Title: "I felt like it was someone's mother scolding me": A mixed methods study of the sexual and reproductive health service experiences of young adult sex workers in Toronto

Abstract:

Background: Young adult sex workers (YASW) may be particularly likely to benefit from sexual and reproductive health services due to risks associated with their work; however, little research has examined their experiences accessing such services. This study therefore aimed to assess barriers and facilitators to sexual and reproductive health services among YASW in Toronto.
Methods: This was a community-based, mixed methods study of 71 young adults (aged 18-29) who were currently or had previously been engaged in sex work. Participants completed an online survey (n=54) or participated in a focus group or interview (n=17). Quantitative data were summarized using descriptive statistics and qualitative themes identified using thematic analysis.
Results: Survey participants reported suboptimal access to sexual and reproductive health care, with 14.8% reporting no regular source of care and only 11.1% reporting that they disclose their sex work experience to providers. Across both qualitative and quantitative data, actual or anticipated sex work stigma from health care providers was the dominant barrier to care, while access to non-judgmental providers, and particularly those who themselves have sex work experience, was identified as a key facilitator.
Interpretation: YASW face many barriers to accessing sexual and reproductive health services which require attention at both the provider (i.e., anti-stigma interventions) and health systems (i.e., availability of anonymous services outside of regular business hours) levels. Including those with sex work experience in the development of such interventions will likely maximize their capacity to address the needs of this under-served population.

Introduction:

Engagement in sex work (that is, the exchange of sexual services for money, services or goods) is associated with higher chance of contact with sexually transmitted and blood borne infections (STBBI) including HIV, both in Canada and globally.[1,2] Indeed, UNAIDS reports that on a global scale, sex workers are 21 times more likely than members of the general adult population to acquire HIV.[2] While participation in sex with multiple partners, exposure to sexual violence, intravenous drug use and unstable living and criminalized working environments are contributors to this elevated risk for some sex workers, stigma in healthcare settings also contributes to inadequate access to health services, including sexual health services (e.g. reduced uptake of HIV and STBBI testing) that can also elevate HIV vulnerabilities.[1] For example, in a study of over 200 sex workers in five Canadian metropolitan areas, in comparison with the general Canadian population, sex workers reported almost three times the rate of unmet health care needs.[3] Although sex workers in this and other studies have reported a variety of reasons for not seeking health care, stigma associated with sex work appears to be a primary barrier.[4]

Young adults (aged 18 to 29) who engage in sex work appear to be particularly at-risk for HIV, other STBBI, and associated risk factors.[5] For example, one Canadian study indicated that sex working youth are more likely than their adult counterparts to be homeless, to inject heroin daily, and to service clients in public places.[6] Another study found that male young adult sex workers (YASW) were more likely to engage in sexual practices that elevate HIV and STBBI exposure relative to their street-involved counterparts who did not engage in sex work.[7] These risks, particularly among youth, are a significant concern, given the well established long term health impacts of untreated STBBI.[8-10]

These studies suggest that YASW are likely to have significant need for sexual and reproductive health services; despite this, little is known about Canadian YASW's experiences accessing sexual and reproductive health services. In a recent local needs assessment of the sexual health service experiences of youth in Toronto conducted by Planned Parenthood Toronto, respondents who reported experience with sex work were more likely than other youth to report unmet sexual health needs and to lack access to sexual health information and services (PPT, 2016). Yet the sample size of sex working youth in this study was small (n=19), calling for additional investigation to examine YASW's sexual health needs. Thus, the current study was developed by Planned Parenthood Toronto and researchers at the University of Toronto with the objectives to a) identify barriers and facilitators to sexual and reproductive health service access for YASW in Toronto, and b) generate recommendations to improve access to health care for this population.

Methods:

This research was carried out in Toronto, Ontario Canada, given that the preliminary research identifying the need for this work was Toronto-centred. However, Toronto is an appropriate setting for research on sex work given that surprisingly little research has been conducted with sex workers in Toronto, despite being Canada's most populous city.[11] The study employed a community-based participatory research design wherein the study was designed and carried out in its entirety in close collaboration with individuals who had lived experience of sex work, as facilitated through a partnership with Maggie's: Toronto Sex Workers' Action Project.[12] The study was also guided by a committee of four youth with lived experience of sex work who consulted with the research team at key stages (e.g., in developing the data collection tools, to reduce measurement bias; and in early stages of data interpretation, to maximize credibility of findings). The study further drew from a transformative mixed methods study design wherein both qualitative (thematic analysis) and quantitative (cross-sectional survey) methods were used with an explicit social justice aim (to improve health service access for YASW).[13] Although the research objectives were best addressed using qualitative methods, study partners identified that participation in focus groups or interviews may involve more identity disclosure than some YASW would be comfortable with. Thus, in order to reduce selection bias, interested individuals were provided with the option of participating in a single 1.5-2 hour semi-structured focus group, 1-1.5 hour semi-structured individual interview, or anonymous online survey administered using the application Qualtrics, all of which included parallel questions regarding barriers and facilitators to health service access and recommendations for improvement (data

collection tools available upon request). Both the qualitative interview guide and the quantitative survey were pilot tested with the advisory committee. Prior to beginning the focus group or interview, participants provided verbal consent to participate, completed a demographic questionnaire, and received a cash honorarium. Survey participants were required to tick a box indicating their consent to participate prior to proceeding to the survey questions. No honorarium was provided for survey participation.

Eligible participants were young adults (aged 18-29) who had previously or were currently engaged in sex work, as defined above. Recruitment was via convenience sampling, predominantly through the online networks of the study partners and youth advisory committee members; hard copy recruitment flyers were also posted at locations likely to be frequented by sex workers. Recruitment materials instructed interested participants to contact the research coordinator for more information (qualitative strand) or visit the study webpage to complete the online survey (quantitative strand). After receiving information from the research coordinator, no individuals refused to participate and none withdrew after providing consent, although some did not ultimately attend the focus groups/interviews for scheduling or other reasons. Fourteen individuals participated in focus groups and three individuals in interviews for a total of 17 participants in the qualitative strand; this sample size was somewhat less than our *a priori* intended sample size of 24 participants in the qualitative strand.

Interviews and focus groups were conducted between October-December 2017 by a female member of the research team who held a graduate degree, had lived experience as a sex worker, had been involved in community activism with the sex work community, and had previous experience conducting qualitative research interviews with sex workers. Only one of the qualitative participants was known to the interviewer prior to the study. In the interviews and focus groups, the interviewer introduced herself as a graduate student who had been extensively involved with sex working communities, and disclosed her own personal sex work experience only if it came up organically in the course of the interview/focus group. Focus groups and interviews were conducted at one of the community partner agencies, a university office, or the participant's home, and no one other than the interviewer and participants were present. Following each interviewer/focus group, the interviewer recorded brief field notes that mostly pertained to the interview guide (recommended changes to wording, order of questions, etc.)

The survey was open between January-March 2018, and the target sample size was the maximum number of participants who could be recruited during this period. A total of 112 respondents accessed the survey; 54 met the screening criteria and provided sufficient data for analysis. Participant demographics are provided in Table 1.

Interviews and focus groups were audiorecorded and transcribed verbatim. Participants did not have an opportunity to review transcripts given that our research ethics protocol required that participant contact information be destroyed immediately following data collection. All members of the research team independently coded the first two transcripts to develop a preliminary coding framework which incorporated both themes determined in advance (e.g., barriers and facilitators) and themes derived from the data (e.g., provider stigma). The coding framework is available upon request. Subsequent transcripts were coded independently by the interviewer and one other member of the research team using an iterative thematic analysis approach (coding framework available upon request).[14] NVivo software was used to assist with data management. Although for

feasibility reasons data collection and analysis were not iterative in this study, data saturation was achieved with respect to the primary themes related to barriers and facilitators to accessing sexual and reproductive health services, and these findings were also triangulated with the quantitative data. Quantitative survey data were exported into SPSS for analysis, which entailed computing descriptive statistics and proportions for the outcome variables of interest (barriers and facilitators to sexual and reproductive health service access) on the basis of our exposure variable (current or past engagement in sex work between the ages of 18-29). Given the mixed methods design of this study, both the STROBE cross-sectional reporting guidelines[15] and the Consolidated criteria for reporting qualitative research checklist[16] were used in the preparation of this manuscript.

Results:

Quantitative Findings

With respect to access to sexual and reproductive health care, 20 (37.0%) of survey participants reported usually seeing a family doctor for sexual and reproductive health care; other sources of health care included clinics (n=28, 51.9%) and community health centres (n=24, 44.4%), while 8 participants (14.8%) reported not having a regular source of health care. Only 6 (11.1%) survey participants reported that they disclose their involvement in sex work to health care providers, while equal numbers (n=24, 44.4%) reported that they sometimes or never disclose. Less than one third (n=17, 31.5%) agreed or strongly agreed that they had access to all of the sexual and reproductive health services and programs they needed. The majority of survey participants (n=32, 66.7%) reported having had bad experiences with health services that made them not want to go back.

Data regarding barriers and facilitators to accessing sexual health services for survey participants are provided in Table 2. The most commonly reported barriers to access were believing that health care providers judged sex workers (33, 61.1%), concerns about anonymity or confidentiality (33, 61.1%) and believing that health care providers will be uninformed/underinformed about sex work (32, 59.3%). When asked what would make them more likely to access sexual or reproductive health services, facilitators included staff and volunteers with sex work experience (41, 75.9%), non-judgmental staff/volunteers (38, 70.4%), and an anti-oppressive space (38, 70.4%).

Qualitative Findings

These findings were echoed in the qualitative data (please refer to illustrative quotes in Table 3). Participants in focus groups and interviews described actual or anticipated stigma from health care providers as the primary barrier to have their sexual and reproductive health service needs met. This stigma manifested in a variety of ways, including condescending treatment, refusal to believe or take seriously participants' self-reported sexual and needs, and efforts to convince participants to leave sex work without any discussion or acknowledgement of the complexities of their individual sex work experiences. Other barriers identified by interview and focus group participants included costs associated with desired interventions (e.g., HPV vaccination), clinic forms and procedures that do not account for the realities of sex work, and intersecting forms of

stigma (particularly ageism, sexism and ableism associated with psychiatric diagnoses participants had received).

Key facilitators to sexual and reproductive health service access also echoed the quantitative data: respectful, non-judgmental service providers to whom they felt they could disclose their sex work experience, access to services that are free and/or anonymous, and personal characteristics that they could leverage in health care encounters (e.g., assertiveness, knowledge of their own bodies) were described as primary service access facilitators.

Mixed Methods Findings

When asked for their specific recommendations to improve sexual and reproductive health service access for YASW, data from participants in the quantitative and qualitative strands of the study generated seven recommendations (Table 4). These recommendations collectively address barriers/facilitators identified at the provider level (e.g., adopting a non-judgmental approach to working with sex workers) and barriers/facilitators at the system or service level (e.g., recruiting staff/volunteers with sex work experience).

Interpretation:

This community-based research study has identified that YASW in the Toronto area have suboptimal access to sexual and reproductive health services, with only 37% of survey participants reporting a family physician who provided this care. Further, YASW are likely to receive suboptimal quality of care, given their actual and anticipated experiences of provider stigma, which in turn are associated with very low levels of disclosure of their sex work experience. For many participants in this study, experiences with provider stigma regarding sex work led them to conclude that disclosure of their experience would do more harm than good with respect to being able to have their sexual and reproductive health needs met.

Our findings align with previous research literature that has identified poor access to health and social services among sex workers both in Canada and elsewhere and extends this literature to include YASW in particular.[4,17,18] Our results further align with prior research identifying provider stigma associated with sex work as a primary barrier to health care access for this population; again, our study extends prior literature to establish institutionalized stigma as a primary barrier to service access for YASW in particular.[4,19]

Our finding that providers' perceived stigma and lack of knowledge about sex work are primary barriers to sexual and reproductive health service access for this population suggests that provider education and training – including stigma reduction - and subsequently communication to the sex work community about improved provider competency, could be important mechanisms to improve access. We were unable to identify any research initiatives to assess inclusion of sex-work related content in medical curricula. Research from the provider's perspective will be necessary to identify specific gaps to be addressed by these initiatives, as well as to determine the best timing (e.g., during training or as continuing education) and forum (e.g., didactic or arts-based, among others). Given our study has identified involvement of individuals with sex work

experience as a primary facilitator to service access, involving the sex work community in the development and delivery of these interventions will be important.

Some limitations should be noted in interpreting this study's findings. First, given that this study was driven by local needs, it included only those YASW who lived or worked in the Toronto area, and thus does not capture the experiences of those working in other settings where both sex work and health care access may operate differently, particularly more rural and remote settings. Additional research will be needed to understand the health service experiences of these YASW. Further, our study had limited inclusion of outdoor sex workers. Although representative data are difficult to collect due to the hidden and criminalized nature of sex work, one widely cited 2006 federal government report suggested that only 20% of sex workers work outdoors.[20] This proportion may have since decreased due to the growth of online sex work.[21] However, the online nature of our survey, primary recruitment and screening methods, and timing of our study (collecting data during the winter months) may have contributed to under-representation of outdoor sex workers, who may have different sexual and reproductive health care needs and experiences.

Despite these limitations, our study offers insights into the sexual and reproductive service experiences of YASW, and suggests that interventions to address provider knowledge and attitudes regarding sex work are necessary. Future research is warranted to explore these and other mechanisms for ensuring equitable sexual and reproductive health service access for those who engage in sex work.

Acknowledgements

The authors would like to sincerely acknowledge the following individuals who made invaluable contributions to this work: our research participants; our Youth Advisory Committee members, including Antoine Ammiro, Bree Daniels, Jenny Duffy, and Azura Rose; our partners at Maggie's: The Toronto Sex Workers Action Project, including Monica Forrester, Jennifer Porter, and Severin Leal; and Olivia Taylor for editorial assistance with this manuscript. This project was funded by the Women's College Hospital Women's Xchange program. The funders had no role in the collection, analysis, interpretation, or dissemination of the study data.

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Table 1: Demographic characteristics of participants

	Quantitative Strand (n=54)	Qualitative Strand (n=17)	Complete Sample (n=71)
Mean Age - Current	25.6[τ] Range: 18-29	25.7 Range: 19-29	20.9 Range: 18-29
Mean Age – First sex work involvement	19.8[ττ] Range: 9-28	20.4[ττ] Range: 15-27	19.9 Range: 9-28
Racial/ethnic identity (%)			
White	32 (59.3%)	15 (83.3%)	47 (66.2%)
Indigenous	5 (9.3%)	1 (5.6%)	6 (8.5%)
Black	4 (7.4%)	0 (0%)	4 (5.6%)
Another racialized identity*	9 (18.0%)	1 (11.1%)	10 (14.1%)
No response provided	10 (16.7%)	0 (0.0%)	10 (14.1%)
Gender identity (%)**			
Woman/Female	32 (59.3%)	15 (88.2%)	47 (66.2%)
Non-binary identity	11 (20.4%)	0 (0%)	11 (15.5%)
Genderfluid/genderqueer	3 (5.6%)	1 (5.9%)	4 (5.6%)
Trans	3 (5.6%)	0 (0%)	3 (4.2%)
Two-spirit	2 (3.7%)	0 (0%)	2 (2.8%)
Male	1 (1.9%)	1 (5.9%)	2 (2.8%)
Femme	1 (1.9%)	0 (0%)	1 (1.4%)
No response provided	9 (16.7%)	0 (0%)	9 (12.7%)
Sexual identity (%)**			
Queer	17 (31.5%)	7 (41.2%)	24 (33.8%)
Bisexual	15 (27.8%)	5 (29.4%)	20 (28.2%)
Straight/heterosexual	9 (16.7%)	4 (23.5%)	13 (18.3%)
Pansexual	9 (16.7%)	1 (5.9%)	10 (14.1%)
Questioning	3 (5.6%)	0 (0%)	3 (4.2%)
Two-spirit	2 (3.7%)	1 (5.9%)	3 (4.2%)
Another identity***	11 (20.4%)	0 (0%)	11 (15.5%)
No response provided	9 (16.7%)	0 (0%)	9 (12.7%)
Sex work experience (%)**			
Agency escort	25 (46.3%)	7 (41.2%)	32 (45.1%)
Fetish	14 (25.9%)	4 (23.5%)	18 (25.4%)
Independent escort	35 (64.8%)	8 (47.1%)	43 (60.6%)
Massage parlor attendant	10 (18.5%)	1 (5.9%)	11 (15.5%)

Outdoor worker	2 (3.7%)	1 (5.9%)	3 (4.2%)
Pornography actor	12 (22.2%)	4 (23.5%)	16 (22.5)
Stripper/exotic dancer	6 (11.1%)	4 (23.5%)	10 (14.1%)
Sugar baby	17 (31.5%)	12 (70.6%)	29 (40.1%)
Survival sex	11 (20.4%)	5 (29.4%)	16 (22.5%)
Webcam host	22 (40.7%)	5 (29.4%)	27 (38.0%)
Other type of sex work	1 (1.9%)	1 (5.9%)	2 (2.8%)

* Includes: Arab, East Asian, South Asian, Mixed Race, Latin

**Participants could check all options that applied so percentages do not add up to 100%.

*** Includes: Demisexual, gay, lesbian, woman who has sex with women, another sexual identity (no details provided)

τ 12 participants did not provide data on this variable, although all answered the eligibility question indicating they were aged 18-29 years

ττ One participant did not provide data on this variable

τττ Ten participants did not provide data on this variable

Table 2: Most frequent participant-reported barriers and facilitators to accessing sexual and reproductive health care among survey participants*

		Participants Reporting (n, %, 95% CI)
Barrier	I think health care providers judge sex workers	33 (62.3; 48.8-74.1)
	I am concerned about my anonymity/confidentiality	33 (62.3; 48.8-74.1)
	I think health care providers are uninformed about sex workers	32 (60.4; 46.9-72.4)
	I feel emotional distress, depression or anxiety	29 (54.7; 41.4-67.4)
	The cost of things I need for my sexual health, like birth control, condoms, or other prescriptions	28 (52.8; 39.7-65.6)
	I am worried about my friends or family finding out	27 (50.9; 37.9-63.9)
Facilitator	Staff and/or volunteers who have sex work experience	41 (78.9; 65.8-87.9)
	Non-judgmental staff and/or volunteers	38 (73.1; 59.7-83.3)
	Anti-oppressive space	38 (73.1; 59.7-83.3)
	Knowing that I will not be reported to the police, social worker, or CAS for my involvement in sex work	32 (61.5; 47.9-73.6)
	Staff and/or volunteers who are similar to me (e.g., age, gender identity, sexual identity, race)	25 (48.1; 35.1-61.3)
	Convenient location	20 (38.5; 26.5-52.1)

*53 participants endorsed at least one barrier, and 52 participants endorsed at least one facilitator.

Table 3: Illustrative quotations from qualitative data analysis

Theme	Sub-theme	Illustrative Quotations
Barriers to accessing sexual and reproductive health services	Provider stigma	Interviewer: What was it like [when you disclosed your sex work experience]? Participant: Incredibly aggravating, frustrating, offensive. I felt like it was someone's mother scolding me. I felt incredibly judged…I didn't seem to matter. So when I had questions they were very vague and unresponsive. Almost like I wasn't even there. (Focus Group 4)
	Cost of interventions	I did get my first round of HPV shots last week. It was disgustingly expensive. I had to pay about $215…I called several health outlets, and all of them were like, no, unless you're a student in high school or you have some sort of coverage as a post-secondary student [you have to pay out of pocket]. (Focus Group 3)
	Clinic forms and procedures	I try to get tested every three months. And there have been times and different facilities, particularly the [sexual health clinic], where they seem to be a little critical of coming so frequently, and they ask why. Which feels like a bit of a judgement, when I'm having as much as I'm having. But I've stopped going there as a result. (Interview 3)
	Intersecting stigmas	I never actually told any doctor that I've spoken to that I'm a sex worker for many, may reasons. Including the fact that I live with PTSD, and the minute you tell somebody that you're somebody who suffers from PTSD, and that you're a sex worker, you can no longer make decisions for yourself as an adult in the medical community. (Focus Group 3)

Facilitators of sexual and reproductive health service access	Respectful, non-judgmental service providers	Interviewer: Could you explain what made [the service encounter] a positive experience, if you can recall how the person responded, or what made you feel comfortable telling them [about your sex work experience] in the first place? Participant: Just right off the bat, just like the tone was very calm and welcoming, so I knew that there was never any hostility in terms of the environment and initial responses. It just felt very casual, like I would just say, 'oh I'm a sex worker, this is how many partners I've had', like, while we're doing testing and stuff, just so they could learn my history. But it was just a lot of like, 'oh I see', nodding, asking if I was being safe, like the precautionary questions that they have to tell everyone. But yeah I think the tone was the biggest factor, and facial expressions. (Interview 1)
	Access to free, anonymous services	I know [service], which for homeless youth, there's free doctors. You don't have to show ID…that's where I was most comfortable going to get tested, rather than going to my family doctor. So things like those – walk in, where you know the doctor's there from 1 to 4, and you can, they don't really know who you are. I think that you're more inclined to be honest [about sex work experience] because they don't know who you are, but you're getting the treatment that you need, if you need treatment. And you don't feel as judged, I guess. (Focus Group 1)
	Personal characteristics	Once they [health care provider] speak to me for a couple of minutes, any sort of stigma that they probably typically have and would hold onto in other situations subsides. So I am fully aware of that privilege. I think that's exactly what it is. And I've even had friends that have come over here, from Russia

		and the Ukraine, that fall into [sex work] because they're just trying to get things in order for themselves and can't qualify for other jobs. They themselves who are highly educated, much more than I am, they deal with attitude when they see a doctor, and it can be the same person who I saw maybe two days before and had a wonderful experience with…I think that I'm lucky in a way, like I can be very assertive and I'm never shunned. But if I were not who I am…I'd have a very different outcome. I don't doubt that for a second. (Focus group 3)

Table 4: Recommendations generated by participants

Recommendation	Illustrative Quotations
Adopt a non-judgmental approach to working with sex workers	So it's just really about education and just, not judging a book by its cover, and I think that'll make the girls feel a lot more open. Like if they know ... there's so many different reasons I could be doing it [sex work], and they're not going to judge me, they're just going to help me. (Focus Group 1)
Become familiar with the social realities of sex work	I think what I would like to see from a medical institutional framework or standpoint would be an understanding of the social context of sex work. So I would like to see an institution come out and say, we understand that sex workers want decriminalization, that sex workers deserve rights, and labour rights, and human rights, that are lacking at this time. So I would like to see an explicit kind of support of that from an institution that I go to. (Interview 3)
Make your work place accessible for sex workers	[Local sexual health clinic] is great but is hard to get to if I'm not downtown. [Local public health] clinics don't have the greatest times and are often full. (Survey respondent)
Provide appropriate services	A sexual health clinic insisted I must be having unprotected sex when I stated I was not, and tried to convince me to leave the industry because I seemed tired and stressed (I'm a student, of course I seem tired and stressed). (Survey respondent)
Publicly voice your position on sex work	I want to know from the get go, with the doctor, that they were sex positive and they were sex work positive…I don't need someone that doesn't get it, or that's really conservative in their mindset. (Interview 2)

Recruit staff and volunteers with sex work experience	Survey question: What are your sources of strength and resilience: Respondent: Being around others working in this industry.
Understand the diversity of sex work experiences	knowing that people in this industry are literally from all walks of life. Some girls are doing it for survival. Some girls are doing it to get through school. Some girls are doing it because they're into sex, you know? Like I have one girl that I used to work with and her dad worked in the parliament buildings. Like she didn't need to be working, she just loved to work. That was her thing. And she went to U of T, and it was just her extra money, like she was, that's what she liked to do, and there was nothing wrong with that. So just knowing that like, we're not all like, damaged, and cause I think a lot of people think, oh my gosh if I tell the doctor this, they're gonna think I have daddy issues, or I've been – something's happened to me, traumatic, that this is why I'm here. It's not always like that. It's, like, you could just be going through school, and it's helpful. Right? (Focus Group 1)