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## Factors influencing transgender and male sex worker access to sexual health care, HIV testing and support study (TaMS) report

# Respect Inc



Jesse Jones, Judith Dean, Sam Brookfield,  
Candi Forrest and Lisa Fitzgerald.

Respect Inc and the School of Public  
Health, Faculty of Medicine, The University  
of Queensland.



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## TaMS: Factors influencing transgender and male sex worker access to sexual health care, HIV testing and support study

### Authors:

Jesse Jones<sup>1</sup>, Judith Dean<sup>2</sup>, Sam Brookfield<sup>2</sup>, Candi Forrest<sup>1</sup>, Lisa Fitzgerald<sup>2</sup>.

<sup>1</sup>Respect Inc

<sup>2</sup>School of Public Health, Faculty of Medicine, The University of Queensland

### Review and contributions:

Joel Valentine, Mish Pony, Brother Hazy.

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### Contact for information:

Respect Inc, 28 Mein Street, Spring Hill Qld 4000, phone +61 7 3835 111, email [info@respectqld.org.au](mailto:info@respectqld.org.au)

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## Contents

List of tables.....	I
List of figures .....	I
Glossary of abbreviations and terminology.....	II
Sex and gender terminology .....	III
Executive summary.....	IV
Introduction .....	1
Background and broader rationale .....	3
Methods.....	8
Rationale for community-based participatory research (CBPR) approach .....	8
Steering committee and peer researchers.....	8
Ethical approval and funding .....	9
Governance and collaborative research agreement.....	9
Research aims and objectives.....	10
Research questions.....	10
Methodological phases.....	11
Phase 1: Respect Inc contact and service operating data .....	11
Phase 2: Systematic literature review .....	11
Search strategy.....	12
Study quality assessment .....	12
Phase 3: Interviews with TMSW .....	14
Inclusion and exclusion criteria .....	14
Sampling and recruitment .....	14
Interview structure.....	15
Phase 4: Focus group with peer educators (peer support workers) .....	15
Inclusion and exclusion criteria .....	15
Sampling and recruitment .....	15
Data analysis.....	16

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Findings .....	18
Phase 1: Respect Inc sex worker contact data .....	18
Trans and male sex worker contact profile .....	18
Patterns of behaviour and sexual health checks .....	21
Phase 2: Systematic literature review .....	22
Phase 2 Themes .....	22
Phase 2 Discussion .....	26
Phase 2 Recommendations .....	28
Phase 3: Interviews with sex workers .....	29
Profile of participants .....	29
Phase 3 Themes .....	35
Sexual health care experiences .....	35
Stigma experiences .....	37
Perceptions of risk: HIV rapid testing, PEP, PrEP, treatment and prevention .....	42
Other wellbeing and health needs: suggested changes .....	47
Limitations of Phase 3 interviews .....	52
Phase 4: Focus group with peer educators (peer support workers) .....	53
Profile of peer educators (peer support workers) .....	53
Phase 4 Themes .....	54
Discussion .....	57
Recommendations .....	60
Implications for practice and policy .....	60
Implications for future research .....	61
Research partners .....	62
Respect Inc .....	62
Research team .....	62
Steering committee .....	65
Appendices .....	67

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Appendix 1: Phase 2 systematic review methodology .....	67
Appendix 2: Study recruitment and promotion postcard.....	78
Appendix 3: Participant interview demographic survey and question guide .....	79
Appendix 4: Participant information sheets.....	83
References .....	89



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## List of tables

Table 1: Respect Inc trans and male contacts by age groups .....	18
Table 2: Sector where Respect Inc contacts reported working .....	19
Table 3: Office region where contact with Respect Inc was initiated.....	19
Table 4: Gender of Respect Inc contacts cross-tabulated with office of contact .....	19
Table 5: Respect Inc appointment contact time.....	20
Table 6: Respect Inc contact communication style .....	20
Table 7: Themes identified from systematic review .....	23
Table 8: Cross-tabulation of sexuality with gender of sex workers interviewed.....	30
Table 9: Cross-tabulation of country of birth and gender with residency/visa and Medicare status .....	32
Table 10: Sex work as primary income among sex workers interviewed .....	33
Table 11: Housing situation of sex workers interviewed .....	34
Table 12: Type of sex work reported by sex workers interviewed.....	34
Table 13: Cross-tabulation of working private by self with other types of sex work.....	35
Table 14: Gender of peer support workers .....	53
Table 15: Sexuality of peer support workers .....	53
Table 16: Gender and sexuality of peer support workers cross tabulation.....	53
Table 17: Time working as a peer support worker .....	54

## List of figures

Figure 1: Age of sex workers interviewed.....	29
Figure 2: Country of birth of sex workers by a) area and b) gender .....	31
Figure 3: Highest education level achieved by sex workers interviewed.....	33
Figure 4 Researchers and steering committee members at TaMS report launch .....	66

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## **Glossary of abbreviations and terminology**

CALD	Culturally and linguistically diverse
CBPR	Community-based participatory research
CI	Co-investigators
CRA	Collaborative research agreement
HIV	Human immunodeficiency virus
HREC	Human Research Ethics Committee
LGBTI	Lesbian, gay, bisexual, transgender, intersex
MOU	Memorandum of understanding
MSM	Men who have sex with men
MSW	Male sex worker(s)
NSWP	Global Network of Sex Work Projects
NVivo 10	Qualitative data management software
PEP	Post-exposure prophylaxis
PI	Principal investigator
PrEP	Pre-exposure prophylaxis
SPH	School of Public Health
SPSS	Statistical software for social sciences
STI	Sexually transmissible infections
TasP	Treatment as prevention
TMSW	Trans and/or male sex worker(s)
TSW	Trans sex worker(s)
UQ	The University of Queensland
WHO	World Health Organization

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## Sex and gender terminology

Cis/cisgender	A person whose gender matches their sex assigned at birth, i.e. not transgender
Crossdresser	Someone who dresses in clothes associated with the opposite sex; refers only to clothes and not to gender or sexuality
Intersex	A person born with physical sex characteristics that don't fit medical and social norms for female or male bodies
Beat	A location or public area frequented by men with the intention of engaging in male-to-male sexual encounters (Brown, Maycock, & Burns, 2005)
Non-binary	A person whose gender is neither exclusively male nor female
Trans/transgender	A person whose gender does not match their sex assigned at birth
Transmasculine	A trans person assigned female at birth; includes trans men and non-binary trans people
Trans man	A man who was assigned female at birth
Transfeminine	A trans person assigned male at birth; includes trans women and non-binary trans people
Trans woman	A woman who was assigned male at birth
Two spirits	A First Nations person of both masculine and feminine spirit; can refer to gender, sexuality and/or spiritual identity. Two spirits is an intertribal term used to communicate numerous tribal traditions and social categories outside dominant non-Indigenous binaries and constructs of gender and sexuality and LGBTI labels (Driskill, 2010)



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## Executive summary

The 'Factors influencing transgender and male sex worker access to sexual health care, HIV testing and support' (TaMS) study was developed to qualitatively assess the experiences and needs of transgender and/or male sex workers (TMSW) in Queensland. Designed collaboratively between The University of Queensland and Respect Inc (the Queensland peer-run sex worker organisation) we considered the following questions in the context of biomedical and HIV campaigns.

1. What is the profile of TMSW in Queensland?
2. What do peer educators understand as the sexual health provision experiences, needs and barriers of TMSW?
3. What are TMSW perceptions of risk in sex work in Queensland?
4. What are TMSW experiences of accessing health care and support, including HIV testing, within (changing) sexual health service provision in Queensland?
5. How does stigma influence trans and male access to these services?
6. What are the disenabling factors influencing non-access to health services and support?
7. What do TMSW think of changes in HIV treatment and prevention, including the introduction of PrEP?
8. What could improve health and wellbeing for TMSW in Queensland?

These questions were explored in research conducted over 4 phases:

1. Analysis of Respect Inc existing contact data
2. Systematic search of existing literature, published and unpublished reports, and written works of Respect Inc and other national and interstate peer sex worker support organisations
3. In-depth qualitative interviews with 35 TMSW
4. Focus group with Respect Inc peer educators.

## Major findings

The number of sex workers in Queensland cannot be determined but around 20% are TMSW; approximately 10% cis male and 10% trans and/or gender diverse. Most TMSW seeking information or support from Respect Inc reported that they worked as private sex workers and they mostly accessed support by spontaneous drop in, phone in and sex worker community social events.

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TMSW accessed a range of services from Respect Inc including:

- supply of personal protective equipment
- information on advertising
- career development
- legal and visa services
- sexual health information
- new worker information
- peer support/debriefing
- reporting dangerous clients and
- a sex worker safe space to hang out.

### ***Barriers to sexual health care, rapid testing, PEP and PrEP***

Queensland TMSW experience a range of barriers to sexual health care despite being motivated to maintain good sexual health. Most TMSW interviewed saw sexual health as an occupational risk and talked about the importance of condom use at work, and almost all said they had voluntary sexual health tests between monthly and six-monthly. Most TMSW interviewed had heard of rapid testing, and about a third had tried it.

Some migrant TMSW reported accessing rapid HIV and syphilis tests as their only sexual health testing. They described barriers including not knowing where to access testing, and fear of stigma. Stigma, biomedical HIV/STI health literacy and criminal laws emerged as the primary barriers.

Similar barriers were identified in the systematic literature review which found that stigma, confidentiality, fatalism, concerns about HIV diagnosis and sexual health literacy were common themes in the global research. The review also noted structural barriers such as transport, cost of health care and migrant access to the health system, which also emerged in the TaMS qualitative research. Strangely, criminalisation and migrant language issues did not feature as prominent structural barriers in the global research review but they were discussed by TMSW in the in-depth interviews and noted by Peer Educators in the focus group. Some interviewees knew about PEP and some had used it but knowledge of PrEP was higher. Most interviewees knew about PrEP, and several were accessing it through the current QPrEPD trial. Around half of the TMSW expressed interest in taking PrEP however there was a widespread perception that the PrEP trial meant that it was an experimental drug, and few TMSW knew about the cost of PrEP or how to access it. Some TMSW had concerns about side effects of PrEP, its lack of efficacy for the prevention of other STIs and/or that it might become mandatory for sex workers.

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## ***Stigma***

Stigma as a barrier to good sexual health and wellbeing emerged in both the systematic literature review and in the interviews and focus group. The literature review found that for TMSW there exists multi-dimensional experiences of stigma, related to HIV, MSM status, gender identity, sex work and internalised stigma which compounds barriers. Most interviewed TMSW concealed their work in some part of their lives due to stigma, including when accessing health care. Peer educators also identified that TMSW wellbeing is affected by stigma and discrimination, as well as related issues including limited anonymous health services and defunding of clinical sexual health services.

## ***Awareness of services and suggested changes to improve health and wellbeing***

When asked about existing health and support services for TMSW awareness was generally poor, particularly among migrant workers and some had not heard of Respect Inc before being contacted to participate in the study.

Most interviewees said legal changes would improve their wellbeing, including decriminalisation of sex work in Queensland. Many TMSW wanted changes to the medical system to improve their wellbeing, including more sex worker–friendly clinics, more free or bulk-billed facilities, and training for health care workers to deal appropriately with sex workers and Trans people.

## **Outcomes**

The TaMS study was conducted as a community based participatory research project. As such the outcomes included:

- This report as a reference document, drawing together the data collected for Respect Inc, key stakeholders and the community to inform future engagement and peer education strategies for TMSW
- Increased TMSW community engagement with Respect Inc
- Increased research capacity for Respect Inc and strengthened relationship with UQSPH.
- Development of a new CBPR with Sex Workers Quality Criteria tool, which includes 12 criteria to assess the appropriateness of sex work research design.
- Presentation of the research at several local venues and the 2018 International AIDS Conference.

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## Recommendations

1. Full decriminalisation of sex work in Queensland
2. Effective marketing and appropriate funding for Respect Inc to ensure TMSW are aware of the organisation
3. Availability of multilingual information resources for migrant sex workers
4. Training for non-peer health care workers on working appropriately with trans and/or sex worker clients to ensure they receive suitable care without encountering stigma
5. Listings of trans-friendly and sex worker-friendly health care facilities available for workers to better choose where they receive care
6. More health care facilities offering full STI checks for sex workers without Medicare cards, and listings of these facilities easily available
7. Peer education that is resourced to be responsive to changing biomedical technologies, targeting sex workers to increase their literacy around the pros and cons of rapid testing, PEP and PrEP
8. Peer education for sex workers, especially overseas-born workers, about the importance of regular testing for all STIs, not just HIV
9. Training for Queensland Police officers to work appropriately with sex workers, possibly incorporated into the LGBTI Liaison Program.
10. Future research with sex workers to be conducted according to the CBPR quality criteria

Future research should address the health care needs of groups underrepresented in the TaMS study, including sex workers who are from Aboriginal and Torres Strait Islander backgrounds, transmasculine sex workers, sex workers based in rural and remote areas, and sex workers living with HIV. The needs of sex workers from culturally and linguistically diverse backgrounds should also be investigated and lead to the development of suitable multilingual resources.

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## Introduction

This report summarises findings from the 'Factors influencing transgender and male sex worker access to sexual health care, HIV testing and support' study, hereafter referred to as the TaMS study.

This project evolved from a May 2015 HIV Foundation Queensland-funded workshop facilitated by The University of Queensland School of Public Health (UQSPH), in partnership with the peer-based Queensland sex workers' organisation Respect Inc and the Ethnic Communities Council of Queensland. The workshop was attended and informed by multiple stakeholders and identified gaps in knowledge, research and services for sex workers in Queensland.

Stakeholders expressed concerns about how the reduction of free and anonymous sexual health services and access to appropriately trained and motivated staff may be having a detrimental effect on the sexual health of sex workers, particularly male, trans, and culturally and linguistically diverse (CALD) sex workers, primarily those born overseas in Southeast and East Asia. For this latter group, it was highlighted that limited access to appropriately translated information and interpreters created barriers, which also proved a challenge in this research.

In particular, the workshop drew focus to research needs for sex workers in relation to how sex workers perceive and manage their risk of HIV and STIs, and other sexual health issues, particularly in the contemporary context of End HIV campaigns.

This research was timely, with biomedical interventions such as rapid HIV testing, treatment as prevention (TasP) and pre-exposure prophylaxis (PrEP) enthusiastically promoted by funders in the HIV and STI prevention education sector, there is much pressure on sex worker organisations to take up promotion to sex workers of these technologies. There is also concern that coercive approaches could potentially mandate biomedical interventions onto sex workers, who are already subject to unwarranted mandatory health interventions and disabling criminalised legal frameworks (Cox, Falcon, & Keegan, 2015; NSWP, 2016a, 2016b; Overs & Loff, 2013; Scarlet Alliance, 2014b).

Cox et al (2015, p.3) described the global consensus position of sex worker organisations on biomedical interventions, stating, "as a low prevalence population with high levels of voluntary testing, sex workers should not be targeted for rapid testing as the likelihood of false positives is high". They discussed rapid testing in the context of jurisdictions such as Queensland where sex workers can be criminalised for working whilst living with HIV or an STI diagnosis, stating "rapid testing can be rapid criminalisation, making workers liable for prosecution and compromising sex workers' careers, incomes and lives" (Cox et al., 2015).

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Cox et al (2015. P.2) also expressed similar concerns about PrEP and TasP:

*PrEP is considered unsuitable as a primary method of safer sex for sex workers, as it only prevents HIV. The need to prevent all STIs remains an important part of health and safety for sex workers. Focusing solely on HIV prevention detracts from proven safer sex approaches that include all STIs and overall sexual health. Sex workers have lower rates of HIV and STI transmission than the non sex working public, due to community based, sex worker led prevention programs and a broad culture of condom use.*

In a 2014 global consultation, the Global Network of Sex Work Projects (NSWP) found that sex workers expressed concerns that unwarranted targeting of sex workers as a key population for PrEP might lead to mandatory testing and could result in increased pressure from clients for sex without prophylactics. Organisations providing peer education to sex workers, such as Respect Inc, need more consultation with sex workers who may most benefit from biomedical interventions, including trans and male sex workers, to be able to negotiate for programs in sex workers' best interests. The NSWP also note that "there has been a lack of meaningful involvement of sex workers in the development of HIV and STI testing and treatment programmes" (NSWP, 2016b, p. 2).

To facilitate this consultation, the TaMS study used community-based participatory research (CBPR), considered best practice in sex work research. The study was developed in partnership with University of Queensland researchers and Respect Inc. Sex work peers and peer researchers were actively involved in every phase of the research project (Abel, Fitzgerald, & Brunton, 2010; Kim & Jeffreys, 2013).

This report is a reference document, drawing together the data collected during this study into one comprehensive report for Respect Inc, key stakeholders and the community. Outcomes of the TaMS study will provide evidence to inform Respect Inc's ongoing strategic planning and service delivery.

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## Background and broader rationale

Traditional HIV prevention programs by and for sex workers have been highly successful in Australia (Donovan et al., 2012; Queensland Health, 2016a, 2016b), with community-driven health promotion and peer education resulting in HIV and STI incidence rates among the lowest in the world (Godwin, 2012; Scarlet Alliance, 2014a). Consequently, the occupational health and safety of sex workers is generally good in Australia, but some sex workers, particularly those who work in criminalised environments, can experience stigma, discrimination and barriers to health service access (Renshaw, Kim, Fawkes & Jeffreys, 2015; Selvey et al., 2017).

Sex workers experience legal and regulatory issues including criminalisation, licensing, registration and mandatory HIV and STI testing in different jurisdictions (Baral et al., 2015; Renshaw et al., 2015). Queensland has a high level of sex work regulation compared to other states in Australia, with a licensing system administered by the Prostitution Licensing Authority and policed under the *Criminal Code Act (Chapter 22a)*, and most sex work is undertaken in the criminalised sections of the industry (Respect Inc, 2015; Schloenhardt & Cameron, 2009). International health and rights organisations, including the World Health Organization and Amnesty International, consider that mandatory HIV/STI testing, along with laws and policies that criminalise HIV transmission and the behaviours of key populations such as sex workers, actually create barriers to testing uptake and access to sexual health services (Baggaley et al., 2016). Subsequently they argue for decriminalisation of sex work worldwide (Amnesty International, 2016; World Health Organization, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, & Global Network of Sex Work Projects, 2012; World Health Organization, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, Global Network of Sex Work Projects, & The World Bank, 2013).

Criminalisation is noted by several authors in The Lancet July 2014 series *HIV and sex workers* as one factor which affects sex workers' ability to access sexual health services (Beyrer et al., 2015; Shannon et al., 2015). Shannon et al. (2015) asserted that, globally, decriminalisation of sex work would have the greatest effect on reducing HIV epidemics across all settings and increase sex workers access to human rights, including healthcare. In Australia, too, sexual health researchers have recommended decriminalisation as best practice for ensuring the health and welfare of sex workers (Harcourt et al., 2010; Selvey et al., 2017). Criminal frameworks around sex work and HIV intersect with sex work and gender stigma to create greater barriers to health care (Baral et al., 2015). These factors may increase individual sex workers' vulnerability to occupational exposure to HIV and other

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STIs. Thus research examining the perceptions of TMSW, who mostly work outside the regulatory framework in Queensland, is needed to begin an assessment of their sexual health and support needs.

Sex workers remain a priority population in the current Australian National HIV and STI Strategies (Commonwealth of Australia, 2014a, 2014b), the Queensland Sexual Health Strategy 2016–2021 and the accompanying Queensland HIV Action Plan 2016–2021 (Queensland Health, 2016a, 2016b). This study attends to the Queensland Sexual Health Strategy 2016–2021 priority area for action 3.6: ‘Enhance the access sex workers have to information and health services that are affordable and non-discriminatory’.

Knowledge of the size of the Australian sex industry is limited, with one estimate suggesting 20,000 people engage in sex work in any one year in Australia (Quadara, 2008). The profile of workers and the population size varies across jurisdictions, but stigma, criminal frameworks, the lack of epidemiological data and rigorous qualitative research means that describing the industry and experiences of sex workers is difficult (Minichiello et al., 2002; Renshaw et al., 2015; Quadara, 2008).

Research on the sex industry in Queensland is limited and consists of a small number of descriptive quantitative studies published prior to 2010. They largely examine the impact of legislative changes on the health and safety of cisgender (hereafter cis) women sex workers, using small convenience samples of women working in the regulated sector (Banach, 2001; Seib, Debattista, Fischer, Dunne, & Najman, 2009; Seib, Fischer, & Najman, 2009; Woodward, Fischer, Najman, & Dunne, 2004).

In Queensland, an increasing percentage of workers in all jurisdictions are from migrant backgrounds, particularly Asian countries including Thailand, China and South Korea (Donovan et al., 2012; Renshaw et al., 2015; Respect Inc, 2015). In 2008, Queensland’s sex work industry was estimated at 5,000 sex workers, with counts of sex work advertising suggesting that between 20 and 60% were from Asian backgrounds (Berg & Bates, 2008). Very few published Queensland-based studies have been conducted with trans, male (Minichiello et al., 2002), migrant or CALD sex workers in regulated or unregulated settings, and even fewer that specifically explore these groups’ sexual health and wellbeing. There have been none conducted using a CBPR approach in partnership with sex workers.

Most Australian sex workers are cis women, and there is limited Australian research on TMSW. Male sex workers have been the subject of more studies than have trans and gender-diverse sex workers, and it has recently been argued that trans women sex workers should be considered separately due to their different needs from those of cis male sex workers (Baral et al., 2015).



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In the 2008 Australian study of men who have sex with men (MSM), known as PASH, researchers recruited participants online from Perth, Adelaide, Melbourne, Sydney, Brisbane and Cairns. The focus of the study was to understand how pleasure affects the decisions that MSM make about sex. It found 18.3% of participants reported having been paid for sex, with 4.3% doing so in the last year (Prestage et al., 2010). The 'Hook-Up' study undertaken in 2014 used similar methodology to research MSM in New South Wales and Queensland and found that, of the Queensland participants, 22% reported having been paid for sex, with 14.4% doing so in the last year (Prestage et al., 2014). Limitations of this study include a small sample size of mainly Australian-born men, an online survey tool marketed via gay and MSM media and an extremely small qualitative component. Authors of the 'Hook-Up' report acknowledge the sample was not representative of the scope and location in which male sex workers operate. The study was marketed as research on gay and MSM sexual activities and using the question "How do you hook up?" as a prompt for men to go to the study site and complete the survey. It was then able to compare the responses of those men who had been paid for sex with those who had not.

Ultimately the number of TMSW remains undefined as they predominately remain hidden and work as private escorts rather than in a brothel environment (Donovan et al., 2010; Donovan et al., 2012; Minichiello et al., 2002). Contact statistics from Respect Inc for the period July to December 2015 show a gender breakdown of 80% cis female, 10% cis male and 10% trans<sup>1</sup>.

Research focusing on trans sex workers is extremely limited. An important international review of HIV risk and preventive interventions in trans women sex workers found a disproportionate burden of HIV in trans women, including sex workers, compared with other populations (Poteat et al., 2015). Trans women sex workers face unique structural, interpersonal, and individual vulnerabilities that contribute to risk for HIV (Brennan et al., 2012; Herbst et al., 2008). Stigma, discrimination and exclusion from social and economic opportunities are common. Although trans sex workers in Australia do not experience the same HIV burden as seen globally, the authors of the TaMS study call for urgent targeted research with the Australian trans and gender-diverse sex worker populations on the basis of the unique issues they have.

The 'Hook-Up' study found that male sex workers are generally well-informed and do not engage in behaviours that unduly place them at risk of HIV (Prestage et al., 2014). However those who are less connected to support and those working outside the formal or regulated

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<sup>1</sup> Prior to July 2016, the gender of trans contacts (e.g. trans woman or trans man) was not further specified during data collection.

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sex work sector may engage in higher sexual and drug related risk-taking behaviours, placing them at greater risk and poorer sexual health outcomes than cis women sex workers. The report also suggested that Queensland male sex workers may be at greater risk and less engaged with support services than their New South Wales counterparts, though it is difficult to generalise due to the small sample size (22%, 55) of Queensland men who reported they had engaged in sex work. Nonetheless the findings raise important Queensland-specific questions about how male sex workers who might not identify as sex workers or as gay men access sexual health services, including HIV and STI testing. Qualitative research with a diverse sample of male sex workers is needed to investigate these Queensland-specific issues and explore how risk is perceived and negotiated.

Australia's HIV epidemic is concentrated among MSM (The Kirby Institute, 2016, 2017), with HIV prevalence among gay and bisexual men at 7.3%, compared to 0.13% for all people in Australia (The Kirby Institute, 2017). Male sex workers mostly offer sex to men, irrespective of their sexual orientation (Baral et al., 2015). Research suggests that men who engage in sex work are at greater risk of HIV infection than cis women sex workers, and more likely to have had recent condomless anal sex compared to those in the broader MSM community (Prestage et al., 2010). However, a recent Australian study comparing HIV and STI prevalence among male sex workers to other MSM attending a sexual health service found little variance in both HIV and STI prevalence rates between these groups (Callander et al., 2017). This study compared HIV risk among MSM attending 40 different Australian sexual health clinics and found that there was no increased risk associated with those men who reported sex work. Nonetheless, the authors suggest more understanding of the HIV and STI risk and pattern of infection among male sex workers is needed (Callander et al., 2017). More research is needed to explore what TMSW perceive as risk in sex work, how they negotiate this risk, and how peer-led health promotion and other health services might best accommodate their needs.

Growing evidence suggests an increasing global burden of HIV among some TMSW (Baral et al., 2015) who are among the populations that are being left behind in the response (UNAIDS, 2017). A proportion of new HIV diagnoses in Australia have been among people born overseas in high-prevalence countries or with partners from these regions, and among Medicare-ineligible populations. This further supports the need for research exploring TMSW in the Australian context, with particular focus on those born overseas (The Kirby Institute, 2014). Such research needs to unpack the structural factors shaping risk and explore the perception that TMSW will be at high risk of HIV and other STIs.

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Australia is a signatory to the United Nations 2011 Political Declaration on HIV/AIDS (Action on HIV, 2012) and is near achieving 90% in each of the 90-90-90 HIV targets (UNAIDS, 2016). However, sex work advocates warn that care is needed to ensure the rapid push toward biomedical intervention models funded by federal and state governments does not negatively affect sex workers' health. Greater understanding of the potential impact of the shifting emphasis to biomedical prevention strategies [rapid testing, TasP, PreP] on TMSW is needed from the perspective of sex workers.

TMSW are an under-researched and more marginalised, 'hidden' population within the sex worker community (Bungay, Oliffe, & Atchison, 2016; Verhaegh-Haasnoot, Dukers-Muijters, & Hoebe, 2015). It is not surprising that TMSW are often missing from research projects, particularly those who are undocumented migrants, those engaging in opportunistic sex for money or favours, not identifying with the term 'sex worker' and working outside the formal sex work sector (Donovan et al., 2010; Renshaw et al., 2015). These factors also influence access to sexual health services and sex worker peer support organisations, which, in turn, increases risk of exposure and transmission of HIV and other STIs. Hidden populations present challenges for recruitment and retention in research (Dean, Wollin, Stewart, Debattista, & Mitchell, 2012; Liangputtong, 2007). Participatory research methodology assists to address some of these challenges and is considered best practice when conducting research involving sex workers (Abel et al., 2010; Kim & Jeffreys, 2013).

The TaMS study was conducted using CBPR methodology. From inception it was developed by researchers from The University of Queensland in partnership with key stakeholder representation from Respect Inc, national peer sex worker organisation Scarlet Alliance, and a steering committee including trans and male peer sex workers.

The close collaborative partnership between researchers, community and peers in the TaMS study ensured that this project could provide contextualised insight and understanding of the complexity of issues TMSW experience, to inform the strategic community development and research needs of Respect Inc and Scarlet Alliance.

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## Methods

### **Rationale for community-based participatory research (CBPR) approach**

This research was conducted as a partnership between Respect Inc (with assistance from Scarlet Alliance) and UQSPH using a CBPR approach. Participatory research methodology is internationally acknowledged as best practice for research involving sex workers (Abel et al., 2010; Kim & Jeffreys, 2013). CBPR is defined as a “collaborative approach to research, [which] equitably involves all partners in the research process and recognises the unique strengths that each brings. CBPR begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities” (Minkler & Wallerstein, 2003). CBPR’s principles include genuine partnership, incorporating co-learning (academic and community partners learn from each other); research efforts that include capacity building (there is a commitment to training community members in research); findings and knowledge benefit all partners; and long-term commitments to reduce disparities (Israel et al., 2003; Shannon et al., 2008).

The UQ research team have experience conducting research using CBPR, working in partnership with sex worker organisations to inform policy and services, and providing sexual health care and education within a peer-led model (Abel & Fitzgerald, 2008; Abel & Fitzgerald, 2012; Abel, Fitzgerald, & Brunton, 2009; Kim & Jeffreys, 2013; Renshaw et al., 2015; Respect Inc, 2015). Members of the team have also conducted studies using CBPR methodology in collaboration with a range of CALD communities (Dean, Mitchell, Stewart, & Debattista, 2016; Dean et al., 2012; Fischer et al., 2011; Fischer et al., 2013; Kelly-Hanku et al., 2016; Vu et al., 2012).

The research experience and established partnership relationship with Respect Inc and the community provided an open, two-way communication pathway and platform to facilitate access to a target population often considered marginalised and ‘hidden’.

### ***Steering committee and peer researchers***

Sex worker peers were actively involved throughout the research project, as is best practice in CBPR (Abel et al., 2010; Kim & Jeffreys, 2013). The collaborative active partnership, a core principle of CBPR (Israel, Lantz, McGranaghan, Kerr, & Guzman, 2005; Koch, Kralik, vanLoon, & Mann, 2006; Liamputtong, 2007), included establishing a steering committee of five male and four trans sex workers. The employment of two peer researchers, also TMSW, facilitated the development of a sense of trust and open, two-way sharing of experiences between the researchers, peers and participants.

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Actively involving community members also provided a means of early identification and guidance on ethical, methodological, or logistical issues and potential cultural violations (Birman, 2005). This is vital when conducting research targeting such sensitive issues as sexual health and HIV among marginalised vulnerable populations such as TMSW and CALD community members (Brondani, Moniri, & Kerston, 2012; Rhodes et al., 2012).

The two peer researchers, recruited and employed by Respect Inc to assist with study planning and data collection, were active members of the study team and steering committee.

The peer researchers and steering committee received training on their roles and responsibilities by the UQ researchers in regards to: what is qualitative research; best practice for conducting sex worker research; gender diversity awareness; informed voluntary consent and principles of confidentiality; introduction to the interview toolkit and interview guide; data collection and management; study communication processes.

The peer researchers communicated regularly with the study team, which allowed exchange of field stories and prompt response should the peer researchers have any questions or concerns during data collection. One of the peer researchers worked with the UQ researchers to perform the qualitative data analysis and prepare this report.

Active participation of Respect Inc members, the steering committee and the peer recruiters throughout the research process—from identifying and conceptualising the research problem and planning and developing the research method, through to data collection and analysis and dissemination of findings—was fundamental to the success of this research. It has also resulted in the collection of data situated in the social and structural context of the sex worker community, thereby increasing the public health impact of findings (Rhodes et al., 2012).

### **Ethical approval and funding**

This research received ethical approval under The University of Queensland Human Research Ethics Committee (approval number 2016001287) and was supported by a grant from the HIV Foundation Queensland.

### **Governance and collaborative research agreement**

All aspects of this study was overseen by a steering committee made up of TMSW. The study team, consisting of Respect Inc staff and UQ researchers, met regularly with the steering committee throughout the research process. In the first three-month period of the study, the primary focus of the meetings was to review the study design, develop the formal research protocol and establish the collaborative research agreement (CRA) and memorandum of understanding (MOU).

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The CRA between Respect Inc (ABN 47 552 535 661) and The University of Queensland (ABN 63 942 912 684) was developed by key stakeholders from the partner organisations, and executed as a signed agreement by authorised officers of each partner. The MOU set out the terms for understanding of roles and expected task responsibility between Respect Inc and the UQ researchers in the daily administration of the project.

The CRA included a commitment of funds from the grant provided by HIV Foundation Queensland to UQ, to be paid to Respect Inc to undertake their agreed roles and expected tasks as set out in the MOU as soon as possible following ethical clearance of the project. The need to wait for ethical clearance presented challenges for conducting CBPR-approach research, particularly in the early phases of the research development, as this hindered Respect Inc partners convening the initial steering committee meetings and recruiting the peer researchers to facilitate progression of the study.

### **Research aims and objectives**

The TaMS study was designed to explore the experiences of TMSW in Queensland, to gain understanding of the personal, social and structural factors influencing their perception of risk in sex work, around HIV, STIs and broader sexual health and wellbeing. The research particularly focused on exploring factors influencing access to sexual health care, HIV testing and PrEP, and community organisation support, in order to inform policy, community development and service delivery, and areas for future research.

### **Research questions**

1. What is the profile of TMSW in Queensland?
2. What do peer educators understand as the sexual health provision experiences, needs and barriers of TMSW?
3. What are TMSW perceptions of risk in sex work in Queensland?
4. What are TMSW experiences of accessing health care and support, including HIV testing, within (changing) sexual health service provision in Queensland?
5. How does stigma influence trans and male access to these services?
6. What are the disempowering factors influencing non-access to health services and support?
7. What do TMSW think of changes in HIV treatment and prevention, including the introduction of PrEP?
8. What could improve health and wellbeing for TMSW in Queensland?

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## **Methodological phases**

This research was conducted over four phases:

1. Analysis of Respect Inc existing contact data
2. Systematic search of existing literature, published and unpublished reports, and works of Respect Inc and other national and interstate peer sex worker support organisations
3. In-depth interviews with 35 TMSW
4. Focus groups with Respect Inc peer educators.

### **Phase 1: Respect Inc contact and service operating data**

Phase 1 involved the analysis of Respect Inc existing contact and service operating data, for the period February 2015 to December 2017. This period included the 15 months prior to the TaMS study instigation, and the duration of the study. This analysis guided development of the Phase 3 research methodology, including the inclusion criteria and data collection tools.

The data analysis for Phase 1 was conducted using SPSS 22 (statistical software for social sciences). Data was described and summarised using descriptive analysis to convey the essential characteristics of the sample. Outcomes of this analysis were used solely to inform the development of this study.

### **Phase 2: Systematic literature review**

A systematic search of recent qualitative literature, published and unpublished reports, and works of Respect Inc and other national and interstate peer sex worker support organisations was conducted to provide an overview of existing knowledge of TMSW in Queensland.

Outcomes of this systematic search were also used to guide development of Phase 3 research data collection tools. A brief overview of the findings is presented in this report. This review provides the first systematic evaluation of qualitative research findings regarding TMSW and barriers to their access of sexual health services.

The review was conducted to answer the following question:

What are the key factors influencing TMSW access to sexual health care, HIV testing and support?

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### ***Search strategy***

Comprehensive systematic searches were conducted on five major research databases (Cochrane Library, PsycINFO, PubMed, Scopus, and Sociological Abstracts), in addition to hand searches of six highly relevant journals, and visual inspection of the reference lists of major articles. Papers were included in the review that reported on peer-reviewed original qualitative research published since 2000, in which either TMSW discuss barriers to accessing sexual health services or the authors discuss these barriers in relation to their findings (see Appendix 1).

### ***Study quality assessment***

A standardised 14-item quality appraisal checklist (National Institute for Health and Care Excellence [NICE], 2012) was used to appraise the methodological rigor of the papers, and whether findings were interpreted through a consistent theoretical lens producing analysis congruent with the data (Noyes et al., 2013). This framework was selected due to its use in other published systematic literature reviews of similarly marginalised populations (T. Lorenc et al., 2011; Lui et al., 2017).

Despite CBPR being best practice for research involving sex workers (Abel et al., 2010), there is no quality assessment criteria to assess the degree of sex worker participation and collaboration in developing and conducting research projects reported in published papers.

The study team, in consultation with the steering committee, therefore developed a quality assessment tool titled Community-Based Participatory Research (CBPR) with Sex Workers Quality Criteria. The new tool is based on the NICE guidelines (National Institute for Health and Care Excellence [NICE], 2012), publications by Scarlet Alliance (2014a), government guidelines (Department of Families, 2012), and other seminal writings on sex worker research methods (Jeffreys, 2010; Shaver, 2005) and CBPR (Baum, MacDougall, & Smith, 2006).

The CBPR with Sex Workers Quality Criteria Tool was endorsed by the steering committee and then used to perform a secondary review assessing the degree to which the sample of literature included adhered to best practice standards of CBPR (Baum et al., 2006; Jeffreys, 2010; Whyte, 1991).



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The CBPR with Sex Workers Quality Criteria Tool includes the following items:

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|---|
| 1. Researchers recognise that sex work is an occupation (Metzenrath, 1998).   |
| 2. Researchers explicitly attempt to use participant-centred, harm reduction, and strengths-based approaches (Shaver, 2005).  |
| 3. Consideration is explicitly given to the positionality of researchers, and how normative identities can also influence the structure and direction of research (Galupo, 2017).   |
| 4. Theories are clearly articulated with regards to gender, sexuality, and sex worker agency, and how these inform methodological choices is explained (Singh, Richmond, & Burnes, 2013).   |
| 5. Research is designed with adequate planning for resources and infrastructure to ensure sufficient reimbursement or compensation for participants and consultants.  |
| 6. Research is conducted with a shared leadership structure that promotes participatory decision making, and the development of a shared vision between professional researchers, peer researchers, and non-researcher community members (Israel, Eng, Schulz, & Parker, 2005). |
| 7. Research addresses priorities identified by sex workers (Jeffreys, 2010).  |
| 8. Sex worker representatives connected to peak-body peer sex worker organisations are demonstrably involved during the design of research, data collection, data analysis, and editing and dissemination of final report (Jeffreys, 2010; van der Meulen, 2011).               |
| 9. Researchers ensure sufficient familiarity with the diversity of the community being researched to avoid exclusion of minority or hard to access populations.   |
| 10. Effort is made to reduce the power differential between researcher and the researched (Baum et al., 2006).  |
| 11. Researchers provide sufficient transparency in research process to verify the absence of bias or pre-existing sex work narratives (Ostergren, 2003).  |
| 12. Consideration is given to potential misuse or misinterpretation of research results by media, government, policymakers or anti-sex work campaigners (Jeffreys, 2010).   |
| 13. The research is oriented towards working in partnership with communities, sex workers and sex work organisations in a manner that leads to action for positive change (Baum et al., 2006).  |

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### **Phase 3: Interviews with TMSW**

Phase three involved qualitative in-depth interviews with 35 TMSW, conducted by two peer researchers who received training in qualitative research by the UQ investigators. Additional training in sensitivity around diversity of sex, gender and sexuality was provided, to ensure that participants were not harmed, such as through inappropriate use of language, during the interviews.

#### ***Inclusion and exclusion criteria***

The inclusion criteria were:

1. Over 18 years of age
2. Self-identify as male and/or trans (including cis men, trans men, trans women and non-binary people)
3. Current or recent sex worker (defined as having done sex work in the last 12 months)
4. Working at least some of the time in Queensland
5. Practical level of spoken English, due to interviews being conducted in English only.

Participants were excluded if they were under 18 years of age and/or are unable to give informed consent, or if they chose not to participate in the study.

#### ***Sampling and recruitment***

Participants were recruited via convenience sampling from the established network of sex workers. A range of active recruitment strategies were used, which have been used previously by Respect Inc for information distribution, communication with target community, previous research and quality improvement activities. These included:

1. Direct contact with clients of Respect Inc, contacting sex workers via their advertising, and distributing postcards inviting sex workers to contact Respect Inc
2. Invitation on the Respect Inc public website, Respect Inc newsletter, Facebook, Twitter and e-list, and the members-only Facebook
3. Call/SMS outreach to sex workers advertising online and in newspapers
4. Advertising on adult websites such as cracker.com.au and rentmen.com.au
5. Distribution of study promotion postcards (Appendix 2)
6. Sex workers referring friends and co-workers.

Participants were purposely sampled to represent diversity of the sex industry in Queensland, with a particular focus on people who work in the criminalised and unregulated sector, and CALD TMSW. The steering committee provided advice and assistance with establishing the sampling quotas. Participants were compensated for their time with a payment of \$100.

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### ***Interview structure***

Interviews were semi-structured, following a set of demographic and interview questions that were developed by the researchers and steering committee (see Appendix 3). All questions were optional. The peer researchers conducted all interviews and most were conducted in person, at either the Respect Inc office, the peer researcher's home, or the interviewee's home or workplace. Several interviews were conducted via phone call due to geographic distance.

Interviewees were provided with a participant information and consent form (Appendix 4) along with a copy of Respect Inc service brochure and a list of sex worker-friendly and LGBTI-friendly support services for Queensland. The purpose of the study was explained before interviewees gave their written consent to participate, and all were made aware that they could withdraw their consent at any time.

### **Phase 4: Focus group with peer educators (peer support workers)**

A focus group interview with peer educators was conducted during the Respect Inc annual Round Table forum. This annual forum brings together sex worker peer educators from around the state, members of the Respect Inc peer-based management committee, and sex work community members for several days of training and consultation.

Focus groups enable participants who share commonalities to discuss and explore their views in an intimate and safe setting (Connell, McKevitt, & Low, 2004; Wellings, Branigan, & Mitchell, 2000). This focus group provided real-life contextualised understanding of peer educator experiences and thoughts about the health care and support needs of TMSW in Queensland.

### ***Inclusion and exclusion criteria***

Eligible participants were people over 18 years of age living in Queensland who were employed and/or volunteer as peer educators with Respect Inc or other community-based organisations that provide services to sex workers. Peer educators were excluded if they were under 18 years of age and/or unable to give informed consent, or if they chose not to participate in the focus group.

### ***Sampling and recruitment***

Respect Inc peer educators and management committee members attending the forum were given the option of volunteering to join the focus group discussion, following an information session provided by the researchers and members of the study steering committee.

The convenience sample of peer educators were informed that participating in the study was not part of the Round Table agenda. They were also told that withdrawing or choosing not to

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participate in the study would in no way affect their employment or volunteering with Respect Inc, or the services they currently receive from Respect Inc or other medical or service providers, or which they may receive in the future.

All 12 peer participants who were in attendance provided written informed consent to participate and for the discussion to be recorded for transcription purposes. The hour-long discussion was facilitated by the UQ researchers, using a semi structured interview guide.

The focus group interview explored topics such as:

1. Their experience as peers providing support to sex workers
2. The positive and negative aspects of sex work that TMSW have discussed with them in their roles as peer educators
3. Where or how TMSW get support
4. TMSW access to sexual health checks
5. What they knew or thought about social stigma towards sex work and sex workers, including examples of experiences they may have had or heard about
6. What could be done to improve the sexual health and wellbeing of TMSW in Queensland.

### **Data analysis**

The phase three in-depth interviews and phase four focus group interview were digitally recorded. Data was transcribed to word accuracy by experienced transcribers from a private external transcription company who have undergone training on ethical issues associated with the project. This company has an ongoing contractual relationship with the UQ investigators on a range of HIV and sexual health related research projects. The transcribers signed a confidentiality agreement before commencing transcription.

Data analysis involved a two-step process: immediate, preliminary, iterative analysis of data on completion of each individual interview, followed by in-depth thematic analysis of data on completion of data collection. Thematic analysis was undertaken whereby transcripts were read and reread for themes that emerge from the data. These themes were then clustered together to form overriding, or larger, themes (Bloomberg & Volpe, 2008; Creswell, 2007). It is important to note that working within a CBPR approach, the research team worked in partnership with the study steering committee while undertaking analysis and presentation of results in this report.

Following importation of transcriptions into NVivo 10 (qualitative data management software), all interviews were coded by one of the peer researchers, the first author of this report, who joined the UQ investigators as a peer research officer for the duration of the project. The UQ investigators and a member of the steering committee then independently coded data and met with the peer researcher to compare and contrast the codes and

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identified themes and to determine inter-coder reliability agreement. When inconsistency or questioning of interpretation occurred, the team reviewed the data and findings to determine the code or theme that more accurately reflected the participant's intent (Bloomberg & Volpe, 2008; Creswell, 2007).

The peer researchers and UQ investigators met with the Respect Inc steering committee to discuss and compare salient themes and assignment of thematic codes and sub-themes to the data. Employing these strategies provided opportunity for the researchers to strengthen the credibility of findings (Bloomberg & Volpe, 2008; Creswell, 2007). Application of these strategies also aimed to increase the trustworthiness of the analysis.

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## Findings

### Phase 1: Respect Inc sex worker contact data

#### *Trans and male sex worker contact profile*

During the period from February 2015 to December 2017—the 15 months prior to the study instigation and the duration of when the study was being conducted—Respect Inc recorded a total of 5,543 occasions of contact with sex workers. This included 941 (17%) recorded as a gender other than cis female, and within this group: male (56.3%, 530), trans (26.4%, 248), trans man (1.3%, 12), trans woman (14.7%, 138) and non-binary or genderqueer (1.4%, 13).<sup>2</sup>

During this nearly three-year period, 23.9% (225) of the TMSW contacts were new to Respect Inc. Contact was predominately initiated following referral by sex worker peers (24.9%), a call or SMS from a Respect Inc staff member (17.3%), or via self-referral from the Respect Inc website (12.9%, 29). Just over half of TMSW contacts were aged between 26 and 40 years (51.8%) (Table 1) and reported English as their primary language (55.8%, 525). Twenty-one occasions of contact were conducted with Aboriginal and/or Torres Strait Islander people (0.4%), most of whom were seen in the regional Townsville office (18, 85.7%).

**Table 1: Respect Inc trans and male contacts by age groups**

Age groups	n	%
17 years and under	3	0.3%
18-25 years	128	13.6%
20-30 years	22	2.3%
26-30 years	202	21.5%
30-40 years	285	30.3%
40-50 years	98	10.4%
50-60 years	57	6.1%
60-70 years	53	5.6%
70 years plus	3	0.3%
Bulk combination	4	0.4%
Multi age group	1	0.1%
Not known	85	9%
<b>Total</b>	<b>941</b>	<b>100</b>

Most TMSW seeking information or support from Respect Inc reported that they worked as a private sex worker or 'sole operator' (75.7%, 712). The vast majority of the remaining 229 reported working in a combination of sectors with only .07% (7) working in a licensed brothel, as outlined in Table 2.

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<sup>2</sup> Note: In July 2016, midway during the reporting period for Phase 1 of the TaMS study, Respect Inc modified how gender was recorded. This is reflected in the group recorded as trans being changed to include trans man, trans woman and other (inclusive of non-binary and genderqueer).

**Table 2: Sector where Respect Inc contacts reported working**

<b>Sector</b>	<b>n</b>	<b>%</b>
Adult entertainment	3	0.3%
Casual/opportunistic	32	3.4%
Casual/opportunistic, adult entertainment	1	0.1%
Casual/opportunistic, unlicensed brothel/agency/co-op	1	0.1%
Combination	33	3.5%
Ex-worker	8	0.9%
Licensed brothel	7	0.7%
Massage parlour	1	0.1%
Massage parlour, unlicensed brothel/agency/co-op	3	0.3%
New worker/about to start	12	1.3%
Private/sole operator	712	75.7%
Private/sole operator, casual/opportunistic	30	3.2%
Private/sole operator, massage parlour, unlicensed brothel/agency/co-op	21	2.2%
Private/sole operator, licensed brothel	2	0.2%
Private/sole operator, massage parlour	1	0.1%
Private/sole operator, public soliciting (street, bar), casual/opportunistic	19	2.0%
Public soliciting (street, bar)	2	0.2%
Public soliciting (street, bar), casual/opportunistic	14	1.5%
Unlicensed brothel/agency/co-op	9	1.0%
Unknown	28	3.0%
Other	2	0.2%
<b>Total</b>	<b>941</b>	<b>100%</b>

The majority of both cis male and trans contacts had interaction with staff from the Brisbane office (58.2%, 548) and were fairly evenly scattered across the three other office regions (Table 3). Table 4 cross-tabulates contacts by reported gender and office region.

**Table 3: Office region where contact with Respect Inc was initiated**

<b>Office region</b>	<b>n</b>	<b>%</b>
Brisbane	548	58.2%
Cairns	125	13.3%
Gold Coast	170	18.1%
Townsville	98	10.4%
<b>Total</b>	<b>941</b>	<b>100%</b>

**Table 4: Gender of Respect Inc contacts cross-tabulated with office of contact**

<b>Gender</b>	<b>Office region</b>				<b>Total</b>
	<b>Brisbane</b>	<b>Cairns</b>	<b>Gold Coast</b>	<b>Townsville</b>	
Cis man	354	43	79	54	530
Trans	93	47	80	28	248
Trans man	12	0	0	0	12
Trans woman	81	33	9	15	138
Other (non-binary, genderqueer)	8	2	2	1	13
<b>Total</b>	<b>548</b>	<b>125</b>	<b>170</b>	<b>98</b>	<b>941</b>

Contacts communicated with Respect Inc for information on a range of topics, including but not exclusive to: supply of personal protective equipment, advertising, career development, legal and visa services, sexual health, and new worker information. They also requested peer support or debriefing, reported dangerous clients or were seeking a sex worker safe space to hang out.

Table 5 outlines the range of contact time the sex workers had with Respect Inc staff, indicating a fair spread of time spent in peer education sessions, with most running between 10 and 30 minutes. The three most common modes of communication between the TMSW contacts and Respect Inc during this period were drop-in to the Respect Inc office spontaneously (33.2%, 312) or via appointment (11.3%, 106), and phoning to talk with staff at one of the offices (17.4%, 164) (Table 6).

**Table 5: Respect Inc appointment contact time**

<b>Time</b>	<b>n</b>	<b>%</b>
0–5 minutes	94	10.0%
5–10 minutes	162	17.2%
10–20 minutes	199	21.1%
20–30 minutes	160	17.0%
30–60 minutes	100	10.6%
1–2 hours	129	13.7%
Over 2 hours	97	10.3%
<b>Total</b>	<b>941</b>	<b>100%</b>

**Table 6: Respect Inc contact communication style**

<b>Contact communication style</b>	<b>n</b>	<b>%</b>
Community development event	54	5.7%
Community education	3	0.3%
Drop-in, by appointment	106	11.3%
Drop-in, spontaneous	312	33.2%
Email in	37	3.9%
Email out	26	2.8%
Meeting	4	0.4%
Meeting, one on one	10	1.0%
Outreach, cold phone call	25	2.7%
Outreach, massage parlour	3	0.3%
Outreach, private visit	30	3.2%
Outreach, street (public soliciting)	4	0.4%
Outreach, with other organisation	4	0.4%
Phone in	164	17.4%
Phone out	42	4.5%
Presentation, attendance by Respect	3	0.3%
Sex worker community development event	7	0.7%
SMS in	51	5.4%
SMS out	38	4.0%
Social media	7	0.7%
Stall	3	0.3%
Other	8	0.9%
<b>Total</b>	<b>941</b>	<b>100%</b>



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### ***Patterns of behaviour and sexual health checks***

During the 16-month period leading up to the TaMS study being conducted (3 February 2015 to 20 June 2016), 64 (14.8%) of the 433 TMSW in contact with Respect Inc staff reported on a number of additional questions about their client services and sexual health check history. While a small sample, these data provided a snapshot that guided and informed the study.

When asked about how often clients requested services without prophylactics (condoms or dams), 32.8% (n = 21) of sex workers reported that their clients requested this 30 to 50% of the time, and 21.9% (n = 14) reported 10 to 25% of their clients requested services with no condoms or dams. The majority reported this was most commonly for oral sex (on penis) (59.4%, 38), but a number reported this request was often associated with insertive anal sex (37.5%, 24). Most clients offered more money when requesting this service (62.5%, 40), but some sex workers reported that clients 'just tried their luck' (25%, 16).

The majority of the 64 reported that their last sexual health check was less than three months ago (54.7%, 35), but 12 (18.6%) reported it was more than a year ago. Only two (3.1%) reported they had never had a sexual health check.

The majority of these sexual health checks were at a sexual health clinic (66.7%, 40) or at a private general practice (32.8%, 21). Most did not know about the z-card<sup>3</sup> sexual health certificate template to take to the service when requesting a sexual health check (trans 60%, 18; cis male 70%, 24). This is expected because only sex workers in Queensland's licensed brothels are required to obtain the mandatory sexual health certificate, and only seven TMSW in the study reported working in licensed brothels. Nonetheless, this data shows that when accessing sexual health care, the TMSW who came to Respect Inc could benefit from more support via the z-card to empower them to obtain complete, non-discriminatory care.

Reasons for sexual health checks included that they thought it was a good idea (57.8%, 37), they had symptoms or experienced a broken condom (17.2%, 11) or it was time for their regular check-up (12.5%, 8). Overall, given that most TMSW are working outside of licensed brothels and do not require mandatory sexual health checks, these figures show high interest in their own sexual health.

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<sup>3</sup> The z-card sexual health certificate template is a resource that Respect Inc produced in partnership with the PLA and Queensland Health. It is a small card about the size of a credit card that unfolds to reveal a sexual health certificate template that can be completed by an STI nurse or doctor. It also contains information about the purpose of the certificate and what STI tests should be conducted for sex workers. Only sex workers who work in Queensland's licensed brothels are required to obtain a sexual health certificate and it is valid for 3 months.

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## **Phase 2: Systematic literature review**

The systematic review provides the first comprehensive evaluation of qualitative research findings regarding TMSW and barriers to their access of sexual health services. The authors reviewed international literature rather than focusing on the Australian context, in recognition of the limited qualitative peer-reviewed Australian research on this topic. This enabled situating the TaMS research project within the wider literature, and demonstrating the commonalities and differences between issues faced by TMSW across global contexts.

The original search identified 1282 articles, with 388 relating directly to TMSW. After applying the inclusion criteria, 22 qualitative articles reporting findings from 16 studies were included in this systematic review.

The most common locations for the selected studies were North America ( $n = 6$ ) and Asia ( $n = 6$ ), followed by Sub-Saharan Africa ( $n = 5$ ), South America ( $n = 3$ ), the Middle East ( $n = 1$ ) and Europe ( $n = 1$ ). There were no Australian studies. The studies were published between 2009 and 2017. Sample size ranged from a MSW discussion group of four (Jones, Rasch, MacMaster, Adams, & Cooper, 2009) to interviews with 68 TSW (Ganju & Saggurti, 2017).

Nearly every paper used in-depth or semi-structured interviewing techniques and thematic analysis. Three papers did not use in-depth or semi-structured interviewing techniques, focusing instead on focus group discussions (Jones et al., 2009; Samudzi & Mannell, 2016; Xavier et al., 2013). Three papers used both interviewing and focus groups (Scorgie et al., 2013; Sevelius, Keatley, Calma, & Arnold, 2016; Underhill et al., 2014). Another three papers used both qualitative and quantitative measurement tools (Giguere et al., 2016; Mimiaga et al., 2013; Reisner, Mimiaga, Mayer, Tinsley, & Safren, 2008). Three papers also employed ethnographic fieldwork (Castaneda, 2013; Infante, Sosa-Rubi, & Cuadra, 2009; Reza-Paul et al., 2012). Thirteen papers in this sample used traditional thematic analysis (76%), with the remaining methodologies ascribing to framework analysis (Barmania & Aljunid, 2016), cross-case analysis (Boyce, Barrington, Bolanos, Arandi, & Paz-Bailey, 2012), descriptive content analysis (Mimiaga et al., 2013), grounded theory approach (Reisner et al., 2008), and concept analysis (Sevelius, Deutsch, & Grant, 2016).

### ***Phase 2 Themes***

Table 7 outlines the key emergent themes identified from the 22 papers included in this systematic review. Six primary themes identified related to barriers to accessing sexual health services for TMSW: stigma, confidentiality, fatalism, sexual health literacy, concerns regarding the consequences of a HIV diagnosis, and structural barriers.

**Table 7: Themes identified from systematic review**

Authors/ year of publication	Country	Themes									
		Stigma					Confidentiality	Fatalism	Sexual health literacy	Concerns HIV diagnosis	Structural Barriers
		Internalised	MSM	Gender Identity	Sex Work	HIV					
Aunon, et al., 2015	Lebanon	X	X		X			X	X	X	X
Barmania & Aljunid, 2016	Malaysia		X	X						X	X
Boyce, et al., 2012	Guatemala		X	X	X	X	X			X	X
Castaneda, 2014	Germany	X	X						X		X
Chakrapani, et al., 2007	India		X			X					X
Chakrapani, et al., 2011	India		X			X	X	X	X		
Ganju & Saggurti, 2017	India	X		X	X		X				
Giguere, et al., 2016	Puerto Rico								X	X	
Infante, et al., 2009	Mexico		X		X		X		X		
Jones, et al., 2009	USA	X	X		X						
Mimiaga, et al., 2013	Vietnam					X	X	X		X	
Okal, et al., 2009	Kenya		X		X				X		
Okanlawon, et al., 2013	Nigeria		X		X						
Reisner, et al., 2009	USA	X			X	X	X	X	X		
Restar, et al., 2017	Kenya		X		X		X		X		
Reza-Paul, et al., 2010	India				X						
Samduzi & Mannell, 2016	South Africa	X	X	X	X		X				X
Scorgie, et al., 2013	South Africa/ Kenya/ Zimbabwe/Uganda		X	X	X	X	X		X	X	X
Sevelius, et al., 2016	USA	X		X		X					
Underhill, et al., 2015 <sup>*</sup>	USA	X	X			X					
Underhill, et al., 2014 <sup>*</sup>	USA						X	X	X	X	X
Xavier, et al., 2013	USA			X		X	X			X	X

<sup>\*</sup>Represent articles reporting findings of the same research project

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## *Stigma*

The predominant barrier to accessing health services identified in the review was multi-dimensional experiences of stigma, related to HIV, MSM status, gender identity, sex work, and internalised stigma. The concept of internalised stigma refers to occasions where individuals may endorse negative stereotypes about themselves, anticipate social rejection, and perceive society to be devaluing them (Livingston & Boyd, 2010), and was referenced in eight studies in this review. This theme of stigma was unsurprisingly associated with a range of mental health issues including substance use, depression, and low self-efficacy.

Stigma from health care workers to TMSW was a common theme and occurred along a broad spectrum, from a lack of trans-competency and undue focus on the patient's sex work history, to disregard for patient confidentiality, or refusal of care. Stigma influenced some MSW to not disclose their sexual practices to health care workers, which can result in inadequate discussion of sexually transmitted infections (STIs) and safer sex practices or risk counselling (Boyce et al., 2012; World Health Organization, 2011).

## *Confidentiality*

Ten studies in the sample identified concerns over confidentiality as a barrier for TMSW to access sexual health services. This included concerns about being seen attending an HIV testing service, or the staff breaching their confidentiality (Boyce et al., 2012; Ganju & Saggurti, 2017). These concerns were more pronounced in less metropolitan areas where privacy is more difficult to maintain (Xavier et al., 2013).

## *Fatalism*

Perhaps in part due to apprehensions around confidentiality regarding HIV testing, another common theme was that of fatalism, which five studies, from Lebanon, India, Vietnam and the US, directly addressed (Aunon et al., 2015; Chakrapani, Newman, Shunmugam, & Dubrow, 2011; Mimiaga et al., 2013; Reisner et al., 2008; Underhill et al., 2014). Fatalism is a belief in one's own lack of agency. It has been linked to social alienation and breakdown, and inhibits long-term, goal directed behaviour (Hess & McKinney, 2007; Meyer-Weitz, 2005).

In the studies that found fatalism to be a theme, participants claimed they did not seek out HIV testing or other forms of sexual health care due to a lack of concern over their serostatus or other potential conditions. In two US studies, participants explained this perspective by arguing that becoming HIV positive was inevitable, or that an HIV diagnosis is a terminal diagnosis with a very poor prognosis, and so it made no difference to be diagnosed (Reisner et al., 2008; Underhill et al., 2014). Other participants in Lebanon and

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Vietnam expressed that their high likelihood of being HIV positive made testing irrelevant (Aunon et al., 2015; Mimiaga et al., 2013).

Trans participants in India reported ongoing fatalism with regards to accessing HIV treatment, even after a positive diagnosis (Chakrapani et al., 2011). The rationalisation for this perspective related to their perceived low quality of life over the long term, as they did not believe they could ever have a family, causing these participants to accept a shorter life expectancy due to HIV. These participants seemed to be expressing a passivity and resignation to the possibility of infection with HIV or other STI, and a belief that something like serostatus or HIV prognosis was beyond their control and not an important fact to how they live and behave day to day. A qualitative study in South Africa reported similar findings among cis women sex workers (Varga, 2001).

### *Concerns regarding HIV diagnosis*

A common barrier to accessing sexual health services across many of the studies was concern about the potential consequences of a positive HIV diagnosis. HIV stigma caused concern about the social affects that a positive diagnosis could have on their personal and professional lives. These included the impact of diagnosis on relationships with partners, especially for MSW who were married or in a heterosexual relationship, and the risk of other workers learning about the diagnosis and using it to limit access to clients (Aunon et al., 2015).

### *Sexual health literacy*

Many studies identified that levels of sexual health literacy influenced TMSW risk perception and subsequent accessing of sexual health services (Aunon et al., 2015; Castaneda, 2013; Chakrapani et al., 2011; Giguere et al., 2016; Infante et al., 2009; Okal et al., 2009; Reisner et al., 2008; Restar et al., 2017; Scorgie et al., 2013; Underhill et al., 2014). Sexual health knowledge was mediated by peer education. Networks of sex workers were able to support and mentor younger participants, whereas isolated newcomers were less aware of their level of sexual health risk (Castaneda, 2013).

### *Structural barriers*

Large-scale structural barriers also restricted access to services (Aunon et al., 2015; Barmania & Aljunid, 2016; Boyce et al., 2012; Castaneda, 2013; Giguere et al., 2016; Mimiaga et al., 2013; Scorgie et al., 2013; Underhill et al., 2014; Xavier et al., 2013). For example, Scorgie et al (2013) found transportation an issue, with some participants unable to travel to services, either because transport was unavailable or because the time would significantly disrupt their workday.

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Cost of services was also identified as a barrier, particularly for economically marginalised populations in sub-Saharan Africa (Samudzi & Mannell, 2016; Scorgie et al., 2013). Several papers found that participants preferred private clinics to the public system, due to less discrimination and increased confidentiality, but often were unable to afford these services (Boyce et al., 2012). Studies in Germany (Castaneda, 2013) and Lebanon (Aunon et al., 2015) found a significant proportion of TMSW to be migrants, both legal and illegal. This migrant status in some cases made them ineligible for health insurance, further reducing their ability to pay for health care (Castaneda, 2013). The quality and organisation of the service could also be an obstacle for TMSW in African settings (Scorgie et al., 2013), in terms of issues such as long waiting times, lack of coordination, the requirement to present with a spouse, and inability to ensure privacy and confidentiality (Restar et al., 2017; Samudzi & Mannell, 2016).

## ***Phase 2 Discussion***

The evidence summarised in this review of qualitative papers points clearly towards stigma as a primary barrier to accessing sexual health care for TMSW. Stigma prevents TMSW from accessing services, and influences the clinical interaction when they do. TMSW frequently reported being unwilling to disclose their medical history or sexual practices, potentially receiving care that does not attend sufficiently to trans-specific or sex work-specific issues such as STI screening or risk counselling (Lacombe-Duncan, 2016; World Health Organization, 2011).

Differences between cis men and trans people in the context of stigma were outlined across the studies reviewed. Many cis men in this sample reported having the option of concealing their sexual orientation or engagement in sex work from friends, family, and intimate partners. Trans individuals, however, more often reported stigma in all spheres of life, as their gender identity can be a more visible social marker that exposes them more frequently to discrimination and violence (Ganju & Saggurti, 2017; Lacombe-Duncan, 2016). This difference between public and private sexual and gender identities can influence what kind of services people access. Boyce et al. (2012) found that non-gay identifying cis MSM preferred clinics that would not identify them as members of this group, whereas trans participants preferred a sense of belonging and community related to sexual health services.

Stigma cannot be disentangled from all the themes identified in this review, due to the mutually reinforcing relationships between intrapersonal, social and structural factors that obstruct TMSW access to health care. A reduction in stigma surrounding sex work would improve efforts to provide sexual health education, reduce the negative consequences of a HIV/STI diagnosis, and ameliorate the fatalism observed among some participants.

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In terms of accessing health care, the stigmatising influence of the health care system itself may remain a dominant causative factor. Inadequate and inappropriate health care is a common experience for people who are trans (Sperber, Landers, & Lawrence, 2005; World Health Organization, 2013) or have a history of sex work (Phillips & Benoit, 2005). Lazarus et al. (2012) found occupational stigma experienced in health care settings to be the primary access barrier for cis women sex workers, even after controlling for individual demographics and factors related to social and work environments. Analysis of this kind with TMSW may further support the recommendation that interventions should target both these structural barriers, as well as the myriad of intrapersonal barriers.

The literature did not feature some of the most important structural barriers, such as criminalised legal frameworks and migrant language issues. These barriers were identified in the TaMS qualitative research but did not feature as prominent themes in the global literature perhaps due to a lack of adherence to the CBPR criteria used for this research

This review includes the first systematic evaluation of how these qualitative studies adhere to best practice in sex worker research. Overall, this sample exhibited very few features of best practice sex worker research, rarely engaging peer researchers at any stage, and frequently characterising findings as objective observations of a subject population. Many studies provided minimal evidence of having used gender, sexuality, or sex work-related theories or concepts as a background to their research. Critical engagement with this body of work not only adds depth and interest for the reader, it is essential for providing procedural transparency in qualitative research. The additional absence of sex worker representatives or organisations in the research process means that the representativeness of samples cannot be established. By treating sex workers as subjects, some studies risk focusing on issues of low priority to sex workers, and generating data and conclusions that do not lead to positive change and action for the community that contributed time and effort to the study.

In many cases, it cannot be determined to what degree researcher preconception has influenced the collection and interpretation of data, or how researchers have considered the agency of their participants as sex workers. In the context of sexual health service access, this lack of sex worker engagement may have resulted in an over-emphasis on HIV over other sexual health issues, inattention to structural barriers such as criminal legal frameworks and migrant language access, and possibly prevention of exploring strengths and enablers that could promote health care access. Adherence to the CBPR criteria used for this review, and adequate communication of this adherence in published reports, would increase confidence in the rigor of results.

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## ***Phase 2 Recommendations***

Participants in many of the studies reviewed had clear ideas on how barriers to sexual health services could be reduced. These ideas congregated around the need for multi-dimensional, holistic services that integrated sexual health and psychosocial services including mental health and substance use treatment. This would enable services to reflect in their structure the connections between various marginalising and compounding factors experienced by TMSW.

Participants also recommended that sexual health services provide staff trained in managing issues specific to this population. This is supported in a report by the Australian Kirby Institute, which found MSW valued services that were gay- or sex worker-specific, with an established record of managing their presentations (Zablotska et al., 2014).

Examples of sensitivity training in African countries have successfully improved health professionals' knowledge of sexual health issues affecting MSM, and reducing homophobia (Dijkstra et al., 2015; van der Elst et al., 2013). Clinics have been developed that specialise in holistic trans health, and have observed significant improvements in access and health outcomes (Reisner et al., 2015).

Tools and best practice standards do exist, therefore, to enable health care services to continue an essential transition to the kind of model recommended almost unanimously by the studies in this review. We would argue that sex worker-led community organisations are best placed to provide referrals to these services because they have the expertise to assess the level of their sex worker-friendly status.

Future research in this area could include a systematic meta-analysis of the quantitative literature. In addition to this qualitative meta-summary, other reviews could also incorporate the many research papers that address the wider syndemic elements that also inhibit TMSW from accessing health care, such as criminalisation (Decker et al., 2015; Lazarus et al., 2012), social and psychosocial capital (Biello, Colby, Closson, & Mimiaga, 2014), chronic health concerns, and domestic violence (Dunkle et al., 2013). These secondary barriers have received much attention in the literature, despite researchers' failure to discuss their implications for health care access.

In conclusion, this review provides an understanding of the ongoing TMSW experience of a complex syndemic, and reveals the international consistency of TMSW requests for non-stigmatising integrated sexual health care. There is also clearly more work to be done to conceptualise and implement high-quality CBPR in the field of sex work, to support this ongoing transition towards equitable health care.



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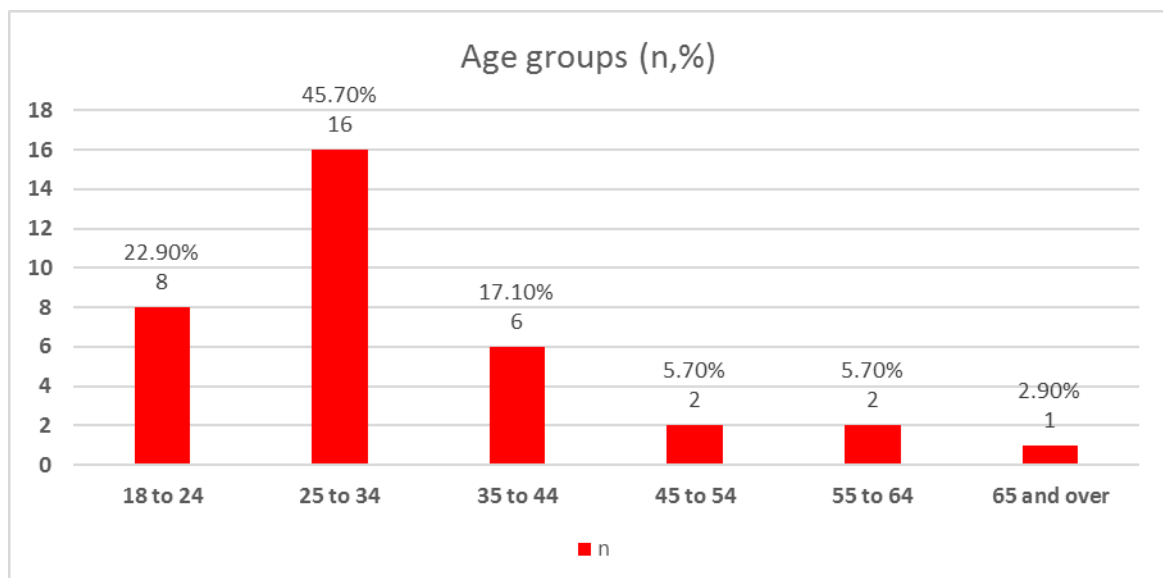
### Phase 3: Interviews with sex workers

In total 35 interviews were conducted by two peer interviewers between January and September 2017. The majority of interviews took place in Brisbane, with some at the Gold Coast and several by phone with participants in north Queensland. Most participants were full service sex workers (that is, offering vaginal and/or anal intercourse as a service). The rest—all Asian-born workers—were erotic massage providers, some but not all of whom also provided oral sex or full service in that context.

#### *Profile of participants*

##### *Age*

The sex workers interviewed for this study, although a relatively small group, represent a broad demographic range of workers in Queensland. Their ages ranged from 19 to 69 years, with a mean age of 32.66 years (Figure 2).



**Figure 1: Age of sex workers interviewed**

##### *Gender*

Participants were able to nominate as many terms as they wished to describe their sex or gender. Aside from one who described themselves only as intersex, participants were either cis men, transfeminine or transmasculine. The participants included 12 trans women and transfeminine people, including one transfeminine intersex person and two other non-binary transfeminine people. Two transmasculine people, both non-binary, were interviewed. Both were early in their medical transition at the time of interview, with one still presenting as a woman for work and the other having just started presenting as a man for a few clients. The remaining 20 participants were cis men, including one crossdresser, and one who previously identified as trans but had detransitioned.

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## Sexuality

Two cis men, and seven trans women and transfeminine people, identified as straight or heterosexual. The remaining 26 participants described their sexuality as gay, lesbian, bisexual, queer or pansexual. One worker of Native American background used 'two spirits' to describe both their gender and sexuality. No workers reported their orientation as asexual.

Table 8 outlines the cross-tabulation of sexual identity with the primary gender descriptor each participant nominated.

**Table 8: Cross-tabulation of sexuality with gender of sex workers interviewed**

Gender	Sexuality						Total
	Gay	Lesbian	Bisexual	Queer	Hetero sexual	I refer to myself as:*	
Cis male	14	0	4	0	2	0	20
Intersex	0	0	0	0	0	1	1
Trans woman	0	0	3	1	6	0	10
Trans man	0	0	0	1	0	0	1
I identify as:#	0	1	0	0	1	1	3
Total	14	1	7	2	9	2	35

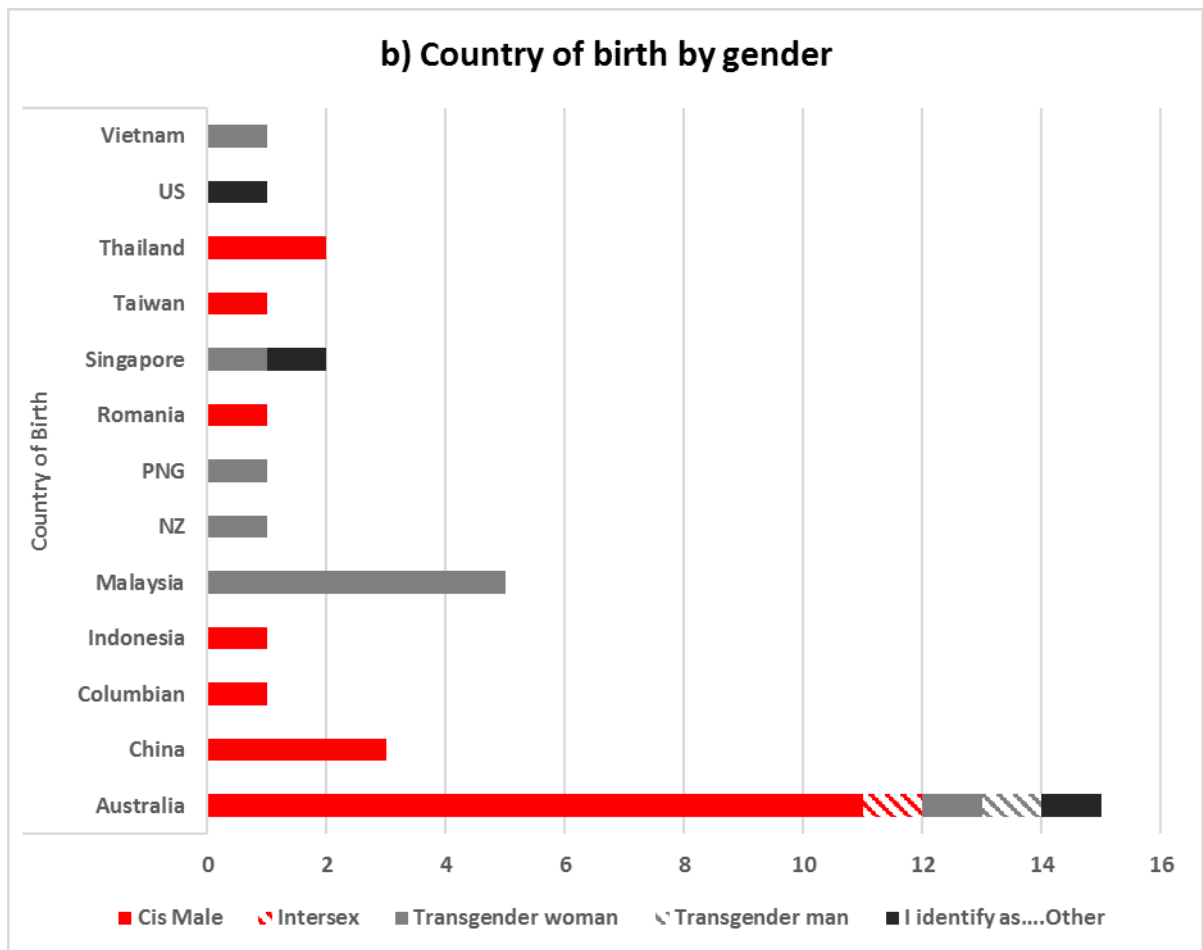
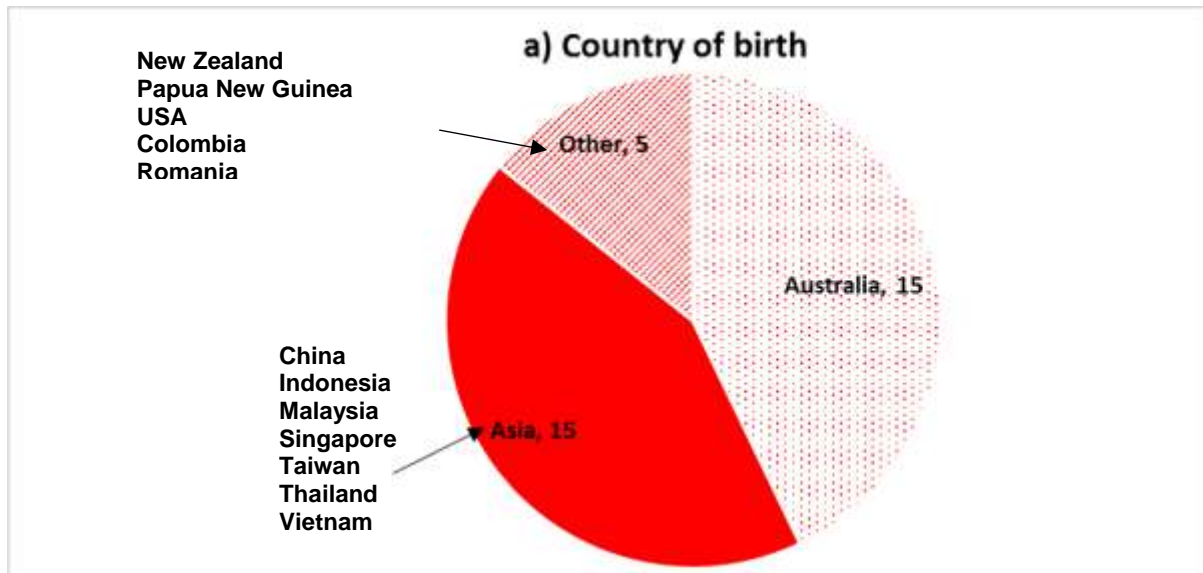
# Trans person; female, intersex, trans woman = androgynous; two spirits, genderqueer trans man.  
\* Pansexual; two spirits, gay, queer.

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## Country of birth and language

Just under half of the participants (42.9%, 15) were born in Australia, with only one (2.9%) Aboriginal person. The majority (75%, 15) of the remaining 20 were born in Asian countries including China, Indonesia, Malaysia, Singapore, Taiwan, Thailand and Vietnam. Five (14.3%) were born elsewhere, in New Zealand, Papua New Guinea, the United States, Colombia and Romania (Figure 3a). Eleven (55%) of the 20 cis men were Australian born, along with the one participant who described themselves as intersex. The majority (78.6%, 11) of the 14 transfeminine or transmasculine participants were born overseas, primarily (50%, 7) in Southeast Asian countries such as Malaysia (5), Singapore (1) and Vietnam (1) (Figure 3b).

Twenty participants (57.1%) reported English as the primary language spoken at home, with the remaining 15 reporting they primarily speak other languages including Mandarin, Thai, Tamil, Vietnamese, Taiwanese, Malay, Bahasa Malaysia, Romanian or a combination of English with languages such as Italian, Persian, Sinhala, Mandarin or Thai.



**Figure 2: Country of birth of sex workers by a) area and b) gender**

## Residency and Medicare status

To discern potential barriers to health care access, participants were asked about their residency and Medicare status. The majority (54.3%, 19) were Australian permanent residents or citizens. Of the rest, eight were on student visas (22.9%), three were on working visas (8.6%), and four were on tourist or working holiday visas (11.4%). One, born in Australia, reported that they did not know their citizenship status, indicating some confusion about legal status—a common issue with sex workers, especially those with migrant history.

All 19 citizens and permanent residents identified they had a green Medicare card, as did two people on a working visa (60%, 21). Of the remaining 14 participants, 12 (34.3%) did not have any Medicare card, of whom six (50%) were trans. Two Malaysian trans women on student visas reported they were unsure whether they had a Medicare card.

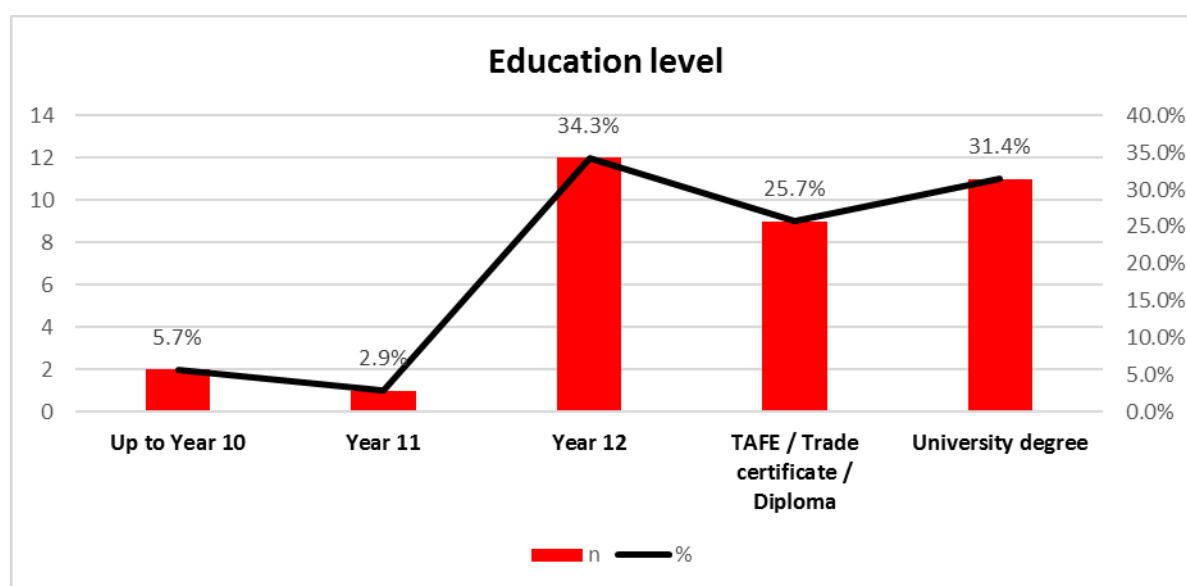
Table 9 presents a cross-tabulation of country of birth and gender with reported residency or visa and Medicare card status.

**Table 9: Cross-tabulation of country of birth and gender with residency/visa and Medicare status**

Country of birth	Residency or visa status					Medicare card		
	Permanent resident or citizen	Student visa	Working visa	Working holiday or tourist visa	Not sure	Yes	No	Not Sure
Australia	13	0	1	0	1	14	1	0
China	0	1	1	1	0	0	3	0
Columbian	1	0	0	0	0	1	0	0
Indonesia	0	1	0	0	0	0	1	0
Malaysia	1	3	0	1	0	1	2	2
New Zealand	1	0	0	0	0	1	0	0
Papua New Guinea	1	0	0	0	0	1	0	0
Romania	0	0	1	0	0	1	0	0
Singapore	1	1	0	0	0	1	1	0
Taiwan	0	0	0	1	0	0	1	0
Thailand	0	2	0	0	0	0	2	0
US	0	0	0	1	0	0	1	0
Vietnam	1	0	0	0	0	1	0	0
<b>Total</b>	<b>19</b>	<b>8</b>	<b>3</b>	<b>4</b>	<b>1</b>	<b>21</b>	<b>12</b>	<b>2</b>
Gender	Residency or visa status					Medicare card		
	Permanent resident or citizen	Student visa	Working visa	Working holiday or tourist visa	Not sure	Yes	No	Not Sure
Cis man	10	4	3	2	1	12	8	0
Intersex	1	0	0	0	0	1	0	0
Trans woman	5	4	0	1	0	5	3	2
Trans man	1	0	0	0	0	1	0	0
Other	2	0	0	1	0	2	1	0
<b>Total</b>	<b>19</b>	<b>8</b>	<b>3</b>	<b>4</b>	<b>1</b>	<b>21</b>	<b>12</b>	<b>2</b>

## Education and income

Only three (8.6%) participants had not completed high school, with one cis male reporting year 11 as his highest educational attainment, and two—one cis man and one trans woman—having completed year 10 or lower. Another 12 (34.3%) participants, half of whom were transfeminine (5) or transmasculine (1), had completed only year 12. The remaining participants had either a university degree (31.4%, 11) or a TAFE or equivalent qualification (25.7%, 9) (Figure 4). Of the 11 participants with a university degree as their highest educational level achieved, three (27.3%) were transfeminine. These are similar educational statistics found in a study of Queensland male sex workers by Minichiello et al in 2001.



**Figure 3: Highest education level achieved by sex workers interviewed**

Almost two thirds (62.9%, 22) of the participants, regardless of gender, reported sex work was their primary income (Table 10). The rest had a full-time or part-time job, Centrelink benefits or family support.

**Table 10: Sex work as primary income among sex workers interviewed**

Sex work is primary income	Total		Cis man		Intersex		Trans woman		Trans man		I identify as...	
	n	%	n	%	n	%	n	%	n	%	n	%
Yes	22	62.9	13	65	0	0	6	60	1	100	2	66.7
No <sup>#</sup>	12	34.3	7	35	0	0	4	40	0	0	1	33.3
Other <sup>*</sup>	1	2.9	0	0	1	100	0	0	0	0	0	0
<b>Total</b>	<b>35</b>	<b>100</b>	<b>20</b>	<b>100</b>	<b>1</b>	<b>100</b>	<b>10</b>	<b>100</b>	<b>1</b>	<b>100</b>	<b>3</b>	<b>100</b>

<sup>#</sup>Centrelink; day job/employed; family allowance and sometimes employment; family support; pension; varies

<sup>\*</sup>Depends

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### *Relationships and housing*

Only eight (22.9%) participants reported they were in a relationship, with the remaining 27 reporting they were single.

The majority of participants were renting their homes, with four (11.4%) renting on their own and 22 (62.9%) in share houses (Table 11). Three lived rent-free with family or friends, and one was trading sex for accommodation. Two (5.7%) participants owned their homes. Three had no permanent address, including one who was homeless, one living in a refuge, and one travelling through Australia staying in hostels and apartments.

**Table 11: Housing situation of sex workers interviewed**

Housing type	n	%
Own home	2	5.7
Rent, pays in full	4	11.4
Rent, shared house	22	62.9
Homeless	1	2.9
Live with friends/family (rent free)	3	8.6
Trade sex for accommodation	1	2.9
Other	2	5.7
<b>Total</b>	<b>35</b>	<b>100</b>

### *Sex work experience*

All but two participants reported that they were still doing sex work, which was consistent with the study inclusion criterion that participants must have done sex work in the 12 months prior to interview.

Participants were asked to identify the types of sex work they do and/or the settings in which they have worked in the past. The participant responses are outlined in Table 12.

**Table 12: Type of sex work reported by sex workers interviewed**

Type of sex work	Private by self	Private with other sex workers	Licensed brothel	Unlicensed brothel/ agency	Street based, bar	Casual or opportunistic	Gifts	Sauna
Yes	31	14	9	10	8	11	1	1
No	4	21	26	25	27	24	0	0
<b>Total</b>	<b>35</b>	<b>35</b>	<b>35</b>	<b>35</b>	<b>8</b>	<b>11</b>	<b>1</b>	<b>1</b>

Thirty-one of the 35 participants (88.6%) reported they work or have worked privately by themselves. Most of these participants additionally reported working in a range of other places and settings (Table 13).

**Table 13: Cross-tabulation of working private by self with other types of sex work**

Private by self	Type of sex work					
	Private with other sex workers	Unlicensed brothel/ agency	Street based, bar	Casual or opportunistic	Gifts	Sauna
Yes	14	6	8	11	1	1
No	0	4	0	0	0	0
<b>Total</b>	<b>14</b>	<b>10</b>	<b>8</b>	<b>11</b>	<b>1</b>	<b>1</b>

The four participants who reported they had never worked privately by themselves were three gay and one bisexual overseas-born cis male sex workers (Thailand, China and Taiwan). They reported they had only ever worked in the unlicensed brothel where they were interviewed as part of this study.

### **Phase 3 Themes**

The following section presents the findings related to the 35 in-depth qualitative interviews with TMSW conducted by two peer researchers.

#### **Sexual health care experiences**

##### *Testing frequency*

Participants overwhelmingly reported diligent sexual health testing, with almost two thirds saying they tested between monthly and quarterly. The only participants who did not report testing at least annually were three migrant workers who said they had not yet been tested in Australia. Of those three, two reported testing monthly to six monthly when in their home country, and one reported testing “sometimes” at home. Notably, none of the participants interviewed were currently working in a Queensland licensed brothel, meaning testing was not mandated for them and they had chosen to attend to their sexual health regularly.

*“Look, I used to do it every fortnight, and then I’ve reached it out to a month.”*

*(cis man)*

*“Every six months. And sometime, if I feel I’m not well. I don’t wait for six months. I go straight away. Even costs money, you still have to do.”*

*woman)*

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### *Location of testing*

Participants reported obtaining sexual health testing by their general practitioner (GP), at sexual health clinics and at rapid testing sites. A number of Brisbane participants named two bulk-billing sexual health clinics, and one private GP clinic specialising in LGBTI health. Almost a third of participants, mostly migrant workers, had tried rapid testing. Several Asian migrant workers reported that rapid testing for HIV and syphilis was their sole regular sexual health testing.

*"I started off just going to my GP, but when I actually was diagnosed with something they recommended I go there for treatment, and I found that they were pretty much the best anyway." (cis man)*

*"In the past I've gone to other suburbs but seeing as I now live in [my suburb] I've recently gone to the [local public clinic]. They're very friendly there. They're very good." (cis man)*

*"I went to [a North Queensland city] and... in [the city] you go to [the local clinic]." (trans person [transfeminine])*

### *STI history*

Almost half of participants—mostly cis men and Australian-born workers—reported having had at least one STI in the past, including human papilloma virus (HPV), herpes simplex virus (HSV), non-specific urethritis (NSU), chlamydia, gonorrhoea and syphilis. Both straight and gay men had had an STI. Most described a straightforward diagnosis and treatment with no particular need for other support. None reported living with HIV.

Several workers who had received an STI diagnosis in the past described impacts on their work behaviours, including more diligent condom use and closer screening of clients for visible STI symptoms. Most were already applying safer sex practices and as such did not see a need to modify their behaviours.

*"I got HPV even though I am always using condoms... it does sort of really make you think that yes, you absolutely need to be checking regularly." (cis man)*

*"Fine for me. Chlamydia just a couple of pills and you're right as rain, don't have sex unprotected for a week yeah and then go get retested." (cis man)*

*"They call herpes. Got no idea where it coming from. I test, I wash myself, I do how much, doesn't matter how much I care. But I get it one time already. I got a treatment and yeah, they doing very well. So lucky." (trans woman)*



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*"I actually did have an outbreak for HSV1 and they have diagnosed that. I've had to be extremely careful with working since then because I don't want to pass it on to anyone and I'm also on antiviral medication to suppress it as well. So it's less likely to be contagious and less likely for outbreaks and everything. So I'm very careful with what I do surrounding that and I'm not sure where it came from, like, which client it was." (trans man, genderqueer)*

### *Experiences of sexual health clinics*

The majority of participants had attended a specialist sexual health and/or LGBTI clinic, and all spoke highly of their experiences there. Feedback on clinics included that the facility was accessible and free, and that the staff were competent and non-judgmental. No participants described experiencing discrimination or poor treatment as a sex worker or as a trans person at a sexual health clinic.

*"They're all so warm and friendly. There was no discomfort or judgement or whatever, no." (trans person [transfeminine])*

*"No, they're like totally cool about it. They're—no judgement, it's purely like a doctor, really open minded sort of funky doctor sort of thing." (cis man)*

The following quote is from a participant who described an experience of subtle discrimination at a GP clinic.

*"It was rather funny because I've just started going to the [local] one and the doctor, she looks at me and she says, 'Now,' you know, with her routine questions, 'Have you ever seen a sex worker?' I said, 'Oh, well, actually I am one.' And she was, 'Oh, okay, you know, fair enough.' And then she started asking you questions about safety and all that sort of thing." (cis man)*

## **Stigma experiences**

### *General experiences*

Almost all participants described experiencing stigma and discrimination related to being a sex worker, a trans person, or both. Transfeminine participants described the multiple layers of stigma they felt with some reporting trans stigma as greater than sex work stigma and that this was internalised.

*"I try to maintain a level of standard, as I represent myself, basically, as a worker, plus being in the minority and being transgender, I don't want to give off a bad – I don't want to give a bad experience to someone, so that they next go and maybe take it out on the next transgender person, or they say they're all the same or something like that". (trans woman, intersex)*

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*Facilitator: "Tell me a little bit more about stigma in relation to sex work in particular. Have you ever had any trouble with seeing doctors or anything like that because of being a sex worker?"*

*Interviewee: Not necessarily being a sex worker but being trans more. Yeah"*  
*(trans woman)*

Notably, several transfeminine participants said that trans women are assumed to be sex workers.

*"You know, when they see transgender people, they always see sex worker. In their mind. Just fucking their mind, that's all we do."* *(trans woman)*

About a third of participants either had experienced, or were afraid of, sex work stigma having an impact on their housing situation. Several were afraid of being evicted if their landlord received complaints about clients coming and going, and one had made a point of purchasing a home so they could not be evicted. Two participants had been evicted from their accommodation for doing sex work. Two participants had roommates who had wanted to do sex work, but been concerned about 'brothel'-keeping laws.

One participant, who owned his home, reported having had trouble getting a mortgage due to discrimination by the bank. (See footnote<sup>4</sup> for some recent press about Australian banks discriminating against sex workers.)

*"Worry about, you know, you get a complaint from, yeah, from your neighbour who, you know, because there is a few people, you know, different face keep coming in and out... Might be again, you know, might be you have 24 hours' notice that you need to pack your bag and then, you know, like you need to move, find a new place and it might be you lost your bond money."*  
*(trans woman)*

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<sup>4</sup> Chau, D. & Evlin, L. 4 January 2018 Sex industry faces 'financial discrimination' from banks, ombudsman says. ABC News  
<http://www.abc.net.au/news/2018-01-04/sex-industry-businesses-face-financial-discrimination/9303376>  
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<http://www.news.com.au/finance/business/banking/australian-banks-are-discriminating-against-sex-workers/news-story/1f2c29dc8bf6ac40628e3f8314642aeb>  
Redrup, Y. 8 October 2017 Banks accused of discriminating against the sex industry.  
<http://www.afr.com/business/banks-accused-of-discriminating-against-the-sex-industry-20171007-gywfga>

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*“75 per cent deposit and then [the bank] just backed out of it after I’d paid the deposit and left me with no loan. And it was horrible, I lost a couple of grand on it.” (cis man)*

*“Because like I don’t generally make enough money to live by myself and in a lot of places, particularly in Germany there’s a lot of really strict rules about checking your credit history before you’re allowed to rent places. So, I could only live with other people and it became really difficult to find roommates that are okay with what you’re doing, even if you’re not working from home. Like I had—I would like interview for like shared flats or whatever and they’re like, we can’t have you here because you might bring home clients.” (trans man, two spirits, genderqueer)*

*“My housemate wanted to try to get into sex work as well but we’re living together so... Well, that’s technically an illegal brothel if we do.” (trans man, genderqueer)*

Eleven participants described hiding their work from their families. Some were fearful of being shamed, while others spoke about subtler concerns including “awkwardness” or disappointing their families. Only three—all trans women—said their families were accepting of their work.

*“If they did find out, it wouldn’t be terribly drastic I don’t think, but you know, I wouldn’t lose my house or anything. I wouldn’t be thrown out or anything but it would be fairly awkward.” (cis man)*

*“Of course, you cannot tell anyone what I do for living. But I think this is the job. You cannot tell.” (cis man)*

*“My family are quite open-minded and understanding. Not everyone in the family sees eye to eye but my closest family members like my brother and my sister are quite loving and accepting so I really don’t have to explain it to them.” (trans woman)*

Six participants discussed gay stigma. Some participants had experienced rejection by peers or family because of their sexuality. One participant described how his brother had been “sort of okay” with his sexuality, but their relationship ended when the brother found out about his escorting.

*“I mean he wasn’t too bad about it. In the back of my mind though I think if he could change it he would want me to have kids and you know, but there was that, but he was sort of okay with it. But when the sex work thing came out that just—nope, you know, that’s the end of that.” (cis man)*

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*"If you told people that you are gay, in China, they would never see you the same way they see you before." (cis man)*

Eight participants discussed trans stigma, ranging from subtle unease about coming out to family, to not being picked by brothel clients, to feeling they had to conceal their trans status where possible. Several described the difficulty of finding or keeping mainstream employment.

*"[My family] don't really give a shit that I'm a sex worker, they give a shit, the fact that I went out and started being a woman. They can't live with that. It's, how could I disrespect them in their country town and their name, you know." (trans woman, female, intersex, androgynous)*

*"It's really difficult to go and work for places when you're trans. Yes, especially when you're working—I applied for work at [a department store] and on the form they would ask oh about disability and I would put gender dysphoria and I'd never hear back from them." (trans woman)*

*"Yeah, my mother was more annoyed that I hadn't told her before. She was like, 'When were you going to tell me?' And I was like, 'It just didn't seem like a good time.'" (trans man, two spirits, genderqueer)*

### *Stigma in health care settings*

A significant number of participants said they had experienced no direct discrimination or stigma at the health care facilities they attend in Australia. Notably, however, most said they attended LGBTI-friendly and sex worker-friendly facilities rather than general medical practices, primarily in urban Southeast Queensland. It would be informative to conduct and compare a similar research project in remote regional areas of Queensland.

A small number of participants described receiving poor treatment as a sex worker. A few discussed experiences of being been treated badly as trans women. Nearly half of the participants expressed reluctance to come out as a sex worker to medical professionals. Many said they would disclose if they felt it was necessary but they would prefer not to. Their concerns ranged from lost respect to potential privacy breaches.

*"I don't know, I've been to some GPs and that and they're like, "Ewww sex worker, eww, no." You know?" (cis man)*

*"I hate them, they hate me. Because I do sex work. So they treat me not kind... Even sometimes I see a doctor and then all the reception and everyone there, you know. When I go inside the doctor, and me and doctor coming out, they say, 'Oh my god, is she a man?'" (trans woman)*

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*"[I've] chosen not to tell them... The doctor knows my mum. It's a family doctor."*  
(cis man)

### *Stigma and other barriers to health care*

Only one participant overtly discussed how stigma was affecting her access to health care. However, about a third of participants said they had chosen not to tell their health care providers about doing sex work. No participants said that they avoided discussing being gay in health care settings. A common theme was that participants would divulge relevant details such as their number of partners but omit that they were paid for sex, suggesting a higher perceived stigma against sex workers than against gay or trans people or promiscuity.

One gay identifying participant discussed his experience accessing PEP following a booking with a client who he thought was living with HIV. He wanted to access the treatment but did not want to explain that he was a sex worker.

*"I said, 'Look, I think I might have been exposed.' And the reason why I thought I might be exposed is something really stupid. I had a little cut.... and you know, the risk of that was just fucking ridiculously low .... And it came back and anyway, everything was fine. And he goes, 'Dude, you've got a psychological problem with this. I don't know why they put you on this medication, you can't get it from that... he was suggesting that I see a counsellor. He said, 'That's not normal.' But I didn't tell him I was a sex worker." (cis man)*

When talking about access to health care, for migrant sex workers practical issues affected access. Three migrant workers discussed how they had not had an STI or HIV test since coming to Australia, due to fear, low confidence with English, and frequent travel. Five participants had no regular GP, due to not having a Medicare card or not feeling that they needed regular GP care.

*"It's none of his business... I'd never tell them." (cis man)*

*"I would say that being a sex worker hasn't impacted being able to access health stuff as much as like being a migrant and being a traveller. Because sometimes when you're travelling you don't know where you can find things, if there's going to be a language barrier, like what the social system looks like in different countries." (trans man, two spirits, genderqueer)*

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*"I don't know. I guess it's because I've been so open and I have a mentality in my mind that when you go to a health professional they must help you. They have an obligation to." (trans woman)*

*"I even don't have a Medicare card... How can I have a GP?" (cis man)*

*"No, I don't have a regular doctor... I'm often not sick." (cis man)*

### **Perceptions of risk: HIV rapid testing, PEP, PrEP, treatment and prevention**

#### *Fear of HIV*

Six participants, half of whom were Asian migrant workers, spoke about specifically fearing HIV. Five of those six were cis men. Several participants discussed HIV when generally prompted to discuss any concerns about work. Conversely, one participant, who was on PrEP, said they were relaxed about the risk of HIV even before starting the medication, due to their age. Most participants fell in between these extremes, not severely worrying about HIV but taking measures to protect themselves from transmission.

*"A couple of times where the condom has broken... I just took it as well it's part of the deal, no big deal, I don't care... It just doesn't really matter in my case I reckon... I am now 69 and it does not matter to me, you know I've lived my life, I've thoroughly enjoyed it. I reckon I will live to 100 but in the meantime I am very happy with what's going on and if I were to go tomorrow I would go tomorrow peacefully and with a smile." (trans person [transfeminine])*

*"Condom broke a while back and ever since then I was like—so far it seems to be good. But, fuck, I get scared... Like, if I got HIV or even, you know, oh my God, I'd hate to think about that." (trans woman, female, intersex, androgynous)*

*"Yeah, I really worry of HIV." (cis man)*

*"I don't want to get any STIs or STDs or HIV or anything like that, so I have to say no to a few things." (cis man)*

#### *Condom use*

Most participants reported stringent condom use at work despite client requests for condomless services. However, several said or suggested that they provided condomless services, either oral or full service. Only cis gay men said they provided condomless full service, possibly suggesting more client pressure on these workers to do so.

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Most who did condomless services described using risk management strategies including visual inspection of the client for signs of STIs and taking PrEP. Some participants also mentioned having condomless sex in relationships outside of work.

*"I think in the last two years I might have used [condoms] once. Most of my clients aren't interested. I get a lot of my clients off a bareback site. So that's a given, you know, about not having protected sex. But I always offer it, I always have them handy." (cis man)*

*"I just use condoms unless it's with my boyfriend or something." (cis man)*

*"I don't like dirty sex... They ask for natural. I don't like." (trans woman)*

*"Maybe sometimes have—I've not used condom. Yeah and when we finish the massage or when we finish the activity, sometimes I worry about why I do that because I have to do for safe sex, but yeah sometimes the feeling makes me keep doing." (cis man)*

*"Using Listerine because it has been shown to reduce the chance of passing gonorrhoea." (cis man)*

*"I worry about men say... without condom. Yeah, but I can't do. I can't do without condom. I must do for protection of me... Sometimes have a problem with client... Sometimes, when I say is my rule, I say is my job that's okay. But some people not accept but I can't accept too. I can't do with... this I don't do." (cis man)*

### *Rapid testing*

Most participants had heard of rapid testing, although nine said they had not. Those who were unfamiliar with rapid testing were a mix of Australian-born and overseas-born workers.

Almost a third of participants, mostly overseas-born workers, had used rapid testing, primarily at one particular inner-Brisbane LGBTI/HIV peer-run rapid testing clinic.

Most participants who had used rapid testing said they liked the quick result, although one expressed fear of a false positive result, and preferred conventional testing. Several Asian-born workers relied solely on rapid testing for their sexual health checks.

*"Yeah, I had one of those done before ages ago, I don't like them though... They flip me out... I want something that's going to be definite. Yeah, I don't want to be false positive." (cis man)*

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*"It was rapid, mostly painless... I think it's nice that it exists. Some of the rapid testing that I have seen [outside of Australia] I feel like maybe they could have done a little bit more delicate on like how they were counselling people and like talking to people." (trans man, two spirits, genderqueer)*

*"Still I go to [a peer-run rapid testing clinic] every three months... HIV and syphilis. Yeah. I always have those tested each time I go there." (cis man)*

#### *Post-exposure prophylaxis (PEP)*

About half of participants (16) had knowledge of post-exposure prophylaxis (PEP). Almost all were cis men, and most were Australian-born. Seven had used PEP, and most described unpleasant side effects (such as stomach cramps, diarrhoea and unusual body sensations) but appreciated the peace of mind of HIV prophylaxis. A number of participants said they knew about PEP but would not know how or where to access it if it were needed.

*"I was thinking about using it once or twice, but I don't know if it's easy for me to get one, just like, you just show up and just said you want one, or is it like that? I don't know. I don't know if they are willing to give it to you or not." (cis man)*

*"I tried that thing one time when I did the post thing and it made me feel sick... Yeah, it felt like I'd swallowed a battery and the battery was releasing chemicals into me or something, it felt horrible... I felt a tingling in my fingers and weird dreams and, oh I'm not going to do this again. But you know, good on people for doing it. If your body can hack it, do it." (cis man)*

*"I was really drunk in Brisbane one night and didn't use a condom and just when I got back to the Gold Coast, I went straight to the sexual health clinic and got Truvada. But, that's the only time I've had to do that." (cis man)*

#### *Pre-exposure prophylaxis (PrEP)*

Most participants had heard of PrEP, although 12 had not. Those who did not know about PrEP were a mix of Australian-born and overseas-born workers, and a mix of cis men and trans women.

Participants who were familiar with PrEP generally considered it as a positive, although the issue of still being at risk of STIs if engaging in condomless sex on PrEP was raised.

*"Yeah, and you can still get other things, like, there's still hepatitis." (cis man)*

*"Funnily enough one thing I noticed a lot in Sydney, when I go to sex parties and stuff like that, guys will be off their tits on drugs, but they will get up and*



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*they will go and have their PrEP... Yeah of all the things to remember in the middle of something is to go and have their PrEP. So I'm more rapt with when they—and proud of them when they do that.” (cis man)*

*“Everyone is fucking more with no condoms.” (cis man)*

When asked if they would have any concerns about taking PrEP, most participants said they would want to know more about potential adverse effects.

*“I guess just the concern of not knowing what the long-term effects of that is. I guess it's a level of toxicity that it would bring to your body, which you don't know what it does” (cis man)*

*“Yeah of course I would want to know whether it'll drop my hair....and I would ask like - like suddenly if I put my body into such medication and once I stop, will I be prone to like.... I have to continue with it or I can stop it? And then immediately something happens and I get - because I'm not taking the tablet anymore, so my immune is not working naturally. I would ask that kind of question” (trans woman)*

Some discussed that they thought that as they were accessing PrEP as part of the QPrEPd trials<sup>5</sup>, it meant it was an experimental medication and several raised concerns about the efficacy of PrEP in trials being less than 100 per cent.

*“Oh, I'm just, like, that's a bit risky. Like, because you can still get other things, and, like, what if you skip a pill or it's only 98 percent?” (cis man)*

*“That it's relatively new, and that people have been known to contract HIV while on it, but not a lot.” (cis man)*

*“It's still in testing, isn't it, like, they're still... Yeah. It's great that they're making accessible even though it's in testing. It's the best way, just a little bit spooky but most I think it's good and that it's so accessible.” (intersex)*

Four participants had used PrEP, including three cis men and one transfeminine person. All spoke highly of taking PrEP, saying they were happy with it as an HIV prevention tool. None of these participants had experienced adverse effects. However, the possibility that PrEP could cause sex workers to become complacent about other STIs was raised, with one

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<sup>5</sup> The Queensland Pre-Exposure Prophylaxis Demonstration Project (QPrEPd) - Second Expansion (QPrEPd-X), funding provided by the State of Queensland, over four years (July 2016 to June 2020) to provide free access to pre-exposure prophylaxis (PrEP) to up to 3,000 people.

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participant in particular noting that there were a range of safer sex strategies that could be used.

*“To be honest I'm a bit sad when I hear people that are very active in their sex lives and aren't on it. Particularly guys who don't have safe sex... And you know it's free, so why not be on it? The only thing from my thing is it gets people the false impression that they can probably be a bit more frivolous with their health and not be worried too much about stuff and rely too much on the pills I guess... Like you know a lot of young people just think there's a pill for everything nowadays, so they take more risks.” (cis man)*

*“I am on PrEP as well so if I want to have unprotected sex in my personal life I have to do it in a way that allows me to have enough I guess time for me to go and get tested to make sure that I am in the clear before I can go back to work. So it is about just kind of knowing what risks I've taken, or if a particular client... explaining that risk to your customer, making sure that they understand that what risk is involved I guess... As a gay man there's so many risk minimisation techniques that you use... A lot of these things could potentially be involved, be like blended into the sex work practice as well where the client is willing to talk and be educated about those things.” (cis man)*

*“But then, you know, a lot of my clients I kind of know them, I don't use a condom, but now I am on the PrEP program.... Yeah. So also it's free.” (trans person [transfeminine])*

Five participants specifically stated that PrEP did not protect a sex worker from other STIs with some stating that condoms were a better option for them.

*“You know what happen if you don't take it? He can pass - it's not secure. Better to use condom every time when you have sex” (cis man)*

Participants were divided in whether they approved or disapproved of other sex workers advertising that they take PrEP. A recurring theme was that including PrEP in sex work advertising could imply that condomless services are available, and that the worker would be at risk of other STIs if they provided this. Other participants worried that those sex workers who advertised that they take PrEP could be pushed into condomless sex by clients.

*“I think it is good, but there is sort of the, um, often it sort of goes unstated that that involves the fact that they do bareback as well stuff, you know... it implies that a little bit.” (cis man)*

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*"I'm not sure if you'd want to because you'd probably get—there's already enough clients who push for unprotected services but I think they might push a little bit more if they see that you're on PrEP because they'd be like cool, it's less risk. Why shouldn't they offer me unprotected services now." (trans man, genderqueer)*

*"I don't like it... Because they are spreading... well, no, not that they're spreading, they don't intentionally go and do it, but it doesn't cure you of everything else but that. It's not stopping everything else but that. And they're opening it up to people with bad intentions, they think that they can be bred or bred or whatever, but they could get something else, it's not foolproof." (cis man)*

Lastly, there was concern expressed about PrEP being legally mandated for sex workers when it was not warranted.

*"Yeah. A substantial risk to your ongoing health, from my point of view, for questionable gain. But it's something very individual. But I think that we're too early down the road to be advocating that people summarily take a drug just to minimise risk to the broader community. I think we should be promoting responsibility. And again, its existence and lack of firm policy on sex work in Australia – again – scares me, that sex workers - or anybody – could ever have a judgment pass that they must take that medication". (transfeminine / gender diverse)*

### **Other wellbeing and health needs: suggested changes**

Participants were asked about what they thought could improve wellbeing for sex workers in Queensland. The answers given overwhelmingly focused on health and safety, either directly in terms of how health care services could change, or indirectly by focusing on factors such as stigma and the criminalised legal framework that affect how sex workers can safely conduct their businesses.

#### *Stigma*

Most participants discussed issues of stigma when asked about how sex worker wellbeing could be improved. Recurring themes included that sex work should be accepted as work and that workers should be treated with dignity.

*"To accept them. To don't judge them. To make them to feel like that it's a normal job and it's them risk if they don't ask the person who are a sex worker about the status. You know what I mean?... Otherwise the government and*

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*everybody they should say sex worker they are human. They pay tax as well. You know you have to pay tax if you—not everybody but they should. They should, you know. Because actually it's a job so this is what the government should say in Queensland.” (cis man)*

*“Fighting social stigma for sure, improving the level of knowledge for health practitioners and any service for that matter. Teaching people how to work sensitively with sex workers...” (cis man)*

*“I feel like there needs to be, like, kind of less stigma and actual genuine want and need to actually help people regardless of what situation they're in; to not actually fucking belittle them and call them prostitutes because the word prostitute is not a positive word to use. So why fucking use it?” (trans woman)*

### *Education*

Several participants described the need for education of health care workers or the public to improve conditions for sex workers. Some suggested that public health–style programs in schools which addressed sex work would help reduce social stigma.

*“Just basic education. You know, this needs to be talked about at school and I know that sounds really strange but when they—when the powers that be have the brains to realise that sex work, sexual identity, all of that—it needs to be a subject that's covered in school, you know. It has to be. And it doesn't have to go into like full-on pictures and stuff like that, just basic information and just like bullying and abuse to women, you know. It's exactly the same. If it's talked about in a positive way with younger minds that will grow up—hopefully at least 20 to 30 per cent of them will grow up with a better understanding and attitude.” (cis man [previously identified as trans])*

Participants also discussed the need for education of sex workers, making them aware of services available to them.

*“Still education and awareness... The use of condom and also the Medicare education and the mental health education. Also, probably we should demand some social worker services... Yeah, psychological services.” (cis man)*

### *Health care*

About two thirds of participants said health care policy and services could be improved to benefit sex workers. Most discussed the importance of sex worker–friendly clinics and education for health care staff on how to provide care for sex workers. Several suggested more subsidised sexual health care, including testing and PrEP.

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*"I wouldn't say it should be free, but it should be at least subsidised so we can actually—because this is all like—it's needed you see, it's a must. So if the price is quite affordable, then I don't think there will be a problem. Like everybody will go and have a checkup. And yeah, and they have to make it more normal that it's so fine that even random people just can walk in and do STD checkup, which is good." (trans woman)*

*"If they could treat us equally, like anybody else... Less judgment. Less attitude." (cis man)*

*"PrEP being, um, government funded would be nice. Ah, it would open it up to a lot more people." (cis man)*

*"Well, it's not so much things that the health services themselves can do, it's more a just lack of government funding for more extensive services. So it's not really the health services themselves that need to change, it's the government funding that does, and it's reasonably accessible but, like, there's not a lot of places outside of, like, Brisbane that are, like—that I know of that would be sex worker-friendly to go to. And I live in [an inner suburb] so it's hard for me to know from personal experience because I'm close to the city but from what I do know there's not much outside of Brisbane city for sex workers that are, like, going to be friendly places for sexual health services." (trans man, genderqueer)*

Some participants discussed mandating or otherwise encouraging regular sexual health testing, indicating that they hold ill-informed ideas about the potential risk that sex workers pose to the health of the general community and the possible benefit of increased regulation of sex workers in regards to mandatory sexual health testing. Such statements can reinforce existing stereotypes and stigma attached to sex work. This suggests that more peer education empowering sex workers to take control of their own sexual health and develop awareness of best practice sexual health is needed.

*"You know, I think, at the end of the day, sex worker if they do contract something, they're going to spread it far and wide. You know what I mean? So, I think, mandatory... And more of a—what's the word?—regimented, I guess, or controlled, overseen results thing. So, if you go get tested, as a sex worker, if you work in a brothel, that brothels directly know, contacted by the health clinic, or whatever. Or, that person's name gets put into a thing where they can't work at any brothels. You know, something like that. You know what I mean... Because if they know that they've got something wrong with them, they still continue to work, they're putting other people's lives at great*

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*risk and I think that's not a really good idea. That's very selfish and not very nice." (cis man)*

### *Legal frameworks*

When prompted for ways sex worker wellbeing could be improved about two thirds of participants discussed legal issues. Most, primarily Australian-born workers, talked about decriminalisation or other legal reform. Notably, overseas-born workers were less likely to have a confident knowledge of Queensland sex work laws.

Other issues raised included the need for better protection by police and by anti-discrimination laws. Several participants discussed the 2011 case of a sex worker who was evicted from a hotel in Central Queensland for sex work. Known as GK, the cis woman sex worker complained to the Anti-Discrimination Commission that the eviction was a breach of the Queensland Anti-Discrimination Act. The case took two years to be heard by the Queensland Civil and Administrative Tribunal and Queensland Court of Appeal before it was finally decided in favour of the motel owners, Dovedeen Pty Ltd (QCAT, 2011, 2012; QCA 2013). During this time the Act was amended to allow accommodation providers to legally discriminate against sex workers, and they can now evict a person if they suspect that person is, or will be, doing sex work on premises. Several participants indicated that this sort of lawful discrimination against sex workers should be disallowed. See footnote<sup>6</sup> for more information.

Many participants talked about the difficulty of working around laws regulating sex work, such as restrictions on advertising, and not being able to work on the same premises as another worker.

*"Definitely lose the double bookings and, like, the use of the words massage, like, it's pretty arbitrary... It would be really great if people could be on premises and that could be legal because... that would improve mental health and safety just, like, so many fold it's just, like, crazy. But, like, people avoid*

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<sup>6</sup> QCAT, GK v Dovedeen Pty Ltd & Anor (No 3) [2011] QCAT 509 (10/ADL134) Brisb Ann Fitzpatrick, Member 25/10/2011 [available at: <https://www.sclqld.org.au/caselaw/QCAT/2011/509>]; QCAT, GK v Dovedeen Pty Ltd and Anor (No 2) [2011] QCAT 445 (10/ADL134) Brisb C Endicott, Senior Member 15/09/2011 [available at: <https://www.sclqld.org.au/caselaw/QCAT/2011/445>]; QCATA, GK v Dovedeen Pty Ltd and Anor [2012] QCATA 128 (11/APL416) Brisb PJ Roney SC, Presiding Member Dr B Cullen, Member 31/07/2012 [available at: <https://www.sclqld.org.au/caselaw/QCATA/2012/128>]; QCAT, G K v Dovedeen Pty Ltd and Anor [2011] QCAT 441 (10/ADL134) C Endicott, Senior Member 22 March 2011 QCAT11-441 <https://www.sclqld.org.au/caselaw/QCAT/2011/441>; QCA, Dovedeen Pty Ltd & Anor v GK [2013] QCA 116 ; [2013] 20 QLR (12/7794) Fraser and Gotterson JJA and Margaret Wilson J 17 May 2013 <https://www.sclqld.org.au/caselaw/QCA/2013/116>; QCA, Dovedeen Pty Ltd & Anor v GK [2013] QCA 194 <https://www.sclqld.org.au/caselaw/QCA/2013/194>

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doing that because of the law. But, like, it actually improves safety so much.”  
(intersex)

“I think that if... the police either turn a blind eye to it and let you do what you want and look after yourself, or the police treat you like a normal job, but not halfway. Does that make sense?... I think the best way to do it is just decriminalisation and just do what you want to do I think. I think New South Wales is decriminalised so I think that that’s a good system I reckon. Because it’s the best because you don’t have to worry about like all these stupid shit like in Victoria... It’s just a load of crap and it’s just screwing money out of you for licencing fees and there’s no way I’m going to give them my photocopy of my licence or whatever they want.” (cis man)

“Look it’s a legitimate business. It’s plain and simple. And yet we’re still—you know, we’re still vilified and we’re still looked down upon by police and those kind of providers and services.” (cis man [previously identified as trans])

“Probably, I mean, doesn’t the law say two people can’t work together or something like that. Is that right?... I mean, that’s silly. Two girls working together are going to be safer than one by themselves. You know what I mean?... You know, some of those sorts of things I think are a bit sort of, I think, antiquated, or a bit silly. That, I mean obviously there’s certain things that the public doesn’t want to see. Out of sight, out of mind. But, especially for females and that. It can be unsafe. I’m sure that two of them at once or two of them in the same place would be better than just one.” (cis man)

“Allow me to work in the hotel. Because some hotels, they allowed to kick me out. Yeah, if they don’t want me to stay, they ask me to go... Oh yeah, if they allowed me to work with my friend. I don’t think so, but this would be nice. You know?” (trans woman)

“I really have a real fear of the police. I’ve just had a few run-ins with them.” (cis man)

“They [police] always search me for drugs. They don’t find drugs, but they always search me.” (trans woman, female, intersex, androgynous)

“I was concerned about when that sex worker brought her case for discrimination... Yeah and she lost... But I was told if something happened to me at a hotel, because I’m transgender there’s more protections in regards to that particular part of the law if I was asked to leave a hotel because I’m a sex worker.” (trans woman)

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### ***Limitations of Phase 3 interviews***

While the sex workers interviewed for this study were very diverse for a small group, particularly in terms of age and country of birth, some demographics were not well represented. Only one Indigenous worker was interviewed, although this is higher than the proportion of sex workers who access Respect Inc (1%) and consistent with those Australians who are Indigenous (3%). All participants lived in urban or suburban settings, primarily in Southeast Queensland. No rural or remote sex workers were interviewed.

Only two transmasculine sex workers were interviewed, though this likely reflects the small number who do sex work in most parts of Australia, due to the difficulty of maintaining work in the industry for trans men. Anecdotally, trans men typically work as women during early transition until physical changes become obvious, after which work is scarce. The pressure to present or perform as other than the worker's actual gender, and the psychological impact on trans sex workers, could warrant further research. Notably, both trans men in the study were early in their medical transition, and may have reported different experiences if interviewed later in transition after a period of presenting as male for work. Only two intersex workers were interviewed, but this is still perhaps more than would be expected given the 1.7 per cent prevalence of intersex variations in the population (Intersex Human Rights Australia, 2013).

A few minor gaps exist in the demographic data collected, such as 'uncertain' ethnicity, which could have been discussed further with participants to collect better information. Language barriers with some of the overseas-born workers—occasionally substantial enough to require *ad hoc* interpreting by another worker—meant that discussions were sometimes superficial, and delving into issues such as stigma with nuance was very difficult. The input of these workers was nonetheless valuable, including insights such as difficulty in accessing health care due to the same language barriers.



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#### Phase 4: Focus group with peer educators (peer support workers)

##### *Profile of peer educators (peer support workers)*

Twelve peer support workers aged between 21 to 61 years (mean age 40.8 years) joined the Respect Inc Round Table focus group discussion. Participants represented a diversity of genders and sexualities (Tables 14, 15 and 16), with the majority reporting they were born in Australia (75%, 9) and a university degree (66.7%, 8) as their highest education level completed.

**Table 14: Gender of peer support workers**

Gender	n	%
Male	3	25%
Female	3	25%
Cis woman	3	25%
Trans woman	1	8.3%
Gender queer/gender divers/non-binary	1	8.3%
Missing	1	8.3%
Total	12	100

**Table 15: Sexuality of peer support workers**

Sexuality	n	%
Gay	2	16.7%
Queer	4	33.3%
Heterosexual	5	41.7%
Pansexual	1	8.3%
Total	12	100%

**Table 16: Gender and sexuality of peer support workers cross tabulation**

Gender	Sexuality				Total
	Gay	Queer	Hetero sexual	Pan sexual	
Male	2	1	0	0	3
Female	0	0	3	0	3
Cis woman	0	1	2	0	3
Trans woman	0	0	0	1	1
Genderqueer/gender-diverse/non-binary	0	1	0	0	1
Missing	0	1	0	0	1
<b>Total</b>	<b>2</b>	<b>4</b>	<b>5</b>	<b>1</b>	<b>12</b>

Half of the participants (50%, 6) had been a sex worker peer support worker for more than two years, and three (25%) had been working in this role for less than one year, giving a good spread of experience and first impressions of this role (Table 17).

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**Table 17: Time working as a peer support worker**

<b>Duration</b>	<b>n</b>	<b>%</b>
Less than 1 year	3	25%
1 to 2 years	2	16.7%
More than 2 years	6	50%
Not applicable	1	8.3%
Total	12	100

#### **Phase 4 Themes**

Focus group participants described stigma and discrimination as key issues experienced by TMSW. Participants also discussed sexual health service issues including the defunding of the trans-specific sexual health service, limited anonymous sexual health services, issues around continuity of services across the state, and limited services in regional areas.

*“Our sexual health service specifically had their trans funding removed a couple of years ago. They had a trans program, and that funding was specifically removed, that was a huge barrier. That’s in my experience, regionally, they just completely lost it.”*

*“And what really amazes me is how discriminatory groups like cultural services and as well as other health services can be towards sex workers. That you’d think they cop enough discrimination and stigma themselves, but then in turn still perpetrate it on other groups such as sex workers.”*

*“I’d just say directly there is a total lack of anonymous sexual health services in Queensland, and there’s the community of health professionals who are sensitive to gender-diverse people, trans people, sex workers, is incredibly, incredibly small, and for a lot of the people in the gender-diverse and gay male community, that includes people that they don’t want to out themselves to as sex workers, so they can’t even access the services that are available to others.”*

*“Oh, continuity with sexual health symptoms, like there’s services that need a Medicare, like sexual health services when if you go in for a sexual health certificate you need a Medicare card, whereas in [one regional city] the condition is that you need a Medicare card if you want to go on the pap smear register, or that was their logic anyway when I rang them and asked. In [another city] you don’t have to, and in [another] you don’t have to either.”*

*“Feedback from people who access our service who are trans or male is lack of services in [regional area]. There’s nothing there.”*

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*“And that really to me identifies a lacking in the gender-diverse support processes.”*

TMSW from CALD backgrounds experienced specific challenges, including limited legal literacy which influenced trust in and access to services.

*“Male sex workers... the most common issue that the legal thing, it hasn't been translated well enough for the broad community in the male sex workers... And because of that, the people come in here, they don't trust the government, they don't trust Respect, a lot of the areas, for them to come in, for example this person doesn't have a Medicare card.”*

Participants described specific issues associated with TMSW accessing Respect Inc services. Cis women peer workers discussed reluctance of some cis men and trans people to access Respect Inc services, especially when cis women peers were working. They discussed the need for appropriate gender-inclusive language to be used by peer workers.

*“But I find I target male and trans workers on the phone they chat on the phone a bit, but they rarely come in unless there's an issue that they would like to discuss. And the male workers generally go “Hello?” I don't know why, it's like as if they don't expect a call, because they don't know it's me when I'm calling, it's a cold call. And I've noticed where I am regionally that they always seem surprised. But I have a bit of a chat to them, but only a couple have come in, probably because I'm a female, I don't know.”*

*“I can't actually name it, I just know that the males rarely come to me... I have no real way of knowing, I'm just thinking perhaps they're not so comfortable to come in and deal with a woman. But maybe they would, I don't know. My experience is I don't have that much to do with them.”*

*“If looking at what impact can be done to minimise discrimination and stigma targeting not just gender-diverse people and sex work, paying a bit of attention to how language creates barriers would be lovely.”*

Participants discussed the value of the peer educator role, and how much they gained from their work. They described their peer role, which included sharing knowledge, legal literacy, health literacy, health promotion, advocacy and support, and discussed what they gained from their experience of being a peer educator, including meeting diverse people, bonding and learning from other sex workers.

*“Critical to peer education I think is that our own lived experience, and our experience of sex workers, I'm wanting to really emphasise that two-way exchange. And some people kind of frame peer education as people with*

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*more experience talking to people with less experience, but I guess I wanted to point out that often I learn as much from people just starting out, or newer workers that have come up with some strategy or way of doing stuff that just increases my repertoire, if you like."*

*"You have to have a massive range of skills, and because you're doing so many different components of your work. It's not just knowing how you, what the risks are of obtaining STIs, or where the local clinic is, or how to use condoms effectively or whatever, there's these massive layers of legality and who's friendly services, what the latest is on tax, and so just really broad sets of information that yep, it's important I think to understand."*

*"Our common ground is sex work. Our common ground is the stigma and discrimination as a sex worker that we have faced, that's our common ground."*

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## Discussion

Sex workers who are male and/or trans in Queensland come from a variety of backgrounds. The data from this study highlight that people of all ages are sex workers, but the average worker is in their early thirties. Most of the overseas-born sex worker participants were from Asian countries, and almost all work independently, though a few work in brothels. Most of the trans participants were transfeminine, with a small number of transmasculine workers. The transfeminine sex workers were primarily heterosexual. Very few cis male workers in this study were heterosexual—similar to the results of Minichiello et al (2002), who found that 7.9% of the 38 cis male sex workers they studied in Queensland were heterosexual. TMSW in this study, like their cis female counterparts, were all relatively well educated as a group, with many having a higher education or university degree.

The sex workers who participated in this study represented a high level of diversity, including a large number of sex workers who are traditionally difficult to access, such as migrants and those working in illegal sectors). This high level of diversity and success in recruiting sex workers from these more hidden hard-to-reach subgroups shows how working in partnership with sex workers organisation can be beneficial and effective in improving the reflectiveness of the study sample and validity of the outcomes.

Most TMSW describe having appropriate access to health care, including sexual health care. However, many of these same sex workers we spoke to are not 'out' to health care providers about their work, which could affect the appropriateness of their care. Few have experienced overt discrimination in a health care setting but many are uncomfortable discussing work indicating an internalised stigma that ultimately affects access.

Experiences of stigma and discrimination featured as a strong theme in this report. Some sex workers had experienced discrimination that affected their access to health services. Most workers described stigma affecting other facets of their lives, especially trans workers, who experience the double stigma of being trans and being a sex worker. In addition to health care, stigma is an issue in relation to family and work, with trans people in particular finding it difficult to get or keep employment outside of the sex industry. Many workers, both cis men and trans people, spoke of the need to keep their sex work a secret, often including from health care workers. A number of workers also said they would like to be more aware of sex worker-friendly clinics.

Access to health care services, and education about what services are available, is crucial to trans and male sex workers, particularly migrant workers. Overseas-born workers frequently expressed uncertainty about where to go for sexual or general health care and how to

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access it without a Medicare card. Language can also be a factor preventing overseas-born sex workers from accessing health services.

Despite various barriers, sex workers in this study overall expressed diligence with their sexual health testing, and most said they are stringent with condom use. The sex workers interviewed were in general very literate around sexual health, with most indicating strong familiarity with HIV and STI prevention, testing and treatment. About half of the sex workers interviewed said they had a history of an STI, which is consistent with the general population. Unlike most segments of the general population, sex workers in this study typically reported testing frequently and therefore detecting and treating infections promptly.

Rapid HIV testing is popular among male and trans sex workers, particularly overseas-born workers who can access peer-run rapid testing clinics without a Medicare card. Some workers are using rapid testing as their only sexual health screening, meaning they may not be tested for STIs such as chlamydia and gonorrhoea. Further, they are not obtaining a fuller sexual health screen because they do not engage with sexual services that require payment or are 'too complicated'.

Most male and/or trans sex workers in this study had heard of PrEP. A small number of participants are taking PrEP, either to facilitate condomless sex or as a backup in case of condom breakage. Many who had not heard of PrEP were interested to know more when it was explained to them, suggesting better awareness of the pros and cons of PrEP could result in higher take-up by these sex workers. Those who were familiar with PrEP were divided in their opinions; many like the idea of a pill to prevent HIV, but some have misgivings about a drug that will only protect them from HIV, is perceived as new or even experimental due to its availability through trials and may become mandatory for sex workers. Although some were already marketing themselves as PrEP users, others expressed concerns about the potential harmful impacts of sex workers using PrEP in advertising. More work is needed to improve trans and male sex workers' understanding of how PrEP could be used in sex work and to ensure that sex worker peer organisations are positioned to best advocate PrEP policy for sex workers without fear that PrEP could become mandatory for sex workers.

Knowledge of PEP was less apparent than of PrEP. Those who knew about it were sometimes not sure where or how to access it. The lower rate of knowledge of PEP compared to PrEP could possibly be attributed to PrEP having recently been in the media, particularly LGBTI media, and promoted through LGBTI health care facilities and the QPrEPd trial.

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Many sex workers were unaware of the peer-based community services available to them, including Respect Inc. While 16 interviewees knew about Respect Inc, seven said the first they had heard of Respect Inc was when they were contacted about participating in the research, suggesting the organisation's profile is lower than it could be to reach and support these workers. It is very possible that the payment offered for research participation generated interest to an extent that it allowed these sex workers to overcome their natural resistance and mistrust and make contact with Respect Inc.

A strong majority of workers discussed the need for changes to the laws around sex work, calling either for reform of particular parts of Queensland legislation such as the ban on private escorts working together, or for full decriminalisation, which is internationally acknowledged as best practice to protect the human rights of sex workers.

Workers also spoke of difficulties dealing with police, including fearing vilification, having been harassed and having experienced police unresponsiveness after reporting a crime.

Respect Inc peer workers also described stigma and discrimination as key issues experienced by TMSW. They raised sexual health service issues, including the defunding of a trans-specific sexual health service, limited anonymous sexual health services, issues around continuity of services across the state, and limited services in regional areas. TMSW from CALD backgrounds experienced specific challenges, including limited legal literacy, which influenced trust in and access to services. Participants described some reluctance of some cis men and trans people to access Respect Inc services. They discussed the need for appropriate trans gender-diverse language to be used by all services and organisations.

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## Recommendations

Participants' suggestions for improvements to wellbeing for sex workers in Queensland showed several trends, and focused primarily on health and safety, stigma and the law. Our recommendations are drawn from all 4 phases of the study. Recommendations from the interview and focus group phases draw both directly from suggestions made by participants and from other needs identified through the interview process.

Our recommendations from this research are:

1. Full decriminalisation of sex work in Queensland
2. Effective marketing and appropriate funding for Respect Inc to ensure workers are aware of the organisation
3. Availability of multilingual information resources for migrant sex workers
4. Training for non-peer health care workers on working appropriately with trans and/or sex worker clients to ensure they receive suitable care without encountering stigma
5. Listings of trans-friendly and sex worker-friendly health care facilities available for workers to better choose where they receive care
6. More health care facilities offering full STI checks for sex workers without Medicare cards, and listings of these facilities easily available
7. Peer education that is responsive to changing biomedical technologies, targeting sex workers to increase their health literacy and inform them of the pros and cons of rapid testing, PEP and PrEP
8. Peer education for sex workers, especially overseas-born workers, about the importance of regular testing for all STIs, not just HIV
9. Training for Queensland Police officers to work appropriately with sex workers, possibly incorporated into the LGBTI Liaison Program.
10. Future research with sex workers to be conducted according to the CBPR quality criteria

### Implications for practice and policy

As discussed, full decriminalisation of sex work is international best practice, and feedback from participants in this research supports the case for decriminalisation in Queensland. Under decriminalisation, sex workers—especially marginalised workers such as trans women—can work together for protection and seek help from the police without fear of legal consequences themselves.

Because of the large proportion of sex workers who conceal their work from their health care providers, practices that are sex worker-friendly should be open about this in the same way



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that LGBTI-friendly clinics display their support. A red umbrella sticker alongside a rainbow flag sticker, for instance, could signal to patients that a practice is sex worker-friendly.

### **Implications for future research**

Future research should further assess the health care literacy and needs of populations underrepresented in this research: transmasculine, intersex and Indigenous Australian sex workers, as well as those in remote regional areas. More research on migrant TMSW, using comprehensive translation services, would be valuable. CALD sex workers in this study communicated less awareness of available sexual health and support services. Future research should further investigate the needs of these workers and lead to development of multilingual information resources and services.

The needs and experiences of sex workers in Queensland who are living with HIV should also be investigated. The specific needs of this group, who experience an additional level of marginalisation and stigma, was not covered by this research as no participants reported being diagnosed with HIV. There have been relatively recent cases where trans and male sex workers living with HIV have been criminalised in the ACT and WA<sup>7</sup>, creating additional stigma through legal and media vilification. It would be valuable to explore how sex workers living with HIV manage their sex work in the era of biomedical interventions (Jeffreys, Matthews, & Thomas, 2010)

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<sup>7</sup> Kelly, C. The case of CJ..., Positive living NAPWHA [ ]; CJ... to be sentenced as concerns raised about criminalisation of HIV, Out in Perth [Accessed 3/5/18 at <https://www.outinperth.com/cj-palmer-sentenced-concerns-raised-criminalisation-hiv/>]; Menagh, J., Transgender sex worker jailed for infecting client with HIV, ABC News, Updated 16 February 2018, [Accessed 3/5/18 at <http://www.abc.net.au/news/2018-02-16/transgender-sex-worker-sentenced-for-infecting-client-with-hiv/9454814>]; No author, Charged sex worker has HIV: ACT Health, ABC News, Updated 30 January 2008, [Accessed 3/5/18 at <http://www.abc.net.au/news/2008-01-30/charged-sex-worker-has-hiv-act-health/1028082>]; No author, HIV sex worker jailed, ABC News, Updated 15 September 2008, [Accessed 3/5/18 at <http://www.abc.net.au/news/2008-09-15/hiv-sex-worker-jailed/510650>]

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## **Research partners**

This research was conducted in partnership between Respect Inc (with assistance from Scarlet Alliance) and UQSPH using a CBPR approach. The UQ research team worked closely with the steering committee, peer researchers and Respect Inc staff throughout the study. The research team acknowledge the invaluable guidance and commitment of the steering committee and Respect Inc staff.

### **Respect Inc**

Respect Inc is Queensland's peer-based sex workers' organisation. It is a non-profit community-based association of past and present sex workers, focused on the rights and wellbeing of sex workers in Queensland. They provide peer education, information and support programs to Queensland sex workers regardless of gender, age, location, industry sector, legal status, cultural background or linguistic abilities. Respect Inc also provides a formal medium to communicate sex worker issues and concerns to improve the rights and respond to the workplace health and safety needs of sex workers.

Since 2010 Respect Inc has been funded by Queensland Health to provide: information, peer education, support, advocacy and referrals; outreach to regional and isolated sex workers; safer sex products (such as condoms and lubricant); allied health services network development; sex worker community development; general community education about sex workers ('myth busting') and policy advice to government.

### **Research team**

The TaMS research team includes a small team of highly experienced academics and sex worker peers with prior experience of working and undertaking research with sex workers (Abel & Fitzgerald, 2008; Abel & Fitzgerald, 2012; Kim & Jeffreys, 2013; Renshaw et al., 2015; Respect Inc, 2015). UQ members of the team have also conducted studies using CBPR methodology in collaboration a range of CALD communities (Dean et al., 2016; Dean et al., 2012; Fischer et al., 2011; Fischer et al., 2013; Kelly-Hanku et al., 2016; Vu et al., 2012). The research team have extensive experience working within and in partnership with sex worker organisations to inform policy and services as well as providing sexual health care and education within a peer led model (Abel et al., 2009).

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***Principal coordinating investigator: Dr Lisa Fitzgerald***

*Affiliation:* School of Public Health, Faculty of Medicine, the University of Queensland

*Position:* Senior lecturer

*Responsibilities of investigator:* The principal researcher in this project took primary responsibility for the research methodology and project management across all sites and phases of the project. Lisa worked closely with the co-investigators from UQ and Respect Inc and the study steering committee (consisting of community and sex worker peer representatives) throughout the study process, including during community consultation, recruitment and selection of participants, instrument preparation, focus group and interview processes, data collection and analysis, and dissemination and reporting of findings. She was also responsible for collaboration and consultation with the study reference group and other key community members and service providers relevant to this project.

***Principal investigator: Ms Candi Forrest***

*Affiliation:* Respect Inc

*Position:* Treasurer

*Responsibilities of investigator:* Candi worked in partnership with principal investigator in the initial design of the project, financial planning and memoranda of understanding for the partnership. She had administration and board-level responsibility for Respect Inc's work on the project, including instrument preparation and recruitment of peer researchers, study steering committee and focus group. She assisted in dissemination and reporting of findings in collaboration with the other co-investigators from Respect Inc and the study steering committee. She took initial responsibility for collaboration and consultation with the study steering committee and other key community members.

***Co-investigator: Dr Judith Dean***

*Affiliation:* School of Public Health, Faculty of Medicine, The University of Queensland

*Position:* Post-doctoral research fellow

*Responsibilities of investigator:* Judith was actively involved in all aspects of the research project, including the community consultation, recruitment and selection of participants, instrument preparation, focus group and interview processes, data collection and analysis, and dissemination and reporting of findings. She worked in partnership with the Respect Inc study coordinator, and was involved with liaison and coordination of the peer researchers and interview schedules.

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***Co-investigator: Ms Annie Mundy***

*Affiliation:* Respect Inc

*Position:* State coordinator

*Responsibilities of investigator:* Annie was responsible for the supervision of Respect Inc staff involved in the project and provided technical support with data collection and upload. She was actively involved in all aspects of the research project including community consultation, recruitment and selection of participants, instrument preparation, focus group and interview processes, and data collection. She also provided expert peer sex worker leadership to the research team and participated in the project's steering committee.

***Co-investigator: Mx Dee-Amela Conti***

*Affiliation:* Respect Inc

*Position:* Secretary

*Responsibilities of investigator:* Dee-Amela was actively involved in all aspects of the research project including the community consultation, recruitment, and selection of peer researchers, instrument preparation, focus group, and interview processes. They also provided expert peer sex worker leadership to the research team and participated in the project steering committee.

***Research officer: Mr Samuel Brookfield***

*Affiliation:* School of Public Health, Faculty of Medicine, The University of Queensland

*Responsibilities of research officer:* Samuel completed the literature search and review for the second phase of the research. He liaised and collaborated with the investigators during the literature search and analysis, and contributed the review content to the final report.

***Peer researcher Mr Jesse Jones***

*Affiliation:* Respect Inc

*Responsibilities of peer researcher:* Jesse was involved in planning the study, including input on the data collection methods, as well as conducting research interviews and uploading interview data to the UQ server. He also worked with the principal investigators and co-investigators to perform qualitative analysis of the study data and prepare the report. During the data analysis and writing up phase, Jesse was engaged as a visiting researcher at UQSPH and was an active member of the HIV research team during this period.

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***Peer researcher Mr T Smith<sup>8</sup>***

*Affiliation:* Respect Inc

*Responsibilities of peer researcher:* Smith was involved in planning the study, including input on the data collection methods, as well as conducting research interviews and uploading interview data to the UQ server.

***Respect study coordinator: Mr Joe Qu***

*Coordinator responsibilities:* Joe was responsible for Respect Inc's share of the project, including the daily coordination of the study, promotion of the study to sex workers, assistance with design of the promotional flyer, recruitment of the peer researchers and steering committee, convening all meetings and driving the agenda. He was the conduit between Respect Inc and UQ, and was responsible for the scheduling of participant interviews and management and coordination of the peer researchers during the recruitment and data collection phase of the study, in partnership with the UQ researchers.

***Steering committee***

The steering committee, comprised of peers working and/or volunteering at Respect Inc, was an active partner in the development of the research questions, methodological approach, and data analysis plan. Members also participated in regular reviews of the findings and approval of the final report.

***Steering committee and Respect Inc staff: Robert Fawkes, Joel Valentine, Mish Pony, Brother Hazy, Jack Black, Dee-Amela Conti, Annie Mundy, Joe Qu, Jesse Jones, T. Smith***

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<sup>8</sup> An assigned pseudonym.

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## Acknowledgement

Respect Inc would like to acknowledge all of the sex worker community members who participated in this study, and in so doing helped us to celebrate the diversity of the sex worker community that we support and are supported by. Respect Inc is very grateful that the researchers at The University of Queensland who drove this project, Lisa and Judith, were supportive of our insistence on a partnership approach to this research. Even though it often required more of them, they supported as best practice that research about sex workers should be sex worker-driven.



***Figure 4 Researchers and steering committee members at TaMS report launch***

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## Appendices

### Appendix 1: Phase 2 systematic review methodology

#### Systematic review methodology

To conduct this systematic review, the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were applied, consistent with previous systematic reviews of research on marginalised populations (Marshall & Werb, 2010). A standardised review protocol was developed prior to commencement of the review, which can be accessed via [www.crd.york.ac.uk](http://www.crd.york.ac.uk). The review focused on original qualitative research that addressed barriers to accessing sexual health services for TMSW. This research question was constructed using the PICO framework (Schardt, Adams, Owens, Keitz, & Fontelo, 2007).

#### *Search strategy*

Comprehensive systematic databases searches were conducted of Cochrane Library, PsycINFO, PubMed, Scopus, and Sociological Abstracts. These databases were selected based on two criteria: the close association of their subject matter or methodological focus to that of the review; or the comprehensiveness of the database due to its volume. The search was restricted to research published since 2000, to ensure contemporaneity of the data. The search included medical subject headings (MeSH) terms and text words for: 'sex work', 'male sex work', *transgender*, *prostitut\**, and *HIV*. These search terms were developed with reference to related reviews and relevant literature, and with an awareness that papers regarding this population may incidentally address the research question without this being a focus in the title or abstract. In addition to these searches, a hand search of titles and abstracts was made of the following journals: *Transgender Health*, *International Journal of Transgenderism*, *The Lancet HIV*, *HIV & AIDS Review*, *Culture, Health & Sexuality*, and *Journal of HIV/AIDS & Social Services*. This yielded two additional articles included in the final review (Boyce et al., 2012; Okanlawon, Adebawale, & Titilayo, 2013). These journals were selected by visual inspection of the journals accessible via the University of Queensland library, and by searching the reference lists of relevant articles and reviews. Grey literature such as government reports, case reports, case series, reviews, editorials, and opinion pieces were excluded, although reviewed for background and inclusion in the discussion.

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### *Inclusion criteria*

Results were imported into a bibliographic management system software program, Endnote ("Endnote X8," 2013). Inclusion criteria for the review were as follows:

1. Published in a peer reviewed journal
2. Original research journal article
3. Published after 2000
4. Qualitative research methods were employed that collected open-ended participant responses
5. Gender of sex workers specified as male or transgender
6. All or part of sample specified as TMSW
7. Listed details regarding data sampling techniques
8. Participants discuss barriers to accessing sexual health services experienced whilst undertaking sex work

And/or:

9. Authors discuss barriers to accessing sexual health services in their findings and/or discussion

For the purposes of this review, a sex worker was defined as a person *'who receives money or goods in exchange for sexual services, and who consciously defines those activities as income generating even if they do not consider sex work as their occupation'* (Overs, 2002). Participants also needed to be describing access barriers experienced concurrently with active sex work. One paper was excluded on this basis, as they stated only whether the MSM participants had 'ever sold sex' (King et al., 2013). The final two criteria were selected in order to restrict the review to papers with findings that directly addressed barriers to accessing sexual health services, and to capture the interpretations of both the participants and the researchers. These are often referred to as first and second order constructs within qualitative meta-analyses (Toye et al., 2014). The stated objectives of some papers focus on HIV exposure risk, however the selected authors also identified the implications of their findings for TMSW ability to access sexual health services. There is a much wider body of research regarding other factors associated with this group, such as substance use, mental health, and stigma more generally. Whilst syndemic theory has established the link between these factors and health care access (Biello et al., 2014; Brennan et al., 2012; Singer, Bulled, Ostrach, & Mendenhall, 2017), these ancillary studies were excluded when neither the participants nor the author identified that link in the final paper. Studies were also selected based on whether there was sufficient methodological detail given to evaluate their rigor and potential validity.



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The original search identified 1282 articles of which 388 were found to relate directly to TMSW. After applying the inclusion criteria, seventeen qualitative articles reporting findings from sixteen studies were selected for review. Two papers extracted from the same research study by Underhill et al (Underhill et al., 2015) were reviewed and both included as they addressed two different elements of service access: perceived discrimination and medical distrust, and past experiences of HIV testing as it influenced PrEP implementation (Underhill et al., 2014).

### *Study characteristics and methodology*

The most common location for the selected studies was North America (n = 6) followed by Africa (n = 5), Asia (n = 3), South America (n = 3), the Middle East (n = 1) and Europe (n = 1). The studies were published between 2009 and 2017. Sample size ranged from a MSW discussion group of four (Jones et al., 2009) to interviews with 68 TSW (Ganju & Saggurti, 2017). Only three papers did not use in-depth or semi-structured interviewing techniques, focusing instead on focus group discussions (Jones et al., 2009; Samudzi & Mannell, 2016; Xavier et al., 2013). Three papers used both in-depth interviews and focus groups (Scorgie et al., 2013; Sevelius, Deutsch, et al., 2016; Underhill et al., 2014). Another three papers used both qualitative and quantitative measurement tools (Giguere et al., 2016; Mimiaga et al., 2013; Reisner et al., 2008). Two papers also employed ethnographic fieldwork (Castaneda, 2013; Infante et al., 2009). Thirteen papers in this sample used traditional thematic analysis (76%), with the remaining methodologies ascribing to framework analysis (Barmania & Aljunid, 2016), cross-case analysis (Boyce et al., 2012) descriptive content analysis (Mimiaga et al., 2013), grounded theory approach (Reisner et al., 2008), and concept analysis (Sevelius, Deutsch, et al., 2016).

### *Study quality assessment*

The basic details and quality scores of the sample are collected in Table 18. Two authors independently reviewed the final sample and assigned quality scores using the standardised 14 item quality appraisal checklist developed by the National Institute for Health and Care Excellence (NICE) (National Institute for Health and Care Excellence (NICE), 2012). One of three quality scores could be applied: (++) indicates nearly all of the NICE checklist criteria have been fulfilled; (+) indicates some of the NICE checklist criteria have been fulfilled; (-) indicates very few or none of the criteria have been fulfilled. The purpose of this review was to appraise the methodological rigor of the sample, and whether findings are interpreted through a consistent theoretical lens that produces analysis congruent with the data (Noyes et al., 2013). This framework was selected due to its utilisation in multiple reviews of similarly marginalised populations (Theo Lorenc et al., 2011; Lui et al., 2017). Where there was

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discrepancy between ratings, these were resolved through critical discussion with a third author. This review did not influence whether studies were included in the review.

A secondary review was then made, in the context of best practice in the field of sex worker research, assessing the degree to which the sample adhered to best practice standards of

**Table 18.** Descriptive details and quality NICE score of qualitative papers on barriers to accessing sexual health services for TMSW\*

<i>Author/year</i>	<i>Country</i>	<i>Data collection &amp; analysis</i>	<i>Aims of Study</i>	<i>Sample</i>	<i>PAR Quality Score</i>	<i>NICE Quality Score</i>
Aunon. et al. 2015	Lebanon	Semi-structured interviews  Thematic analysis	Explore factors influencing sexual risk behaviours and HIV testing among MSW	MSW employed in bathhouse ( <i>n</i> = 9), majority self-identified as heterosexual or bisexual  Male escorts ( <i>n</i> = 7), majority self-identified as homosexual	–	+
Barmania & Aljunid. 2016	Malaysia	Semi-structured in-depth interviews  Framework analysis	Critically analyse how perceptions of Islam affect HIV prevention policy	Religious leaders ( <i>n</i> = 11)  Ministry of Health officials ( <i>n</i> = 5)  PLWHIV ( <i>n</i> = 19), unspecified number of MSW & TSW	–	++
Boyce, et al. 2012	Guatemala	Semi-structured in-depth interviews	Identify barriers to accessing sexual health services among MSM and MTF transgender persons	Gay/bisexual identifying MSM ( <i>n</i> = 16, 1 sex worker)  Non-gay identifying MSM ( <i>n</i> = 5, 3 sex workers)  MTF Transgender ( <i>n</i> = 8, 4 sex workers)	–	+
Castaneda. 2014	Germany	Ethnographic fieldwork  Semi-structured interviews  Thematic analysis	Discuss health issues faced by migrant MSW  Analysis of increase in migrant SMSW as response to economic opportunities	Physicians, social workers, health department staff, MSW ( <i>n</i> = 46)	–	+
Chakrapani, et al. 2007	India	Semi-structured interviews	Explore the lived experiences of stigma and discrimination among HIV-positive and high-risk kothi-identified MSM, and ramifications for HIV prevention	Total ( <i>n</i> = 18)  TMSW ( <i>n</i> = 9)  Study 1: ( <i>n</i> = 10) HIV positive kothi-identified MSM & three key informants  Study 2: ( <i>n</i> = 8) high risk kothi-identified MSM of unknown HIV serostatus	+	+

Chakrapani, et al. 2011	India	Focus groups Semi-structured interviews	Identify and understand barriers faced by kothi and aravanis in accessing free ART at government treatment centres	Total ( <i>n</i> = 34) Kothi-identified MSM ( <i>n</i> = 17) Aranvani (transgender women) ( <i>n</i> = 17) Engaged in sex work ( <i>n</i> = 11)	–	+
Ganju & Saggurti, 2017	India	Semi-structured interviews Thematic analysis	Describing TSW experiences of stigma and violence, and exploring coping responses	MTF TSW ( <i>n</i> = 68)	++	++
Giguere, et al. 2016	Puerto Rico	Semi-structured interviews Quantitative survey Thematic analysis	Studying acceptability of three methods of HIV-prevention that sex workers can control	MSW ( <i>n</i> = 4) MTF TSW ( <i>n</i> = 6) FSW ( <i>n</i> = 2)	–	–
Infante, et al. 2009	Mexico	Fieldwork observation In-depth interviews Thematic analysis	Provide an account of the social context in which MSW and TSW sex workers live	MSW ( <i>n</i> = 23) TSW ( <i>n</i> = 13)	–	++
Jones, et al. 2009	U.S.A.	Semi-structured focus group Thematic analysis	Explores experiences of African American MSM involved in commercial sex trade, and gain insight regarding accessing outreach services	MSW ( <i>n</i> = 4) 3 identifying as gay/bisexual	–	+
Mimiaga, et al. 2013	Vietnam	Semi-structured interviews Quantitative surveys Descriptive content analysis	Investigate transactional sex among MSM as risk factor for HIV transmission	MSM engaging in transactional sex ( <i>n</i> = 23) Straight-identified ( <i>n</i> = 7) Bisexual-identified ( <i>n</i> = 7) Gay-identified ( <i>n</i> = 7) Other-identified ( <i>n</i> = 1)	–	–
Okal, et al. 2009	Kenya	Structured interviews In-depth interviews	Exploring social and behavioural determinants of sexual risks among men who sell sex to men	MSW ( <i>n</i> = 36)	–	+

		Thematic analysis				
Okanlawon, et al. 2013	Nigeria	In-depth interviews	To understand issues affecting MSW in Nigeria with the intention of reducing their vulnerability	MSW ( <i>n</i> = 4) TSW ( <i>n</i> = 2)	–	+
Reisner, et al. 2009	U.S.A.	Semi-structured interviews Quantitative assessment Grounded theory approach	Increase knowledge on how to reduce HIV and STI risk among MSW	MSW ( <i>n</i> = 32) 18 gay-identified	–	+
Restar, et al. 2017	Kenya	In-depth interviews Thematic analysis	Address the inaccessibility / underutilisation of PrEP and PEP by MSW & FSW	FSW ( <i>n</i> = 21) MSW ( <i>n</i> = 23)	–	+
Reza-Paul, et al. 2017	India	Ethnographic field notes Qualitative interviews Programme data / community-based monitoring system	Case study description of sex worker-led structural intervention addressing violence as a HIV prevention response	2006 research: 12 community researchers each interviewed 5-6 MSW  2008 research: FSW ( <i>n</i> = 20) MSW ( <i>n</i> = 14) Key informants ( <i>n</i> = 12)  2 focus group discussions with FSW and MSW - number not specified	++	+
Samudzi & Mannell, 2016	South Africa	Semi-structured focus groups Thematic network analysis	Explore experiences of MSW and TSW and what their gender identities bring to understandings of stigma and exclusion	MSW ( <i>n</i> = 6) MTF TSW ( <i>n</i> = 15)	–	++
Scorgie, et al. 2013	South Africa, Kenya, Zimbabwe, Uganda	In-depth interviews Focus group discussion Thematic analysis	Understand barriers to accessing care for sex workers	FSW ( <i>n</i> = 106) MSW ( <i>n</i> = 26) TSW ( <i>n</i> = 4)	–	–
Sevelius, et al. 2016	U.S.A.	In-depth interviews	Examining PrEP acceptability among transgender women	Transgender women ( <i>n</i> = 30)	–	++

		Focus group discussion Concept analysis		Unspecified number with history of sex work		
Underhill, et al. 2015	U.S.A.	Semi-structured interviews Thematic analysis	Exploring experiences of perceived discrimination, medical mistrust, and behaviour disclosure among MSW compared to other MSM	MSM ( <i>n</i> = 25) MSW ( <i>n</i> = 31) Gay/homosexual ( <i>n</i> = 4)	–	++
Underhill, et al. 2014	U.S.A.	Semi-structured interviews Focus group discussion Thematic analysis	Investigating men's healthcare and HIV testing experiences to inform PrEP implementation	Mostly gay ( <i>n</i> = 2) Bisexual ( <i>n</i> = 13) Mostly straight ( <i>n</i> = 6) Straight/heterosexual ( <i>n</i> = 4) Other ( <i>n</i> = 1) Did not know ( <i>n</i> = 1)	–	+
Xavier, et al. 2013	U.S.A.	Focus group discussion Thematic analysis	Identify factors associated with greater risk of HIV infection and the principal social determinants of health status among transgender people in Virginia.	Male-to-Female Transgender ( <i>n</i> = 32) Female-to-Male Transgender ( <i>n</i> = 15) Unspecified number with history of sex work	+	++

\*In this table MSW and FSW refer to cisgender male and female sex workers. In cases where TSW is used in isolation, the gender of the transgender sex workers was not specified. In cases where sexual orientation is not included, it was not reported in the original study

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CBPR (Baum et al., 2006; Jeffreys, 2010; Whyte, 1991). Community-based participatory research is a versatile and reliable research methodology that addresses many of the ethical challenges encountered when studying socially excluded populations such as sex workers (Abel et al., 2010). There is no established standard for assessing the degree of participation and collaboration engaged in by sex worker research projects. Therefore the following criteria were developed with reference to related publications by the Scarlet Alliance, the national peak sex worker organisation in Australia, government guidelines (Department of Families, 2012), and other seminal writings on sex worker research methods (Shaver, 2005), and CBPR (Baum et al., 2006).

Community-based participatory research (CBPR) with sex workers quality criteria:

1. Researchers recognise that sex work is an occupation (Metzenrath, 1998).
2. Researchers explicitly attempt to use participant-centred, harm-reduction, and strengths based approaches (Shaver, 2005).
3. Consideration is explicitly given to the positionality of researchers that are not members of the subject community, and how normative identities can also influence the structure and direction of research (Galupo, 2017).
4. Theories are clearly articulated with regards to gender, sexuality, and sex worker agency, and how these inform methodological choices is explained (Singh et al., 2013).
5. Research is conducted with adequate planning for resources and infrastructure to ensure sufficient reimbursement / compensation for participants and consultants.
6. Research is conducted with a shared leadership structure that promotes participatory decision making, and the development of a shared vision between professional researchers, peer researchers, and non-researcher community members (Israel, Lantz, et al., 2005).
7. Research addresses priorities identified by sex workers (Jeffreys, 2010).
8. Sex worker representatives connected to peak-body peer-sex-worker organisations are demonstrably involved during the design of research, data collection, data analysis, and editing and dissemination of final report (Jeffreys, 2010; van der Meulen, 2011).
9. Researchers ensure sufficient familiarity with the diversity of the community being researched to avoid exclusion of minority / hard to access populations.

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10. Effort is made to reduce the power differential between researcher and the researched (Baum et al., 2006).
  11. Researchers provide sufficient transparency in research process to verify the absence of bias or pre-existing sex work narratives (Ostergren, 2003).
  12. Consideration is given to potential misuse or misinterpretation of research results by media, government, policy makers, or anti-sex work campaigners (Jeffreys, 2010).
  13. The research is oriented towards working in partnership with communities, sex workers and sex work organisations in a manner that leads to action for positive change (Baum et al., 2006).

Quality scores (++, +, or -) were developed to mirror the NICE Guidelines system. This set of criteria were also reviewed and endorsed by a steering committee of sex worker representatives from Queensland, Australia, who were also advising on other research projects related to sex work at the University of Queensland.

#### *Data extraction*

The initial stage of data extraction included inputting descriptive details of the selected studies into a standardized data extraction tool. These details included the authors, year of publication, aims of the study, country the study was conducted, sample characteristics, method of data collection and analysis, and limitations. This extraction tool was developed with reference to the NICE quality appraisal checklist and the relevancy, appropriate, transparency, and soundness (RATS) review guidelines (Clark, 2003). The second stage was to extract findings and conclusions relevant to the research question, identifying first order constructs within participant quotes, and second order constructs in the author's discussions (Toye et al., 2014). Care was taken to avoid additional interpretation of participant responses and author conclusions beyond what was evident in the original text. The extracted data was then reviewed by another independent reviewer to improve accuracy, consistency, and reliability. Disparities were resolved in discussion with a third reviewer.

#### *Data synthesis*

The findings examined in this review were primarily in the form of thematic surveys, or descriptive summaries of the data. Therefore a 'qualitative meta-summary' approach was utilised as the most appropriate (Sandelowski, Barroso, & Voils, 2007). This approach grouped the findings into themes that were discernible across studies, and independently identifiable. The results and discussion sections of each study were read multiple times to





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identify mentions or discussion of barriers to service access for TMSW. Some studies meeting inclusion criteria also included data from cis-gendered FSW. Care was taken to exclude these responses from the data extracted for analysis. In cases where the gender of the respondent was not specified, the data was left out. After this coding process, the results were entered into a table to assess the prevalence of each identified barrier. In cases where very few papers identified a certain barrier, this was incorporated under another heading where appropriate. For example only one paper studied MSW in a brothel, and they identified concerns over losing their employment if they tested positive for HIV (Castaneda, 2013). As this was the only example of employment concerns as a barrier, this was included under '*Concerns Regarding HIV Diagnosis.*' These groupings included when the participants reported having directly experienced the barrier, or only perceived it to be a barrier for TMSW as a group.


## Appendix 2: Study recruitment and promotion postcard

**Earn yourself \$100 bucks by  
answering some questions**



 **THE UNIVERSITY  
OF QUEENSLAND**  
AUSTRALIA

 **HIV**  
FOUNDATION  
QUEENSLAND

 **Respect  
Inc**


**Calling All Transgender Sex Workers  
And Male Sex Workers**

**Respect Inc. is conducting a research project with the  
University of Queensland and supported by the HIV Foundation.  
We want to know what transgender and male sex workers feel about  
about sex work, HIV testing, PrEP and sexual health services.**

**If you are a Queensland based transgender sex worker or a male sex  
worker we need your opinion - and you get paid for it too!**

**For more information  
please contact Joe**

Phone - 07 3835 1111  
Mobile - 0424657064  
Email - [Joe@respectqld.org.au](mailto:Joe@respectqld.org.au)



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### Appendix 3: Participant interview demographic survey and question guide

1. How old are you? _____years	2. Country of birth: _____
3. Ethnic background: _____	4. Primary language spoken at home
5. What is your gender and/or sex? <i>(You can choose more than one)</i> a) Male b) Female c) Intersex d) Cis man e) Cis woman f) Transgender woman g) Transgender man h) Sister girl, i) Brother boy j) Gender queer/gender-diverse/non-binary k) I prefer not to say l) I identify as ____	6. Do you think of yourself as: <i>(You can choose more than one)</i> a) Gay b) Lesbian c) Bisexual d) Queer e) Asexual f) Heterosexual/Straight g) Not sure yet h) I refer to myself as ____
7. Are you Aboriginal and/or Torres Strait Islander? a) No b) Yes, Aboriginal c) Yes, Torres Strait Islander d) Yes, Aboriginal and Torres Strait Islander	8. What is your highest level of education completed? a) Up to Year 10 b) Year 11 c) Year 12 d) TAFE / Trade certificate/diploma e) University degree f) Prefer not to say g) Other:_____

<p>9. Is your primary source of income from sex work?</p> <p>a) Yes</p> <p>b) No</p> <p>c) If no what are your other sources of income (optional) _____</p>	<p>10. Current relationship status.</p> <p>a) In a relationship/s</p> <p>b) Single</p>
<p>11. Which best describes your housing situation?</p> <p>a) Own</p> <p>b) Rent, pays in full</p> <p>c) Rent, shared house</p> <p>d) Homeless</p> <p>e) Subsidised Housing</p> <p>f) Live with family/friend (rent free)</p> <p>g) Trade sex for accommodation</p> <p>h) Other: _____</p>	<p>12. What colour is your Medicare card?</p> <p>a) Green (Australian Residents)</p> <p>b) Blue (Interim card)</p> <p>c) Yellow (Reciprocal Health Care Agreement visitors)</p> <p>d) I don't have a Medicare card</p> <p>e) Other: _____</p>
<p>13. Which best describes your residency and visa status?</p> <p>a) Permanent residents or citizen</p> <p>b) Student visa</p> <p>c) Working visa</p> <p>d) Working holiday visa</p> <p>e) Partner or marriage visa</p> <p>f) Special category visa (eg. From New Zealand)</p> <p>g) No current visa</p> <p>h) I would rather not say</p>	<p>14. How many years of experience do you have as a sex worker?</p> <p>a) Less than 1 year</p> <p>b) 1 to 5 years</p> <p>c) More than 5 years</p>
<p>15. Do you still do sex work?</p> <p>a) Yes</p> <p>b) No</p>	<p>16. What type of sex work do you do now and or have you done in the past? (Can chose more than one)</p> <p>a) Private by myself</p> <p>b) Private / with other sex worker(s)</p> <p>c) Licensed brothel</p> <p>d) Unlicensed brothel / agency</p> <p>e) Street Base, bars etc.</p> <p>f) Casual / opportunistic</p> <p>g) Other: _____</p>

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## Interview guide

- 1) Tell me about your sex work experience?
- 2) What do you like about sex work?
  - Money, Flexibility
  - Self esteem
  - Travel
  - New people and place
- 3) What don't you like about sex work?
  - Can you describe what sort of risks, dangers or concerns you think you have doing sex work?
    - i) What impact do you think doing sex work will have on your housing situation
    - ii) What do you think the economic risks could be?
    - iii) Not enough income to support needs?
    - iv) Law/police/immigration?
    - v) What about physical health?
    - vi) What about sexual health?
    - vii) What about mental health
    - viii) What about emotional health?
- 4) Where or how do you get your support?
  - Services/organisations
  - People
  - Peer educators (sex worker organisations like Respect; other peer orgs, does peer educators tell you about STIs information?)
  - Any other services that you are aware of but might not use
- 5) What do you do in regards to sexual health checks?
  - When do you go
    - i) Go when condom breaks?
    - ii) Go when you found some symptoms on your body?
  - Do you use internet to check your symptoms before you see the doctor?
  - Where do you normally go? Why do you choose this doctor/service?
  - Do you go to your normal GP or a sexual health clinic? Why/Why not?
  - Does your GP/Sexual Health doctor know you are doing sex work? What is your doctor's attitude to you doing sex work?
  - Describe any experiences you have had with your doctor/GP in regards to sex work and sexual health?
    - i) Negative, positive, financial, not enough sexual health Dr who bulk bills, transport, time, privacy
    - ii) gender
  - Do you know about sexual certificates?
    - i) If yes. Do you know you don't have to put your real name on them
  - What kinds of tests have you had for HIV & STIs?
  - What is your preferred method for testing?

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- 6) Have you ever had a positive result?
- If yes, how was that for you?
  - If yes, what sort of treatment and support did you seek if any?
  - If no, how does that affect your future testing and use of protection?
- 7) What do you know about Rapid HIV testing?
- What do you think of it?
  - Have you ever tried? Will you give it a try?
  - Would you like to see more of rapid test in different STIs?
- 8) What do you know about PrEP (Pre Exposure Prophylaxis)? [If they have not heard of PrEP explain what it is; Truvada is the drug brand]
- What do you think of PrEP
  - What do you think about using PrEP as advertising point?
  - Have you ever tried prep?
  - Will you give PrEP a try?
  - Do you have any concerns about using PrEP
  - Tell me how you it has influenced your sex work and sex in private life
  - What do you know about PEP (Post Exposure Prophylaxis)?
- 9) What do you know or think about social stigma (pressures, judgements) towards sex work and sex workers?
- How does stigma affect you accessing health services
    - i) Sexual health, mental health, etc.
  - How does stigma affect how much you can discuss your needs with your friends, family, and community?
- 10) What do you suggest could improve health and well-being for sex workers in QLD?
- Law, Decriminalisation
  - Sex worker community
  - Health services
- 11) Is there anything else you would like to discuss?
- What about positive things? (if there isn't one in the respond)

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## Appendix 4: Participant information sheets

### Participant Information Sheet Interviews

<b>Title</b>	<b>Factors influencing trans and male sex worker access to sexual health care, HIV testing and support</b>
<b>Short Title</b>	T & M Study
<b>Protocol Number</b>	UQHREC Approval Number: 2016001287
<b>Project Funder</b>	The HIV Foundation of Queensland
<b>Coordinating Principal Investigator (CPI)</b>	<b>Dr Lisa Fitzgerald</b> The University of Queensland (UQ)
<b>Principal Investigator (PI)</b>	<b>Ms Candi Forrest</b> Respect Inc
<b>Associate Investigator(s)</b>	<b>Dr Judith Dean</b> The University of Queensland <b>Ms Annie Mundy</b> Respect Inc <b>Mx Dee-Amela Conti</b> Respect Inc

#### Part 1 What is the Study?

Researchers from the *University of Queensland*, in partnership with *Respect Inc* are undertaking an exciting qualitative research project aimed at the experiences of trans and male sex workers in Queensland to understand personal, social, and structural factors influencing their sexual health and wellbeing including access to sexual health care provision and support.

#### What is the purpose of this study?

The findings of the study will help inform the ongoing service provision, existing and future sex worker policy and legislation and Respect Inc strategic planning.

#### Who is finding this study

This study is being funded by the HIV Foundation of Queensland

#### Part 2 What does my participation involve?

##### Introduction

You are being invited to take part in an interview to share your experiences and thoughts about the personal, social and structural factors influencing your sexual health and wellbeing. The Interviews will also elicit information about your experiences accessing sexual health care and support, HIV testing practices, movement to/within the sex industry, health and legal literacy, and forms of social support.

This Participant Information Sheet tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or local health worker.

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Participation in this research is voluntary. There is no obligation to take part in the study. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described
- Consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

### **What does participation in this research involve?**

The interview will take approximately 1 to 2 hours and will be conducted by a trained peer researcher, in a location of your choice.

During the interview, you will be asked questions about your experiences and opinions - there are no correct answers to the questions we will ask and you are free to answer or not. You can choose to not answer any question. The peer researchers and the study team have no legal obligation of disclosure regarding any information you provide.

As part of the interview you will be asked to complete a brief written survey recording details such as your age, gender, and education level. This information will be de-identified to ensure confidentiality and only used to broadly describe the profile of people participating in the study.

The interviews will be digitally recorded with your consent so we can accurately capture what you are say. Any identifiable information recorded during the interview will be altered to ensure confidentiality.

However, you do have the option of not giving your consent for the interview to be recorded or withdraw from the interview if you do not want your comments to be recorded. Signing the consent form tells us you have read this form and understand that you have the option to consent or not consent for the interview to be recorded.

### **What will happen to the information collected?**

The digital recording will be transcribed by experienced transcribers from a transcription company who have undergone training on the ethical issues associated with the project and has an ongoing contractual relationship with the UQ CPI on a range of research projects being undertaken. The transcribers will sign a confidentiality agreement before commencing transcribing.

Any identifiable information digitally recorded during the focus group will be altered to ensure confidentiality. The only identifiable information will be on the consent form and it will be stored separately and securely in a locked cabinet in a locked facility to which only the CPI has access.



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If you withdraw from the interview the digital recording of the interview will be deleted in full at the time you withdraw from the study. No information collected from you will be included in the data transcription, analysis or in any study output.

### **Thank-you for your time**

You will receive a \$100.00 visa gift card (or cash) immediately following the interview as a token of appreciation for your time.

You will be required to sign a record of receipt for accounting purposes and study records. Like other data collected during this study this form will be stored separately and securely in a locked cabinet in a locked facility to which only the Principal Investigator has access.

### **Do I have to take part in this research?**

Participation in the study is entirely voluntary. There is no obligation to take part in the study.

### **Can I withdraw from the study?**

You can discontinue your participation any time without comment or penalty.

If you do withdraw from the interview any reference to or comments made by you will not be included in the data analysis or any study output. Withdrawing from the study will not in any way affect the services you currently receive from Respect Inc or other medical or service providers, or which you may receive in the future.

### **What are the possible benefits of taking part?**

Your involvement in this study will provide valuable information for understanding but may not be of any immediate direct benefit to you.

Your answers will not in any way affect the services you currently receive from Respect Inc or other medical or service providers, or which you may receive in the future.

### **What are the possible risks of participating?**

Generally, the risks of participating in a study are required to be explained before any consent can be obtained from you regarding participation. The primary risk involved in participating in this study is related to the confidentiality of the information provided. The handling of this information is discussed below in the section entitled "Statement of Privacy".

The risks inherent in this study design are minimal. The main risk is the potential for participants to mention the content of discussion to people outside the group. We will ask you and the other participants to use only 'working' first names during the discussion and not to tell anyone outside the group what any particular person said.

Additionally, discussion of topics in the interview has a small potential to raise unpleasant memories for some individuals. This may include previous negative episodes or particular points in your sex work history. Care will be taken to ensure you are able to share your experience in a safe and comfortable environment.

## **Part 3 What will be the outcome of this study?**

### **What will be the outcome of this study?**

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The findings of the study will help inform the ongoing service provision, existing and future sex worker policy and legislation and Respect Inc strategic planning.

Your involvement in this study will provide valuable information for understanding but may not be of any immediate direct benefit to you. Your answers will not in any way affect the services you currently receive from medical or service providers, or which you may receive in the future.

**How will the results from this study be returned to participants?**

Outcomes from this study will include a report to inform ongoing service provision, existing and future sex worker policy and legislation and Respect Inc strategic planning. We will also produce peer publications that advance our understanding of transgender and male in Australia and internationally.

Targeted dissemination of study findings to Respect Inc Management Committee, employees and volunteers, sex workers, services providers and policy bodies, such as the HIV Foundation, Queensland, will be tailored to the specific groups' responsibilities, needs, and priorities within a policy, HIV education, promotion, and service provision context will be undertaken.

Respect Inc will provide copies of the final study report to interested participants and other members of the sex work community. Further, information in the report will be used to present at annual sex work community forums, such as the Respect Round Table and the Scarlet Alliance National Forum. Non-participant sex workers will also be able to obtain feedback on the research via Respect Inc Newsletter and social media and presentations given at annual community forums.

**What happens if I feel upset during or after taking part in this study?**

If you suffer any distress or psychological injury as a result of this research project, you should contact the research team as soon as possible.

As part of the study information pack you will be provided with a copy of Respect Inc. Service Brochure and Peer Support Booklet which are also available on-line in a range of languages. You will also be given a list of appropriate local services which you can contact for support. This list has been compiled by the study team in consultation with Respect Inc.

The researchers will also be able to assist with arranging appropriate treatment and support.

**Statement of Privacy**

Consent forms will be stored securely at the *School of Public Health, The University of Queensland, Brisbane*, and will be accessible only to the Principal Investigator, Dr Lisa Fitzgerald. Any reports or articles published from this study will only include de-identified data and no personal information will be disclosed. You may nominate a pseudonym, such as your working name, or another name, for use throughout the research on the consent form. If any personal data is collected it will be used for the purpose of this study and no other, without your expressed permission.

**For more information or to express interest in volunteering to join the study please contact:**

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**Co-ordinating Principal Investigator #1:**

Dr Lisa Fitzgerald  
Lecturer  
School of Public Health  
The University of Queensland  
288 Herston Rd  
HERSTON QLD 4006  
E: l.fitzgerald@sph.uq.edu.au  
P: 07 3346 5244

**Principal Investigator #2:**

Ms Candi Forrest  
Treasurer  
Respect Inc.  
28 Mein Street  
SPRING HILL QLD 4000  
E: candi@respectqld.org.au  
P: 07 3835 1111

**Co-Investigator**

Dr Judith Dean  
Post-Doctoral Research Fellow  
School of Public Health  
The University of Queensland  
288 Herston Road  
HERSTON QLD 4006  
E: j.dean4@uq.edu.au  
P: 07 3346 4876

**What happens if I have a query re the study or a complaint?**

This study adheres to the Guidelines of the ethical review process of The University of Queensland. Whilst you are free to discuss your participation in this study with project staff (contactable on the phone numbers above), if you would like to speak to an officer of the University not involved in the study, you may contact the Ethics Officer of the University of Queensland Human Research Ethics Committee. If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in you can Ethics Officer of the University of Queensland Human Research Ethics Committee directly on:

**Ethics Committee Contacts:**

The Ethics Officer  
Research & Training Division  
Cumbrae-Stewart Building  
University of Queensland, St Lucia, 4072, AUSTRALIA  
Phone: 0061 7 3365 3924



Public Health Building  
Herston Road, Herston  
Brisbane QLD 4006  
Telephone: +61 7 3365 5541  
Facsimile: +61 7 3365 5442  
Email: [l.fitzgerald@uq.edu.au](mailto:l.fitzgerald@uq.edu.au)

## Consent Form Interviews

<b>Title</b>	<b>Factors influencing trans and male sex worker access to sexual health care, HIV testing and support</b>
<b>Short Title</b>	T & M Study
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<b>Coordinating Principal Investigator (CPI)</b>	<b>Dr Lisa Fitzgerald</b> The University of Queensland (UQ)
<b>Principal Investigator (PI)</b>	<b>Ms Candi Forrest</b> Respect Inc
<b>Associate Investigator(s)</b>	<b>Dr Judith Dean</b> The University of Queensland <b>Ms Annie Mundy</b> Respect Inc <b>Mx Dee-Amela Conti</b> Respect Inc

### Declaration by Participant

- I have read the Participant Information Sheet or someone has read it to me in a language that I understand.
- I have had explained to me the aims of this research project, how it will be conducted and my role in the research.
- I understand the purposes, procedures and risks of the research described in the project.
- I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future care.
- I understand that I will be given a signed copy of this document to keep.
- I understand that the information I provide will be kept confidential
- There is no obligation to take part in this study and will be used only for this project
- If I choose not to participate there will be no detriment to my future health care or access to Respect Inc services
- The research results will be made available to me as per the information sheet, on my request and any published reports of this study will preserve my anonymity.

I consent for the Focus Group to be digitally recorded YES ☐ NO ☐

Name of Participant (please print) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

### Declaration by Researcher<sup>†</sup>

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher<sup>†</sup> (please print) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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