

4. Findings

4.1. The Republic of Ireland

Overall, among the 24 participants in the Republic of Ireland there were low levels of trust in health professionals, particularly GPs and nurses working in mainstream health services. This resulted in very few participants disclosing their sex work in this context. For the few participants who said that they would feel comfortable disclosing their sex work in primary health care settings, this was because they had an expectation of confidentiality. Lisa said that she would feel comfortable disclosing in this context because, "they cannot tell anybody and they are not like close to me". For these participants, the main consideration was their privacy and they believed that this had to be respected by medical professionals.

However, for the most part, participants did not trust medical professionals and this lack of trust was connected to a belief that they would receive adverse treatment if they did disclose their sex work. Sarah explained "I never did [disclose my sex work]. I didn't really believe or trust that I would be treated in the same way as like a regular civilian person and so no, I never brought it up with doctors". For Debbie, a reluctance to disclose to GPs was connected to shame, explaining that she would not tell because "I'd be ashamed of my life". While Caroline was comfortable disclosing sex work to her own GP, who she trusted because they worked in specialist clinics with other marginalised communities, she was very cautious about medical professionals generally. She explained "I would be cautious with any doctors or nurses because I find that they can be quite judgemental". Roberto, a migrant sex worker, said that he would not ever disclose his sex work because he would be concerned about judgement. He explained, "I wouldn't do it because I will feel judged and probably they would refuse to see me, or, I don't know what will happen… no way am I going to tell a doctor I am a sex worker, I would instantly have STDs or STIs or whatever". Roberto had previously been directly asked if he was a sex worker at a sexual health clinic, and he felt that there had been a judgemental tone. He explained "I didn't tell them anything more than a number [of sexual partners] and they were

like 'are you a sex worker', [and they said it] in a bad way… I don't know the way they view sex workers but even without them knowing I was one, I feel judged".

For other participants, a reluctance to disclose was about more than fear of judgement and related to the possible consequences that could eventuate. For Jennifer this was due to a fear of children being removed:

> *"… no, definitely not because at the start it was because my daughter was living with me and I know straightaway the first thing they [GPs] do is contact the social workers. So that's why I would never disclose it to them and now my grandchild being here, definitely not" (Jennifer)*

While Jennifer had never experienced this herself, she knew another street-based worker who this had happened to. She explained:

> *"… she had literally told - the day before - told the Doctor and boom, within 24 hours, the little one was gone… It's not as if she was bringing anyone around the child or taking drugs around the child or anything. It was just because the girl was out working. I mean the child wasn't even in her care when she was going out working, he'd stay with the grandmother" (Jennifer)*

The reluctance to disclose sex work experience in healthcare settings was also described as meaning that sex workers often do not get access to the care they may need. Emily explained that "people who are afraid to talk about how they are a sex worker are denied Post-Exposure Prophylaxis (PEP)". Reflecting this, Monica was unable to access PEP after a client covertly removed his condom in the booking. She felt unable to say she was a sex worker and used a cover story instead:

> *"I was asking for the PEP, the pill that you take in case of other person has the HIV and she then wouldn't give me any of those pills because she said that it was like, I'm heterosexual and not homosexual… I didn't mention that like it was a client. I said that I met this guy from Tinder and I was really worried but they didn't care. I don't know if I said that I was an escort or something it will change something, maybe if I told her okay it was a client or something like that, maybe she would worry more or something." (Monica)*

Thus, it was clear that participants in the Republic of Ireland mostly did not disclose their work due to a lack of trust, and this could negatively impact the care that they have access to. Catriona contrasted this with her experience working as a sex worker in Australia, explaining:

> *"I just wouldn't trust them in Ireland but I know in other countries, I'm thinking Australia… I knew that they would be good because actually I did go to a GP and I did disclose what I did, in Australia, and that was a good experience" (Catriona)*

While most participants in the Republic of Ireland did not disclose their sex work in healthcare settings, those who did described receiving judgemental and unhelpful responses. These responses indicated that the healthcare provider perceived sex work as inherently harmful and believed that sex workers should be encouraged to leave the industry. Emily described attitudes towards sex workers among some healthcare providers as "seething contempt". Reflecting this, when Bya disclosed her work to a nurse she recalled that "she told me I should change my life, that I should have a 'normal' job". Two participants recounted being directly asked if they were victims of trafficking when they disclosed their sex work in a healthcare setting. Poppy recalled what she described as "the most atrocious experience I have ever had with healthcare", explaining that she had been directly asked by a doctor if she was being trafficked. She went on to explain that the Doctor had then examined in her such a way that inferred she was likely to have a disease, explaining "… she made me lie down on the table and like she said very like firmly, "I'm checking you for lesions"". Following this experience, Poppy sought to resist the assumptions that had been made about her and how she had been treated. However, the Doctor was not receptive to that. She explained:

> *"… afterwards I was like look, I have to just say it, that trafficking question you asked is not appropriate, especially as I have already said to your Nurse that I'm happy doing what I'm doing, there's no coercion involved and she was like, 'oh well, you know, people don't often know themselves and after a few sessions they often reveal things and also my Nurse isn't qualified to ask these questions'" (Poppy)*

Ronan, who frequently disclosed his work to medical professionals and described responses overall as "good and bad" described a similar experience and felt that female doctors were often more judgemental. He explained:

> *"The women doctors don't react as well as the male doctors. Most of my male doctors they are like, 'are you safe?' and I'm like, 'yeah', and they are like, 'okay!' Right, they do not blink. The women, I had a GP who was like, 'are you being trafficked?' And I'm like, is that the first question you are going to ask me? And I was like, 'obviously fucking not'. Like, I'm sorry but it's like what trafficking victim would just be like, 'hey, by the way, this is what I do'. Like come on!" (Ronan)*

This explicit questioning around trafficking is likely to reflect the dominant narrative in the Republic of Ireland that prostitution is a form of violence against women, which often results in

the conflation of sex work and trafficking. As Poppy and Ronan's experiences demonstrate, such direct questioning is unhelpful on several levels. At the very basic level it is a strategy that is unlikely to identify anyone who is being exploited, since as Ronan intimates, victims of serious exploitation do not typically speak openly about their circumstances in this way. Such questioning is also othering and could be particularly anxiety inducing for migrant sex workers with insecure immigration status, who may fear information being shared with authorities.

While several participants in the Republic of Ireland described mistrust of mainstream health providers, which meant many did not disclose their sex work, and negative experiences when they had disclosed, more positive experiences were described accessing more specialist services. Such services were focused broadly on marginalised communities such as sex workers, LGBTQIA+ populations, and people who use drugs. Poppy described her preferred healthcare provider for sexual health checks, explaining:

> *"… there's a service, it's at [specific hospital] and it's like a very sex worker friendly combined with being trans friendly and LGBT like by and large friendly but specifically for sex workers and trans sex workers, it's been a godsend." (Poppy)*

Ronan connected his positive experience at a clinic to the medical professionals having the knowledge to work with their health needs and not seeing this as outside of the norm, explaining:

> *"I have a fantastic PrEP clinic… Yeah, so the nurses and the doctors are fantastic but they are all like queer, and like you know that is kind of like what they specialise in, so it's like it's not new for them." (Ronan)*

Caroline felt that her GP is trustworthy because "she also works in the safety net clinics so with people in addiction and homelessness and that". For Suzanne, disclosure was not even a question as the healthcare services they accessed "would be through voluntary organisations or outreach and it would be assumed [that I am a sex worker]". However, sex workers should not have to rely on specific services to feel safe disclosing their work, and to receive good quality, respectful care that meets their needs. The experiences of participants in this research indicate that healthcare services are, for the most part, not safe nor meeting the needs of sex workers in the Republic of Ireland.

4.2. Scotland

Participants in Scotland were slightly less reluctant to disclose their sex work to GPs but there was still hesitance because of fears around judgement. Lucifer Lee explained that while he sees

Doctors often in relation to his gender transition, he had never disclosed sex work, explaining, "as a trans person, I see doctors quite often, I would tell fuck all to any of them and that is because of stigma…how they would look at me differently". For several participants, withholding their sex worker identity from GPs was also related to concerns about the possibility that their sex work could be documented alongside their legal name, as government agencies may share information. For Madeleine, this was important due to her immigration status, explaining:

> *"Not with my GP… I'm still a migrant, I can't afford to have it on record anywhere… there is this whole good character clause or something and I don't think that being a whore is going to get me higher up on the scale of good character/bad character thing." (Madeleine)*

For Rosie, this was also partly because she believed NHS workers were being trained that sex workers need to stop doing sex work, and she wished to avoid being given this advice. She explained:

> *"Yeah, I wouldn't tell them. I never have, I wouldn't feel comfortable to. I think I read something like, this was years ago now so it's maybe like, you know, older training but it was about training that they gave NHS workers and it was very much like focus on help to exit sex working." (Rosie)*

Similarly, Lucy was concerned that her GP might take some sort of adverse action if they knew about her sex work and did not disclose it on this basis:

> *"My GP doesn't know… I would just feel that they would do something, I just don't know what they would do... I do not trust the NHS because you just don't know who you are going to talk to and what their opinions are." (Lucy)*

For L, it was important to not tell their GP sex work because they felt that this would mean their chronic physical health condition would not be taken seriously and stigmatic assumptions would be made that would impact the level of care that they received. They explained:

> *"Not my GP because I have complex health issues and as is very frequent with general practitioners and people who are assigned female who have complex disabilities, they cannot separate your body from your mental health. Once you say you are a sex worker, you're immediately assumed to be depressed and have all manner of things wrong with you, personality disorders, all kinds of things, right. And I'm working very hard to get them to take my physical health issues seriously… I have a joint condition, a degenerative joint condition and that's only very recently been discovered despite me asking for years and years and years for help and being*

> *pegged as a drug seeker, like, 'oh, you just want painkillers'. I'm like I would just love to see a Physio. If you start saying you're a sex worker - sex worker plus painkillers equals they will never speak to me again. So, no." (L)*

Jenny, a street-based sex worker in Glasgow, said that she avoided all healthcare services if she could because she did not trust medical professionals and had adverse experiences in the past. She explained, "If my leg was hanging off, I'd try and Sellotape it back together before going to the doctors", and that, "my faith in them is kind of like my faith in the Police". For Elektra, a Swedish sex worker based in Scotland, her hesitance to disclose sex work to a GP was based on negative experiences she had in this context with medical professionals. She stated:

> *"I am very hesitant to disclose anything to a medical professional. I've had bad experiences in the past with medical professionals…I'm like super, super cautious and I'm also a drug user occasionally and that is also something that you can't really - in Sweden - disclose to like a medical practitioner without putting yourself in like lots of legally tricky situations. So, I hide a lot of things that are relevant to my health when I go to the Doctor." (Elektra)*

However, a few participants did feel that they could disclose their sex work in this context and that it was important to do. Lavender explained:

> *"I feel given the push I feel like you should disclose to a GP, that's like maybe the most important ones that you should because they are there to like keep you safe as well". (Lavender)*

Nevertheless, among participants who had been open about their sex work to GPs and nurses, the response was not always positive. Golden Tantric, for example explained:

> *"I kind of outed myself to my own GP Nurse because I thought, I forgot what was on my records and what wasn't and said about working and then she just like literally jumped back from me and it was quite horrible." (Golden Tantric)*

Specific sexual health clinics were a setting in which most participants in Scotland were comfortable disclosing their sex work, but only with the condition that they could use a pseudonym. Keeping sex work separate from their legal name was important to most participants due to concerns about information sharing between government agencies, and the possible implications of this. Heather for example explained "No way. And so to get like even a STD check I always have to make up stories about being like a prolific slag…don't want it on record".

While most participants felt that they could anonymously disclose sex work in sexual health clinics, responses to disclosures were mixed. Lucid explained that they had a positive experience because there was a trusted person at the clinic who was dedicated to working with sex workers:

> *"… only like the specific person that is assigned to see sex workers at the [clinic]…that would be the only person that I would tend to disclose that to…a lot of people here have had positive experiences with the Nurse at [clinic]. Umbrella Lane and NUM have the specific contacts and phone number to get through to them so that you don't have to out yourself to everyone in the clinic and things like that." (Lucid)*

Madeleine, however, had a very different experience at a clinic in a different city to the one described by Lucid. She explained:

> *"I actually basically I stopped going there because every single time I go there, they say something else, or do something else that is — I'm feeling so angry right now, just thinking about it, you know - my heart is pounding…I mean generally they are very much with the Scottish government's policy that sex work is violence against all women. I think they are more into the whole saviour thing…I think they maybe don't know how to listen to people, or rather maybe they have a very specific view of what a sex worker is and when you don't fit into that view, then they don't actually know how to treat you…They always know better than me and I never know shit. Basically, that's the description of every situation. (Madeleine)*

This condescending attitude was evident in several situations that Madeleine outlined. One specific incident related to a nurse stating that it would be useful for the clinic to learn from the author of a book on sex work issues, who is a former sex worker. When Madeleine suggested that they could talk to her – a current sex worker – instead she was informed "well, you don't have the hindsight". Madeleine was understandably incensed by this inference that she lacked perspective on her own lived experience. She explained:

> *"This is how I learnt the word 'hindsight' in English. This is the first time I heard it… I mean [the author], I mean, yes, she has done sex work but never in Scotland… it was not in this country, not right now, not this type of sex work and you still think her opinion matters more than mine? I'm literally here. Ask me what I need. You don't have to go out of your fucking way! (Madeleine)*

Thus for participants in Scotland, accessing healthcare services was something that they had to very carefully navigate. Disclosing to GPs was felt to be very risky so most participants did not, and instead preferred to only disclose at services where they could remain anonymous. The

government narrative regarding sex work was clearly impacting experiences accessing healthcare services, with participants either not disclosing their sex work because of this, or experiencing infantilising and demeaning treatment when they did.

4.3. New Zealand

Participants in New Zealand were, overall, a lot more relaxed about disclosing their work to GPs and other health professionals in primary healthcare settings, and mostly described positive reactions from health professionals. Abby says that she had disclosed her work on numerous occasions and it had been a positive experience for her, explaining:

> *"Yes, I have told my GP. I've told multiple GPs I'm a sex worker. It's generally a good experience, they just stick to the basics with their questions for sexual transmitted infections, like check-ups. Yeah, it was good telling them… I haven't had any awkward situations with that. They've encouraged me to get all of the immunisations" (Abby)*

Similarly, Billie said that she would regularly disclose her work, explaining: "Oh, absolutely I disclose it almost always. I had to go to my doctor about a jaw problem and he asked me if could keep my jaw shut for a while and had to talk about it then". For Jane, along with several participants, being able to safely disclose sex work in healthcare settings was considered essential to receiving the most appropriate care. Jane explained:

> *"I'm definitely straight up, it's an important thing for me [and] it's an important thing for the doctors to know as well - that's super important. [I was] in hospital just recently, I had a virus so it was like talking about when can I work again. And that's stuff that I'm not going to know - I'm not a doctor. So I've got to be straight up and I've got to say yes, I sometimes share bodily fluids because I kiss people and so how long do I wait until I can go back to work." (Jane)*

Michelle, described the trusting relationship she has with her GP, explaining "My personal GP knows about it and she went, "oh good on you", and she always sort of laughs because I tell her work stories and stuff so we have a great laugh". However, Michelle's experiences had not always been positive, and she described a very different experience that had occurred prior to sex work being decriminalised:

> *"I went to family planning…I sort of told them because I was young and I'd just started. I didn't think there was anything wrong and I remember the nurse going, 'ooh gosh... really dear, ooh". And she was very sort of judgmental and quite*

> *condescending towards me. And then I remember one of the doctors came in and they were sort of whispering in the corner and stuff before they came over and sort of did an exam on me… I didn't think that was incredibly professional" (Michelle)*

More than 20 years have passed since the law changed in New Zealand, and Michelle is one of the few participants who also worked as a sex worker prior to decriminalisation. Her experience at this time echoes that of several participants in the Republic of Ireland and Scotland, who most often felt judged by medical professionals and received condescending responses. Michelle's two contrasting experiences pre- and post decriminalisation highlight how much has changed.

While participants in Scotland and the Republic of Ireland guarded their sex work very closely and were particularly keen to avoid having sex work experience on their health records, Chloe in New Zealand had no concerns about this. She described deliberately having her sexual health checks through her GP surgery even though she could have them confidentially for free through NZPC or another sexual health clinic, because she wanted to be able to see her test results online in her medical records. She said: "I don't go to the free ones because I like seeing the results on my health records… I like seeing the data points". Chloe described a situation in which she had a sexual health check and the medical professional she saw would not do the tests that she felt were necessary. She explained:

> *"… she wouldn't do a throat swab and I was like [telling her] 'do the throat swab' and we had this whole thing about it and it turned out didn't even know how to do the throat swab and I had to show her how to do that… So I was just like look this is what I do and this is why I'm so stringent… She was pretty cool. It was just like oh that makes a lot of sense no wonder you've got so much knowledge…. I guess because I was in the position of educating her she couldn't exactly turn around and be like oh no [judgmental]. I've just schooled you so you can't shame me." (Chloe)*

The response that Chloe received to her disclosure – one of respect – is telling. Instead of talking down to Chloe in the way that several participants in Scotland and the Republic of Ireland described experiencing, the nurse in this situation acknowledged that Chloe's job was conducive to her being knowledgeable about sexual health. Chloe's response also highlights a sense of power that she had in this interaction, which made it far less likely that she could be shamed. A similarly affirming response was also evident in the experience of Mel, a street-based sex worker who had gone to her GP after being sexually assaulted by an acquaintance. In recalling this experience, Mel tearfully described how her GP had supported her and encouraged her to report the assault:

> *"… she said, 'it doesn't matter whether you're a working girl or not it shouldn't have happened. And you said no - it doesn't matter, end of story...' I said, 'oh, they will probably say I was asking for it', and she goes, 'no I don't give a fuck, mate'. This was my doctor, she goes 'I don't give a flying fuck'. She said, 'at the end of the day, you said no and that's the end of it. He shouldn't have just assumed because you work that that's what was going to happen'." (Mel)*

Thus, experiences of participants in New Zealand contrasted starkly with those in Scotland and the Republic of Ireland, with participants feeling freer to disclose their work in healthcare settings and having helpful and affirming experiences when they did. However, it is important to acknowledge that there were still a few participants who were reluctant to disclose their sex work or highly selective about when they would do this. In some cases, this was because of family connections, living in a small community, and having the same GP since childhood, which created discomfort. In Debbie's case, her GP was like "a mum figure" and she did not feel comfortable telling her about her work. However, she described how liberating it was when she could disclose her work:

> *"I wouldn't tell my family doctor but there was a locum there once and she was really cool. She said, 'are there things that you would like to tell me that you haven't told [usual doctor]?' I said 'fuck yes'. I don't know how we got into it; I think it's because she told me she used to work full time at family planning, maybe. So, I told her and it was like such a relief, it was so nice to be able to tell and she was so cool." (Debbie)*

Rose did not disclose her sex work because her history of drug use being officially documented had negatively impacted her healthcare in the past and she was concerned that the same would happen if she disclosed her sex work. She explained:

> *"No I'd be afraid that it would be on my notes. I've already got was addicted to drugs on there and that has stopped me from getting the best care that I can already and it's been twelve years ago that I got off drugs. And when I go to ED they just assume that I'm on drugs. So don't want to add stigmas to my records." (Rose)*

Additionally, there were a few isolated cases of participants not receiving the most helpful responses when they did disclose their work. While Natasha felt it was helpful to disclose because in one instance when she had to go to hospital, "I think they were able to kind of get the diagnosis a lot quicker because of that", in Jane's case it meant that assumptions were made that led to an incorrect diagnosis. She explained:

> *"I was in hospital just recently and it's always the first thing I bring up, I'm a sex worker. I had like a really bad stress episode and my whole body got covered in a rash… Because I was so straightforward with 'I'm a sex worker' they were straight to the point with 'okay it's got to be syphilis then'. Excuse me? Yeah. And I had like a spinal tap and they did all of this shit trying to figure it out." (Jane)*

Thus, while the experiences of participants in New Zealand were significantly better than those in the Republic of Ireland and Scotland, in that they could be far more open about their work and most often received supportive responses, it is important to acknowledge that stigma does continue to impact sex workers in this context and thus work must continue to challenge stigma.

5. Conclusions

Throughout this paper, we have explored experiences accessing primary healthcare services among 70 sex workers working in New Zealand, Scotland, and the Republic of Ireland. The narratives of participants clearly illustrate that in the Republic of Ireland and Scotland participants felt less able to disclose their sex work to healthcare professionals than those in New Zealand. This reluctance to disclose reflected a lack of trust both in the individuals providing care, and the overarching systems. The experiences of participants highlight how accessing healthcare was negotiated as another risk to be managed, and a setting in which participants may be surveilled and policed. Several participants were concerned about information sharing between government agencies and the risk of their sex work being documented alongside their legal name. Primary health care was positioned by several participants as one part of a chain of hostile state agencies that could cause them serious harm.

In New Zealand, participants were a lot more relaxed about disclosing their work in this setting, and in many cases felt that it was important to do so. It is important to acknowledge that there were some participants in Scotland and Ireland who felt comfortable disclosing their sex work, and there were a few in New Zealand who still had misgivings about doing so. Nevertheless, experiences among participants overall indicate that New Zealand is a context that is more conducive to openness in healthcare settings.

Similarly, when participants did disclose their sex work to healthcare providers, the responses that they received differed between each context. Among the few participants in the Republic of Ireland who had shared information on their work in primary healthcare settings, several described feeling judgements, with assumptions being made that they were coerced or that they

should aspire to leave sex work. In Scotland, while most participants felt comfortable anonymously disclosing their sex work in sexual health clinics, and perceived there to be benefits to doing that, participants described mixed responses from health professionals. The government narrative that prostitution is a form of violence against women appeared to shape experiences in healthcare settings, and an awareness of this underpinned why several participants did not feel able to disclose their sex work. In New Zealand, participants described responses to their openness about their work that were comparatively much more positive and affirming.

On the basis of these findings, it is reasonable to argue that the legal framework in place plays an important role in shaping the everyday experiences of sex workers accessing healthcare. Decriminalisation is the model that was most conducive to participants feeling able to be open and, overall, receiving good quality care when they did. Comparatively, participants working under a variant of the Nordic model were most apprehensive about disclosing their work and described particularly adverse reactions when they did. Criminalisation – even when not directly focused on sex workers – creates a climate of fear, entrenches stigma and compromises the right to health for sex workers. While decriminalisation certainly does not eliminate stigma in healthcare settings, it alleviates it and sex workers are better placed to resist and challenge it. As such, we conclude that decriminalisation is an essential starting point for ensuring more positive and equitable healthcare experiences.

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