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Self-reported access to health care, communicable diseases, violence and perception of legal status among online transgender identifying sex workers in the UK

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ABSTRACT

Objectives: Transgender-identifying sex workers (TGISWs) are among the most vulnerable groups but are rarely the focus of health research. Here we evaluated perceived barriers to healthcare access, risky sexual behaviours and exposure to violence in the United Kingdom (UK), based on a survey of all workers on BirchPlace, the main transgender sex commerce website in the UK.
Study design: The study design used in the study is an opt-in text-message 12-item questionnaire.
Methods: Telephone contacts were harvested from BirchPlace's website (n = 592 unique and active numbers). The questionnaire was distributed with Qualtrics software, resulting in 53 responses.
Results: Our survey revealed significant reported barriers to healthcare access, exposure to risky sexual behaviours and to physical violence. Many transgender sex workers reportedly did not receive a sexual screening, and 28% engaged in condomless penetrative sex within the preceding six months, and 68% engaged in condomless oral sex. 17% responded that they felt unable to access health care they believed medically necessary. Half of the participants suggested their quality of life would be improved by law reform.
Conclusions: TGISWs report experiencing a high level of risky sexual behaviour, physical violence and inadequate healthcare access. Despite a National Health System, additional outreach may be needed to ensure access to services by this population.

Introduction

In the United Kingdom (UK), sex work is complexly regulated, and while for the most part it is legal in England, Wales and Scotland (although activities like running a brothel and street crawling remain criminalised), in Northern Ireland it is illegal to pay for sex.[1] In recent years, although, with the development of apps for mobile phones and websites, it is widely believed that the market for sex has expanded. Little research, however, is available to ascertain the health and social risks experienced by sex workers[h] using these digital means, with the vast majority of public health studies of sex workers around the world drawing on samples from street-based sites or convenience samples at healthcare clinics.[2–4] However, researchers suggest these sampling frames are skewed and likely to

[h] We note the controversy surrounding language and sexual commerce. Throughout we acknowledge the subjectivity of those engaged in selling sex by referring to them as 'sex workers', whereas we refer to sexual commerce often as 'prostitution' to reflect the contention around exploitation and sex work. Herein we seek not to form direct opinions on these linguistic debates and so we use 'sexual commerce', 'prostitution' and 'sex workers' throughout, and in line with an author's own language preference.

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overlook the highest risk groups, marginalising some sex workers who do not operate in public spaces, including those working online, from both qualitative and quantitative research.[5] Weitzer[6] notes, for example, that whilst street-based prostitution comprises as little as 20% of the market in the US but comprises 80% of academic research. Although emerging research in the UK explores digital sex work, such research has itself also highlighted the general continued focus on female street sex workers.[7]

One especially high-risk group is transgender-identifying[i] sex workers (TGISWs). Although public health research into sexual commerce has recently begun to diversify whom it researches,[8] notably engaging with Lesbian, gay, bisexual, transgender, queer and intersex + (LGBTQI+) sex workers,[9] transgender and non-binary sex workers continue to receive far less attention.[10–12] Such a limited lens is concerning research from the Americas suggests that transgender women sex workers have higher rates of human immunodeficiency virus (HIV) than non-transgender sex workers and the general population.[13] Research suggest that these transgender women engage in sex work in greater numbers because of their experience of social stigma and employment discrimination which limit income generation options, whereas the cost of gender confirming surgeries may drive higher risk taking behaviours as clients generally pay more for condom-free sex and drug use.[13–15] This research also surmises that sex work may be taken up not just as a means of survival and surgery access but also as a way to access social support and acceptance of who they are from other members of the TGISWs community.[13] Indeed, the limited available research suggest TGISWs face many barriers to good health and well-being as a result of discrimination around their gender identity, and that sex work both reflects and magnifies these factors.

What literature exists on TGISWs is available, mostly from qualitative studies, has yet to address how the shift to using online spaces might impact on their exposure to risks.[8] Recent recommendations from the *Lancet* series on promoting health in sex workers was to make health care available for all,[16] which ostensibly is the case in the UK environment. Yet little is known whether, in fact, TGISWs who now operate in online spaces are receiving adequate healthcare access, without risk of stigma and are safe from exposure to violence.

To address these limitations, here we conduct a survey of all TGISWs actively operating on BirchPlace UK, which markets itself as '[t]he original home of transgender and bi-curious, happy people!' and has facilitated online sexual commerce since 1995. BirchPlace UK was selected not only because of its dominance in the market but also because of its representational diversity Terms of Use permitting data scraping (which most websites prohibit).

Methods

Survey design

We performed a structured SMS survey of TGISWs who advertised services on BirchPlace UK. We used a closed-question, structured survey method. Albeit critiques by feminist and queer scholars, who argue quantitative surveys and statistical data processing reflect a masculine, positivist tradition and cannot capture the complexity of social life,[17–19] we contend that this approach does, with appropriate care, offer a means to collect large and diverse data sets able to inform public policy reforms, particularly considering debates in the UK over the legal status of sex work.[20]

Participants

We collected respondents' contact details and information from the website using *R* software. Specific tags were used to retrieve information from the advertisements where available, including: sexual orientation; self-reported age and prices for different sexual services.

A twelve-item questionnaire was then administered using Qualtrics Ltd survey software to all scraped numbers through an SMS link (refer Web Appendix 1 for full survey). These messages were only sent to those identifying as transgender. The message contained a link to the online survey, which was mobile optimised and could also be answered on a conventional browser. Participants were provided information on the study and consent processes required to participate before receiving the questions. After completion of the survey and its closure, all text numbers were deleted from the software to protect participants. In addition, the responses remained deidentified from the number contacted.

Analysis

All statistical analyses were performed using STATA, version 15.1. To describe and cross-tabulate the results of the survey, we used simple descriptive statistics. As the population represented the entire universe of BirchPlace online sex workers, there was no adjustment performed for clustering or sampling. Thus, survey means and standard deviations were calculation without weighting.

Ethical review

Ethical approval for the study was obtained from the Institutional Review Board (IRB) at Bocconi University. It precluded direct contact with participants, thereby limiting potential to enhance sample response rates through offering prizes for participation.[10] It did, however, reduce the chance of fraudulent responses.[20] The survey questions related to participants' own sexual and recreational health practices, their opinions on sex work (il)legality, as well as their access to and experiences of health care providers. To proceed, participants had to actively 'click' in agreement to a standardised informed consent form, as approved by the IRB and in line with incoming General Data Protection Regulation (GDPR) requirements. To ensure data confidentiality, no identifying information was retained (including IP address). All researchers were fully blinded.

Results

Our initial harvesting from BirchPlace identified 1703 advertisements, of which 1241 corresponded to unique telephone contacts. Among those, 592 numbers were active, yielding a final sample of 592 phone numbers corresponding to unique TGISWs listings.

In a successive wave of three SMS contacts, starting in June 2018, we received 69 responses to our SMS links, from which 53 participants completed the survey whole or in part. Where a participant failed to answer a question or selected an option that they did not wish to answer, we have included these in the denominator figure, but demarcated them as 'declined to answer'. Failure to answer a question may have indicated either an inability or unwillingness to respond.

[i] We use 'transgender-identifying' or 'trans-identifying' throughout to represent the self-identifying nature of those we scraped data from online. Because some individuals identify as pansexual and/or non-cisgender, but do not demarcate their gender identity in online advertisements, we may not have identified all participants. We note the diversity of identity terms preferred by individuals.

Access to health care

Although health care, including sexual health care, is free-at-the-point-of-use across the UK from the National Health Services, nine respondents (21%) replied that in the last year they, for any reason, felt at one least once that they were unable to access any kind of health care that they believed to be medically necessary. Thirty three respondents (62%) identified they feel comfortable contacting general practitioners (doctors) if they needed help or treatment, whereas six (11%) reported not being comfortable doing so and fourteen respondents declined to answer the question.

Turning to sexual health screening, thirty five respondents (66%) reported having been tested for gonorrhoea, thirty one (59%) for chlamydia, thirty seven (70%) for HIV/AIDS and thirty four (64%) for syphilis, within the previous twelve months. For those who had been tested, they were then optionally asked if they had tested positive for any of these sexually transmitted diseases, of which nine reported having been treated in the last year for gonorrhoea, nine for chlamydia, one for HIV/AIDS and three for syphilis.

Risky activities

We asked questions about high-risk activities including intravenous (IV) drug use and sexual activity without a condom. Two respondents (4%) reported that they currently inject IV drugs, whereas forty five respondents (85%) stated that they do not and six participants (11%) declined to answer. The two respondents who reported using IV drugs were then prompted with a further question about whether they use these drugs with clients, to which one responded that they do so 'very rarely' whereas the other responded 'at least once a week but not every day'.

Among high-risk sexual activities, we asked only about condom use, segregating vaginal/anal sex from oral sex. Fifteen respondents (28%) confirmed that they have engaged in vaginal or anal sex without a condom with a client in the preceding six months. Of these, ten identified that this was 'rarely', whereas four reported they do this 'regularly', and one declined to answer. Thirty six respondents (68%) confirmed that they have engaged in oral sex without a condom with clients during the preceding six months. Twenty seven identified that they do this 'regularly', whereas eight stated they do this 'rarely' and one declined to answer.

Intimidation and accessing law enforcement

Twenty one respondents (40%) reported that they have been threatened by a client while working or felt physically intimidated to do something they did not want to do. Twenty three (43%) respondents reported that they would hesitate to contact law enforcement if they needed them.

Perceptions of the law regarding sex work

Respondents were asked about their current understandings of the law, which form of regulating sex work they believe would improve their quality of life, and which legal arrangement would best improve their accessing of health care.

First, we asked about knowledge of institutional frameworks governing sex work. Of those reporting operating in England ($n = 40$; 75%), three believed both the buying and selling of sex are currently illegal, twenty seven believed both the buying and selling of sex to be legal, six believed that buying of sex is illegal while sale is legal, and six individuals declined to answer. Of those identifying they operate in Wales ($n = 4$; 7.5%), all believed the buying and selling of sex are legal. Of those reporting operating in Scotland ($n = 7$; 13%), all believed that the buying and selling of sex are legal. Of those who reported working elsewhere ($n = 5$; 9.5%), three reported that, where they work, they believe both the buying and selling of sex to be legal, one that the buying of sex was illegal but the selling of sex legal, and one declined to answer.

We further asked which legal measures they perceived would most improve their quality of life. Twenty four identified sex work being made entirely legal, whereas seventeen believed it would be best if it were made legal, but some aspects restricted like owning a brothel. One believed that both the buying and selling should both be illegal, whereas eleven declined to answer the question.

Finally, we asked the TGISWs which legal provisions would be best to increase access to health care. Twelve respondents identified sex work being decriminalised, twelve if the law required obligatory health checks for those selling sex, even without their consent, thirteen identified buying and selling being legalised, and two identified making selling sex legal but buying illegal. Fourteen individuals declined to answer the question.

Discussion

Main findings

Our study revealed that, despite operating in an environment where health care is free at the point of use, a significant portion of TGISWs did not receive sexual health screenings and reported being unable to access medically necessary health care. Furthermore, our study found that many experience high levels of exposure to physical violence and engage in risky sexual activities, including condomless vaginal or anal sex.

What is already known on this topic

Access to safe and effective sexual healthcare services for TGISWs widely recognised as a human right. Globally, TGISWs experience a higher prevalence of HIV and sexually transmitted infections than the general population or other sex workers, leading many studies to highlight the unique challenges faced by transgender and non-binary sex workers in accessing appropriate health care.[21] The literature presents a complex set of factors including stigma, social disadvantage and exclusion acting to produce and reinforce health disparities.[21] Little research has explored health access for TGISWs who use digital technology rather than street-based methods for procurement.[10,11]

What the study adds

The study design has several important strengths. It is, to our knowledge, the first time a systematic and comprehensive sampling frame has been defined and tested for online operating TGISWs in the UK. This overcomes limitations of convenience samples at clinics, which select into the sample those accessing health care. It also overcomes the street-based selection bias of much of the research on sex workers in the UK. This enables our study to evaluate real and perceived barriers to healthcare access, which other quantitative analyses have not been able to do thus far in the UK comprehensively. Methodologically, our findings demonstrate the potential for using Internet contact methods to identify and evaluate the experiences of sex workers. TGISWs should be identified and considered in their own right in future research and proposed reform projects.

Study limitations

Before turning to the implications of our study for research and policy, we must first acknowledge its many limitations. First, as

with all self-reported data, there is potential for misreporting, creating measurement error. Second, much prior public health research has identified sex workers at healthcare clinics, creating potential for sampling bias and also yielding low numbers of TGISWs. Although our sampling frame covers the main population of online TGISWs, their risks may not correspond to those who work on street-sites, brothels or other settings. Nonetheless, it is believed that Internet procurement creates an environment less risky for workers to operate in, as they can negotiate their own terms and sites with clients, as well as screen potential clients for risks. Third, our response rate was relatively low for a traditional SMS survey, although this is not to be unexpected given that we faced a difficult-to-reach population and the IRB did not give approval for response-rate boosting techniques, such as offering prizes or cash for participation. However, by not using incentive-based methods to increase response rates, it may also have prevented differing biases, such as agencies responded as if they were workers. Because the survey method involved an opt-in approach, we do not know what role the inclusion of advertisements managed by an agency, rather than specific individuals, will have had on the denominator, complicating the task of calculating a valid response rate.

Conclusions

Taken together, our results show that despite access to publicly funded healthcare services, which offer free sexual health services and communicable disease treatment to all in the UK irrespective of immigration status, nine respondents reported feeling unable to access needed health care in the last year. All but one of these individuals identifies being a British or European Union (EU) citizen in their nationality, hence we can rule out the impact of overseas migrant charging on dissuading access to health care.[22,23] However, there are many other reasons why need is not met, including access to facilities where they are needed, and with convenient opening hours.

Only 62% of our respondents identified feeling comfortable accessing a doctor, and therefore it is critical for future qualitative research to explore why TGISWs in the UK might feel unable or unwilling to access health care. Past studies show apprehension with accessing care amongst the general population is hugely varied, and therefore it is critical to explore TGISW' feelings about access both quantitatively and qualitatively to inform interventions to improve access.[24] We note that access to health care is vital not only because the respondents identified experiencing sexual infections and high-levels of risky behaviour but also because 40% of respondents reported that they have been threatened by a client while working or felt physically intimidated to do something they did not want to do. These results corroborate a previous study of internet-based sex workers (n = 240) which found that about half had experienced crime in their work, including threatening and harassing texts/calls/emails, verbal abuse and removal of condom.[25] Forty three % of respondents reported that they would hesitate to contact law enforcement if needed.

For policy, our research is consistent with support for decriminalising sex work. Consistent with prior studies, criminalising many aspects of sex work may marginalise and lead sex workers into vulnerable positions.[25,26] Our survey found that vast majority of TGISWs strongly favoured decriminalisation. But this is not enough. In addition, the survey makes clear risk to health arise from exposure to physical violence and crime. TGISWs struggle to access police and legal representation when needed to safeguard their health.

Author statements

Ethical approval

Approval was granted by the Institutional Review Board (IRB) at Bocconi University, Milan, Italy.

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Competing interests

There are no competing interests to declare amongst any of the authors.

Availability of data and material

The data sets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Authors' contributions

J.S. initiated the study. D.S., S.S. and M.V. collected the data. V.T. and S.S. processed and interpreted the data, discussing findings regularly with all members of the team. All authors contributed to the drafting of the article, interpretation and revisions.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.puhe.2020.05.066.

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