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Culture, Health & Sexuality

An International Journal for Research, Intervention and Care

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/tchs20

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To cite this article: Paul Ryan & Kathryn McGarry (2022) 'I miss being honest': sex workers' accounts of silence and disclosure with health care providers in Ireland, Culture, Health & Sexuality, 24:5, 688-701, DOI: 10.1080/13691058.2021.1879271

To link to this article: https://doi.org/10.1080/13691058.2021.1879271

Published online: 02 Feb 2021.

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CULTURE, HEALTH & SEXUALITY
2022, VOL. 24, NO. 5, 688–701
https://doi.org/10.1080/13691058.2021.1879271

'I miss being honest': sex workers' accounts of silence and disclosure with health care providers in Ireland

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ABSTRACT

In this paper, female sex workers tell stories of their interactions with health care providers (HCP) in four cities in the Republic of Ireland. While Irish society has made great progress in listening to the sexual stories of women that were historically silenced (e.g. stories of abortion, sexual abuse), sex workers have not benefited from this new climate. Regularly silenced by parliamentarians and non-governmental organisations who speak upon their behalf, sex workers are consigned within a narrative of victimhood and coercion. This paper draws from a participant action research study conducted in 2019–20 and explores women's motivations in whether to disclose their sex work, and the strategies deployed to conceal it while seeking access to sexual health care. These strategies included traveling beyond their own communities for health care and STI home testing. The paper identifies women, particularly, migrants who felt their precarious position made it impossible for them to be truthful about their sex work to health care providers, exposing them to greater health risk. The paper understands this marginality within a context of structural violence where sex worker health is shaped by institutional power relations creating unequal health outcomes but is also challenged by stories of solidarity.

ARTICLE HISTORY
Received 5 October 2020
Accepted 18 January 2021

KEYWORDS
Sex work; structural violence; health care; sexual story telling; Ireland

Introduction

In this paper, female sex workers tell stories of their encounters with heath care providers in four cities in the Republic of Ireland. Their stories hinge on disclosure – whether to choose to tell a health care provider about their involvement in sex work or not– with many embarking on tactics of non-disclosure to seek treatment which undermines their ability to seek holistic medical care. We should not be surprised by a reluctance to disclose stories of sex work. The stigma attached to sex work and prostitution is well documented (see Whitaker, Ryan, and Cox 2011). It is pervasive across all types of criminalised sex work, including male sex work (Ryan 2019) but also legal forms such as stripping (Trautner and Collett 2010) and frequently intersects with racism, homophobia and transphobia (Sanders 2018). There is an emotional and

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physical cost of carrying a stigma that can be concealed or hidden and it is the strategies that sex workers engage in to control information related to stigmatisation, including by health care providers, that can cause isolation, anxiety and low self-esteem (Oliveira 2012, 2018; Koken 2012). This paper explores these strategies within a newly adopted legal framework in Ireland, which criminalised the purchase of sex in 2017 while maintaining offences against ancillary activities such as brothel keeping (See Ryan and Ward 2018; McGarry and FitzGerald 2017; Ward 2017 on this campaign).

Sex worker health care provider disclosure stories cannot be understood outside the context in which women talk about sexuality in Ireland. This context has changed dramatically in the last thirty years. Ireland's transformation into a modern, export oriented neo-liberal economy has had far reaching consequences for the social fabric of the nation; accelerating urbanisation, immigration and ushering in the slow decline of the Catholic Church's influence over social and political life (Ryan 2011). Women's lives have been transformed by these changes. Stories of women's sexuality previously deemed transgressive, rendered silent and marginalised in Irish society have increasingly found a voice in the public sphere. Stories of single mothers incarcerated within religious run Magdalen laundries have received state apologies with redress schemes established to compensate victims. Recent successful referendum campaigns on gay marriage (2015) and abortion (2017) have had women's stories at their centre – often stories of stigma and shame as women struggled with their sexuality and reproductive choices in a state that had created a symbolic and idealised version of womanhood. Women working in the sex industry have not, however been the beneficiaries of this new climate of sexual story telling. Routinely excluded from legislative debate governing their lives (FitzGerald and McGarry 2016), sex workers have remained infantilised as objects of rescue in which their stories have been mediated by others – journalists, academics or spokespersons from non-governmental organisations.

Understanding sex worker access to health under models of (de)criminalisation

Studies have attempted to chart discrepancies in sex workers' access to healthcare across different legislative models internationally. The Platt et al. (2018) meta-analysis reviewed 40 quantitative and 94 qualitative research studies published between 1990 and 2018 in English, Russian and Spanish. The analysis of the quantitative studies clearly showed that sex workers living in countries subject to repressive policing measures were, on average at an increased risk of contracting HIV/STIs compared to those that were not (p.9). Repressive policing increased the use of sex without a condom across 9,447 sex worker participants from four studies. The analysis of qualitative studies revealed that criminalisation regimes impede and rush negotiations with clients where there is limited time to screen potential clients or discuss safer sex (p.22). Criminalisation regimes act as a clear impediment to safer sex practices with studies finding police use the possession of condoms as evidence of sex work.

Specific research studies provide greater insight into the difficulties that varying degrees of criminalisation present to sex workers. In Canada, for example, criminalised aspects of buying and selling sex create stigma and violence against sex workers who

are seen as deserving of criminal sanction (Lyons et al. 2017). Trans sex workers specifically are afraid to report or seek medical assistance after assaults by clients for fear they will be arrested for sex work. The impact of criminalisation on sex workers' ability to implement safety strategies in Vancouver led to insufficient time to screen clients in increasingly isolated areas where pressure of time and the risk of arrest transformed how sex workers negotiated the terms of the transaction (Krusi et al. 2014).

In New Zealand, where sex work has been decriminalised since 2003, Abel (2014) revealed that most sex workers were accessing their GP for both general health (91.8%) and sexual health (41.3%). Local sexual health centres were the second most popular services utilised. with one-quarter of participants stating it was their preferred option. Laverack and Whipple (2010) also reported improved sex worker health outcomes in New Zealand, with 87% of all survey participants having a regular doctor and with sex workers being less likely to report that they felt pressured to accept a client when they did not want to.

Given that sex work is criminalised to varying degrees in most jurisdictions, the health of sex workers, including their mental health lies beyond the remit of occupational health. This is reinforced by a societal construction of sex work as a 'public health' problem with a focus on STI and HIV transmission (Rössler et al. 2010, 144). In the Rössler et al.'s (2010) study of 193 female sex workers in Zurich, the research team found a higher prevalence of mental health disorders among the cohort than the general population, although it was difficult to control for those who had conditions prior to their involvement in sex work. This disparity was associated with the violence, both physical and structural, to which women were exposed, even though a regulatory regime governed sex work in the city.

Structural violence

The concept of structural violence is regarded by some writers as an important way to frame unequal outcomes in terms of health and exposure to risk and violence that many sex workers face (Shannon et al. 2008; Simiç and Rhodes 2009; Krüsi et al. 2016). While many research studies have provided evidence of the physical, sexual and emotional violence experienced by individual sex workers, structural violence relates to wider social structures creating unequal conditions and unequal access to power shaping life experiences for many (Bourdieu and Wacquant 1992; Galtung 1990). Those with less power and reduced access to opportunities to acquire power are more likely to be subjected to structural violence. Such inequalities are mediated through macro social arrangements (e.g. criminalisation of sex work, poverty) rooted in socio-historical and economic processes (e.g. colonialism, globalisation) inflicting injury upon more vulnerable populations. Indeed, for sex workers, regimes of criminalisation, poverty, racism and sexual stigma become institutionalised as everyday violence (Scheper-Hughes and Bourgois 2004) and structural violence becomes internalised as a symbolic violence, regarded as both natural and inevitable (see McGarry and Ryan 2020).

Grenfell, Platt, and Stevenson (2018, 104) argue that challenging the inequalities that shape sex workers' health requires a 'fundamental shift […] in power relations that institutionalise, legitimise and normalise suffering and inequalities.' Grenfell, Platt,

and Stevenson (2018: 107) also call for a social justice frame to sex workers' health by "ensuring access to appropriate and respectful services, tackling structural inequalities, dismantling institutional cultures of stigma, and supporting sex worker-led organisations".

The stories of encounters with health care providers in this paper are understood within the framework of structural violence (Galtung 1990; Krüsi et al. 2016). While much research on sex work has focused upon physical violence, structural violence moves beyond the physical to 'include assaults on self-respect and personhood' (Scheper-Hughes and Bourgois 2004). In this paper, we follow Kurtz et al. (2013) in suggesting that the silencing of marginalised women's stories about their health care is an act of structural violence itself.

Study setting

Data for this paper are drawn from an action research project funded by HIV Ireland and conducted in conjunction with the Irish Sex Work Research Network (ISWRN) and the Sex Workers' Alliance Ireland (SWAI) between June 2019 and May 2020. The ISWRN is a network committed to advancing research and scholarship on sex work and sexual governance in Ireland and promotes inclusive and democratic research practices for sex workers, who have been long disenfranchised from the production of knowledge on their lives (McGarry and FitzGerald 2017). In February 2017, the Criminal Law (Sexual Offences) Act was introduced in Ireland and criminalised the purchase but not the selling of sex. There is mounting international evidence of the negative health outcomes for sex workers under criminalised regimes, while decriminalisation offers a potential alternative reducing harm as seen in New Zealand and New South Wales (Australia) for example (Levy and Jacobson 2014: Platt et al. 2018; Krüsi et al. 2016). HIV Ireland commissioned the ISWRN to undertake a study, funded through the Open Society Foundation (OSF), to explore the impact of the current laws governing sex work in the Republic of Ireland on the health and well-being of sex workers. The research was undertaken in collaboration with Sex Workers Alliance Ireland (SWAI), a front-line advocacy and support service promoting the health, participation and rights of sex workers in Ireland.

Methodology

The research used a participatory action research framework (O'Neill and Laing 2018) to engage in a dialogue with participants to understand their experiences of sex work in a criminalised environment, specifically looking at access to health and justice. The research design facilitated a flexible approach, to encompass multiple perspectives and in which participants are not seen as passive actors in the research process. Our commitment to a peer-led approach sought to challenge undemocratic research practices and dominant narratives controlling knowledge production about sex workers (McGarry and Ryan 2020: Ryan 2020). We were guided by the idea that group processes lie at the heart of facilitating change (Chui 2003) and used the opportunity to meaningfully engage with sex workers throughout the research process. There are two

key orientations to participatory action research according to O'Neill and Laing (2018, citing Fals Borda 1987) – partnership in designing, conducting and writing up the research, and commitment to change. A fundamental aspect of the approach according to O'Neill and Laing (2018, 173) is 'a commitment to doing research that develops partnership responses, shared ownership and innovative ways of consulting and working with sex workers that lead to actions, interventions and social change'. The study was granted ethical approval from Maynooth University and all names used here are pseudonyms.

Methods

Two peer researchers were recruited from SWAI along with a key SWAI researcher to work to develop the research instruments, co-facilitate focus groups in Dublin, Cork, Limerick and Galway and play a key role in dissemination of the research through conference presentations and publications. The findings were reported back to SWAI for feedback.

After recruiting the peer researchers, we used snowball sampling to access sex worker groups through social media, advertising on Escort Ireland and through sexual health projects like GOSSH – Gender, Orientation, Sexual Health, HIV (Limerick) and Sexual Health Centre (Cork). Four focus groups were held in Dublin, Galway, Limerick and Cork respectively. Participation rates varied in each venue to the size of "networked" cohorts of sex workers achieved by snowballing as well as time and availability issues. In Dublin, 9 participants attended focus group sessions, while 5 did so in Galway, 4 in Cork, and 3 in Limerick.

A small remuneration was offered to participants including a stipend for the peer researchers' role in the focus group co-facilitation and expertise in recruitment, in line with best practice in research with marginalised groups (Shannon et al. 2007). The focus group discussion guide was developed jointly with peer researchers to generate discussion on what effects, if any, the new laws were having on sex worker health, well-being and lived lives as well as support and service requirements.

Our analysis included a thematic coding of the data according to the overall objectives of the study. As focus group data allowed for the coding of both content and process (Morgan 1998), we were able to build up a picture of key issues as perceived by sex workers as well as ongoing and potential solutions.

Findings

Motivations for non-disclosure to health service providers: gossip, shame and isolation

International evidence suggests that non-disclosure of involvement in sex work is a barrier to accessing comprehensive health care (Lazarus et al. 2012; Benoit et al. 2018; Slabbert et al. 2017). Stigma is reported as a key motivating factor in this non-disclosure. While stigma may be be enacted, for example by shunning, the internalisation of stigma can lead to shame, self-hate and self-derogation (Whitaker, Ryan, and Cox 2011). Stigma also creates an environment in which sex workers feel compelled to

hide their involvement in sex work, a process that increases stress and contributes to negative health outcomes (Lazarus et al. 2012: 140; Benoit et al. 2018). In Jeal and Salisbury's (2004) study of sex workers in Bristol, 83% of their respondents had failed to disclose their involvement in sex work to their GP, leading to low take-up of preventive health care services. In Oliveira's (2018) study of male and transgender sex workers, 61% of participants said they had never disclosed sex work to a health care professional. Transgender workers in particular were afraid how such a disclosure of being a sex worker would affect subsequent medical or therapeutic interventions they might need.

Participants in this study expressed a similar reluctance to disclose their experience of sex work with a range of health professions, recognising, with regret, that this hindered their ability to receive comprehensive care.

> I don't like the subterfuge; I can't go to my GP and say 'test me there I'm doing this job' … I could never go to my GP. And my GP is very open-minded, I just wouldn't want her to know. I have come here [sexual health clinic] once when they did have a doctor for the testing, that was fantastic, but I got an awful grilling. I didn't tell them I was a sex worker, I had to make up a big lie, 'oh I've discovered my boyfriend's been unfaithful' and I gave them a false name, everything was false (Daisy, Cork).

The fear associated with disclosure is well founded, with a large body of research pointing to insensitive and abusive language being used against sex workers in health care settings (see Benoit et al. 2018). Even within designated sexual health screening services, participants living outside of Dublin often felt uncomfortable disclosing their involvement in sex work for fear, or experience of judgement. International health care models point to the importance of peer led health interventions (Cohan et al. 2006) and/or greater sensitivity training. Sensitivity training on issues of sex work are deemed important in contributing to non-judgemental services leading to continued client engagement with health services. (Lazarus et al. 2012; Slabbert et al. 2017). There was a similar fear for respondents when it came to accessing mental health services, who believed workers within such services to be judgemental about their involvement sex work.

> Or even to find a counsellor that isn't going to be judgy about what you do, or to be moralistic "oh those aren't my morals, I wouldn't do sex work, so therefore you shouldn't be" (Gina, Dublin).

Study participants felt that their negative experience accessing sexual health services before they entered sex work made them more circumspect in disclosing their involvement in sex work to staff.

> I went up there [a clinic in rural Ireland] just as a civilian, and she was like "how many men have you had sex with this year", and I was like "mmmm, 15?", and she left, and they started tittering and gossiping, and I was like, oh that's just them because of that Jezebel thing, no. This is a common experience for people who are genuinely honest about their sexual experiences when they go to sexual health clinics in a lot of rural Ireland. And that shit is fucking annoying … they're not being trained right (Cassandra, Galway).

Here, the clinic is seen as a space of disclosure, and the disclosure of female sexuality as transgressing normative gender expectations by being promiscuous, immoral or

deviant reinforces the madonna/whore dichotomy. For gay men too, clinics were spaces of surveillance – by the wider public but also specifically by other gay men. Tan et al. (2020) point to the experiences of gay and other men who have sex with men in sexual health clinics in Singapore, signalling anxieties about being publicly identified as sexually promiscuous, which often acted as a barrier to accessing health care.

In urban centres, experiences were slightly different. Here, there was greater confidence in using sexual health services, although participants lamented the fact that they were often poorly resourced.

> Well I would like more health services, this centre is fantastic, but they can't get a doctor, that's a problem. I would like to be able to go to see someone confidential and say, "I'm a sex worker, please run all the tests" (Daisy, Cork).

Participants reported that when accessing health services where they had disclosed their sex work involvement they were offered services to enable them to exit, although these were often deemed insufficient or not tailored to the specific circumstances of their lives.

> I go up to them and say, ok, you want to get me out of sex work, hook me up with a job, hook me up with what I need to do, they're offering me how to draw up a CV, and how to talk English … bitch, I been talking English! (Cassandra, Galway).

Given the diverse nature of sex work markets, 'exiting' is not always desired and is rarely a unitary event. As a result, exit strategies from sex work and prostitution are generally deficient in meeting sex workers' holistic needs (Cusick et al. 2010). Moreover, in contexts where exit-based services dominate, there is a threat to the sustainability of harm reduction support to those sex workers who remain in the industry with provision being seen as promoting the continuation of sex work (Levy and Jacobson 2014).[1]

Lack of a community belonging has been identified as important in contributing to poor physical and mental health outcomes among sex workers (Benoit et al. 2018). In Portugal, Oliveira's (2018) study points to the stress caused by concealment and isolation from others, while Koken et al. (2012, 218) describe participants as 'living in the closet'. Participants in this study reported how stigma, isolation and a lack of community had contributed negatively to their mental health and wellbeing.

> Yes … OK, what I miss, what is so bad, in this job, we don't have a community, we don't keep in touch. This job, if you are working in this job you are getting lonely. This is what I miss. I don't come here [the focus group] because I need the money … I miss being honest. We don't have a community; we don't keep in touch' (Daisy, Cork).

[1]In Ireland, there exists a pre-dominance of exit-based services for sex workers, with organisations governed by a religious ethos, such as *Ruhuma*, receiving substantial government funding for work with victims of trafficking and those exiting sex work. *Ruhuma*, an agency dealing with victims of sexual exploitation including prostitution and trafficking, was a key player in the Turn off the Right Light (TORL) campaign to introduce a sex purchase ban in Ireland. The Department of Justice is reported to have written to the leading front-line advocacy group Sex Work Alliance Ireland (SWAI), telling them that they will never receive government funding if SWAI continues to deny that sex work is gender-based violence (letter seen by the authors – see also https://www.irishexaminer.com/news/arid-40028396.html, accessed August 25th 2020)

The Sexual Offences Act 2017, and specifically brothel keeping measures, which increased penalties on sex workers working together, was frequently cited as contributing to isolation.

> Isolation, working alone. I have … I could work with a friend. It's probably not such an issue… But the isolation is intense. And the risk is intense. And not being able to screen [clients] (Freya, Galway).

Participants from migrant backgrounds felt a keen sense of isolation, believing that they lacked crucial information to access health services, especially when they were not fluent in English. Similar findings have been reported among female sex workers from South East Asia working in Australia, where non-disclosure of sex work created isolation and increased stigma (Selvey et al. 2018). The risk of violence and coercion combined with isolation was also identified as having a corrosive effect on mental health and wellbeing.

> And we're vulnerable, which has an impact on your mental health. Every day you go out, and you're getting ready, and you're thinking what might happen today? What could happen? And when you have something that you need help with, where do you go for support … how can you go for counselling and sit down with someone that is actually going to understand a tenth of what you're saying about what you're feeling (Gina, Dublin).

Participants felt that this structural marginality was compounded by its intersection with marginality such as being queer, trans, migrant or disabled.

> We [migrants] don't always feel safe to say that [admit sex work] Similar things happen to other girls, but because of their position, where they knew their rights, and they knew what to do and what to say, to get the PEP in the same situation, they got it. And obviously it's a horrible situation at any level, but when you're a migrant and you don't have the same information and you don't feel safe to talk to people at the same level (Laura, Dublin)

In Laura's quotation above, we can see structural violence moving beyond individual experience to engage with broader contexts and structures of power – including migration policy – with real and damaging effects for how women seek information about their healthcare. Kurtz at al.'s (2008, 55) study reveals how Aboriginal women's access to health care in Canada is heavily racialised, with assumptions freely made about their alcohol use while their 'little power is consistently challenged and contested' by health care providers. It is these 'unequal power relations which can lead to oppressive interactions that silence women's voices' (p.56).

Adaptations resulting from non-disclosure to health care providers: half-truths, travel and home testing

Reluctance to disclose sex working in health spaces resulted in participants deploying a range of strategies to negotiate sexual health screening, resulting in medical care that was clearly deficient.

> I mean, while I was living in Ireland, I'd go back to England for a sexual health check, because I'm in rural [west of Ireland] and the only STD clinic [names clinic] And I'm not going to go to a general hospital … for an STD check because I would see… I'm not

> going to … In England there's STD clinics, most of them have worked with sex workers before, you just say you're a sex worker, they say fine (Freya, Galway).

> I can check it by myself, I order it online, a kit, and I can send it to a lab, but every year I go home, in my country and I check in there. (Lena, Cork).

This willingness to seek health care treatment from professionals who were unknown to sex workers and located far from their homes is an identified feature of previous research. Ghimire and Teijlingen (2009) study of female sex workers in Nepal found that workers travelled far from their homes or persuaded pharmacists to give them the antibiotics needed after self-diagnosis.

The decision not to disclose sex work to medical professions has more serious health implications than difficulty and embarrassment. Non-disclosure leads sex workers to have higher rates of attendance at accident and emergency departments (Lazarus et al. 2012). Participants in this study reported similar experiences.

> I made call out, he [the client] picked me up, it was in the night, he brought me to his house, and we start to have sex, and he looks like a gentleman, but I didn't realise when he took off the condom. So, I just saw when I was really wet, and I get really crazy, and I start screaming at him, but the action was made. I went to the hospital the next day, and I was nervous to say that I was a sex worker, so I didn't say anything, I just said that I had unsafe sex. But it was a really bad experience. I didn't realise he take off the condom, because I put the condom on to make sure, but I don't know when, I just felt the cum … I asked for PEP (Post Exposure Prophylaxis) and they said to me, that the situation wasn't enough to have PEP, so they said no, because it was heterosexual, so they didn't give it to me (Lola, Dublin).

Here Lola's treatment reveals how the institutionalisation and routinisation of dominant discourses regarding sex work, creates a vacuum in which structural violence thrives. Lola not only fails to get the health care she needs, but like others who are vulnerable in society, has internalised her treatment as the natural order of things. This story illustrates the pervasiveness of symbolic violence for many sex workers (Scheper-Hughes and Bourgois 2004). Stealthing, or the removal of a condom during sex without a partner's knowledge would be seen as an assault under Irish criminal law. Brodsky's (2017, 184) research participants, who experienced the non-consensual removal of a condom referred to it as a 'violation of trust and a denial of autonomy, not dissimilar to rape'.

Coercive experiences with clients influencing non/disclosure with health service providers

Research participants who were the most marginal and/or working under coercive conditions were less likely to disclose high-risk practices to their health service providers. They frequently reported that clients did not have adequate sex education or were indifferent to risk – putting workers' lives at risk. In keeping with previous research in Ireland (Whitaker and Cox 2009) that found sex workers were knowledgeable about safer sex and health risks, negotiating sex with clients was sometimes difficult.

> I mean people out there that are offering unsafe services, and because of misconceptions, they don't even get the concept that "you're not only putting my life at risk, you're putting your own life at risk" … I come from Africa, I know what AIDS is, I know the

severity of it … When I tried to tell this to clients, they'd be like "no" or "it doesn't matter". It's like "you want to stick a dick into a mouth bareback, you want to stick it into a mouth you don't know, how many other dicks have been there today?" (Gina, Dublin).

They [clients] think they're special. They don't really think that they're in a day full of clients. Because these men, these clients, they have this fantasy that they're like special. And of course, that's part of your work, but I think part of their brain doesn't process that I'm handling cocks all day. I'm not just handling your cock, I'm handling a series of cocks in one day, why would you want me to handle one cock, and then handle yours (Freya, Galway).

Research participants felt that the Sexual Offences Act 2017 had created an environment which encouraged clients' demand for unsafe sex creating a more widespread expectation. Highly publicised brothel raids had left sex workers without regular clients. The most vulnerable workers were more likely to accept clients they previously would have declined over a health concern or the potential risk of aggression or violence.

They are having to offer bareback because some clients have gone away or do go away when there's a raid, but people still need to make money, so some people start offering bareback (Kate, Galway).

While the lack of sex worker inclusive health and support services in some parts of the country places some sex workers in a position where they do not feel comfortable disclosing sex work, our findings suggest that variations in health risk exposure are less likely to be associated with regional variation than by the context in which sex workers engage in sex work. Participants felt that the most vulnerable women were those most likely to be voluntarily engaging in unsafe sex for extra money or who were coerced into doing so by clients or third parties. This finding aligns with those in other studies (e.g. Kamal, Hassan, and Salikon 2015; Quaife et al. 2019). One woman in our study, reflecting on her time working in a brothel, wondered why certain workers were more popular with clients.

Lena: When I meet this fella in a room [in the brothel], and I ask, "can you tell me why is she so busy this woman?", and he says "well she does everything without a condom".

Interviewer 1: Why would a sex worker … ?

Lena: For extra money. For example, my customer from Dundalk, he visited someone, and she said, "it's €100, but if you want without the condom, plus €50", and my customer asked "why?" "it's dangerous, for €100 it's dangerous, but for €150 it's not dangerous."

(Cork focus group)

Once again, study participants felt that women's lack of engagement with sexual health services was motivated by the fear that this information would be passed to other State agencies. This was particularly the case for marginalised migrant women such as those in Direct Provision (refugee holding centres).

They're afraid that if any hint of them being involved in sex work gets out, their applications might get delayed, they might get stuck in DP [Direct Provision] for even longer (Cassandra, Galway).

Coercion was another factor preventing sex workers from accessing sexual health services or negotiating safe sex with clients.

> If you're working for a pimp there's no time for this kind of discussion, for checking your blood. So, when you come in Ireland to working, you are starting at 11, you finish at 12, maybe you have half an hour to go to the shop and come back, and you have to work. And if you have any problem, go back in your home, and you can check everything that you want in your country. This is what's happening (Lena, Cork).

A participant in Limerick revealed how she was being blackmailed into sending money to stop the illegal distribution of her photographs, threatening her safety and mental well-being:

> I'm just feeling so powerless with it all like. The more stuff that goes around like, this guy was blackmailing me basically going "send me more pictures and I'll delete it" (Carla, Limerick)

Findings from this peer-led study, while illuminating stories of everyday violence shaping sex workers' health and access to health supports, also challenge ideas of sex workers as passive to health risks. Participants presented stories demonstrating solidarity amongst sex workers in promoting messages of safety and reducing harm. Sex workers also spoke about the need to extend the capacities of community policing/ Garda liaison personnel in order to better respond to sex workers.

> We need an An Garda Síochána rep who is willing to work with sex workers whilst following their ethical guidelines, because we all know that ain't been happening so far. And that all goes back to what you were saying about building a different culture, where the Gardaí don't feel like they can take the fucking piss (Cassandra, Galway)

Conclusion

Throughout this paper we have argued that factors influencing women's decision to disclose their involvement in sex work – in health care settings and beyond – are complex. Sometimes, women felt unable to tell a health service provider about their sex work involvement because of the stigma it carries. Other women were silent because of their previous experience of judgement about their sex lives by the staff they had encountered. For yet other women, there was little option but to keep silent, fearing a negative response from state agencies adjudicating claims for refugee status or migrant work visas, or those working under coercive control. Whatever the motivation, lack of disclosure of sex work to health service providers can lead to negative health outcomes. Research participants siloed their sexual health from their regular GP visits – often going to extra-ordinary lengths to seek care, with migrants even returning to their home countries in order to access services of using STI home testing kits.

In this study, it was migrant sex workers who experienced the greatest vulnerability. Data revealed how lack of spoken English and knowledge of available sexual health services led women to receive deficient health care. Those with a precarious migration status were least likely to disclose their sex work, least likely to have a regular GP, and most likely to have to attend hospital Accident and Emergency departments. Their precarious status made them more vulnerable under the current law criminalising clients to taking clients who they previously had health or safety concerns about. This was compounded by isolation from both fellow sex workers who could share

knowledge and support about clients, and their non-sex work colleagues and friends, leading to a dual life.

Understanding the stories presented here through the frame of structural violence (Galtung 1990) allows us to understand how sex workers' health is shaped by pervasive and institutional power relations creating unequal health outcomes. The accounts described also reveal how the solidarity of peer networking within and across sex working communities offers the potential to challenge such structures (Grenfell, Platt, and Stevenson 2018).

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This project was funded by HIV Ireland supported by a grant from the Open Society Foundations.

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