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SEXUAL HEALTH

Transgender women sex workers' experiences accessing sexual health care in Iran: a qualitative study

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ABSTRACT

Background. This study aimed to examine the experiences of transgender women who work in the sex industry regarding their access to health care facilities for sexual health. Transgender women sex workers are recognised worldwide as a high-risk group for HIV and sexually transmitted infections (STIs). **Methods.** In Iran, between January and May 2022, we employed a snowball sampling technique to recruit a diverse group of 22 transgender women sex workers aged 19–42 years. Semi-structured interviews were conducted with these participants to provide insights into their experiences with accessing sexual health care. **Results.** The data was analysed using thematic analysis, revealing four overarching themes: experiences of violence, contextual barriers to health, socioeconomic challenges and HIV/STI risk practices, and 11 sub-themes. The results demonstrate that many participants experienced difficulties in accessing sexual health services due to violence, discrimination, financial difficulties and lack of awareness about STIs. **Conclusion.** Sex workers face extraordinarily challenging occupational risks, including sexual and physical abuse, mental health issues, and HIV and STIs. Targeted public intervention programs and research for this group are urgently needed. Outreach programs engaging with underserved transgender women sex workers have the potential to enhance access to healthcare services, and contribute to the reduction of HIV transmission rates.

Keywords: discrimination, HIV prevention, public health, sex workers, sexually transmitted infections, stigma, transgender women, qualitative.

Introduction

Sex work refers to the exchange of sexual services for monetary compensation or goods.[1] Comprehensive sexual health (SH) is important for sex workers, but unfortunately, transgender sex workers receive inadequate attention and recognition in Iran.[1,2] Transgender is an umbrella term used to describe individuals whose gender identity differs from the sex they were assigned at birth. 'Transgender women' refers to those individuals whose gender identity is women, but who were assigned as male at birth.[3] Globally >19.1% of transgender women are living with HIV. In addition, the risk of HIV infection is 49-fold higher among transgender women compared with the general population.[4] The prevalence of HIV among Iranian transgender women is 1.9%.[5]

Transgender individuals have diverse SH needs. Among them, transgender women sex workers (TWSWs) face significant obstacles in accessing SH services and enjoying their rights.[6] These challenges stem from biases, stigmatisation, and discrimination present within various societal systems and institutions, including politics, economics, social structures, education and health care. These factors are especially exacerbated in low- and middle-income countries where sex work is not legal.[7] Criminalisation of sex work in various forms remains widespread across most global settings and is linked to negative outcomes, including HIV and sexually transmitted infections (STIs) transmission, and increased rates of violence and mortality among sex workers.[8] Studies demonstrate that transgender sex workers are at a 2- to 3-times higher risk of physical and sexual violence

compared with other individuals.[9] Due to their profession, TWSWs are exposed to higher risks of contracting diseases, such as STIs and HIV, but also other health issues, such as intense stress, alcohol and drug use, and urogenital problems.[10] Condom use among Iranian transgender women is low.[5] The reasons reported for lack of condom use included trust in their intimate partners and opposition to condom use from paying clients.[5,11] Other studies have also documented insufficient awareness about STIs, limited bargaining power and customer preferences as factors for why TWSWs do not consistently use condoms during sexual encounters.[12] Multiple sexual partners with unknown HIV status, vast diverse sexual relations, and condomless receptive anal sex increases the risk of STIs and HIV.[5] Furthermore, the practice of chemsex, which involves the use of drugs before or during planned sexual events to enhance and prolong the experience, poses additional risks. Excessive alcohol consumption combined with sexual activity is also recognised as a risk factor for engaging in unprotected sex.[13,14]

Sex work is criminalised in Iran and punishable by imprisonment or monetary fine.[15] Access to health services is critically challenging for TWSWs, particularly in criminalised settings, and TWSWs report mistreatment and discrimination in the health sector.[16] Due to the fear of judgement and mistreatment, TWSWs often conceal their involvement in sex work and are less inclined to seek healthcare services.[17] Denying healthcare services to TWSWs constitutes a violation of their fundamental human rights, as it hinders their access to health care, and infringes upon their rights to equality and non-discrimination.[16] Additionally, research has demonstrated that by reducing the barriers faced by TWSWs when accessing health care, HIV incidence rates among their clients and the broader population can be effectively decreased.[17]

To our knowledge, no study has focused on TWSWs' experiences accessing SH care in Iran. The purpose of this study was to explore the experiences of TWSWs in Iran in accessing health care facilities for sexual needs. A qualitative approach is taken here, because such outcomes have received little attention in the TWSWs' literature and, to the best of our knowledge, few to no measures exist that can help us quantify the long-term benefits of SH access in this particular population.

Materials and methods

The study was approved by the Shahroud University of Medical Sciences ethics committee (IR.SHMU.REC.1398.234).

Study design

The present study utilised a qualitative approach to investigate and understand the experience of TWSWs in accessing SH health care facilities. The aim was to identify factors related to access to SH services, and thematic analysis was chosen, as it is inductive and, therefore, useful for exploring topics in which little is known or documented.[18]

Setting, sampling and recruitment

The interviews took place in the Iran Institute of Psychiatry, and the Mahta non-governmental organisation in Tehran, the capital city of Iran, between January to May 2022. This study's research population included 22 TWSWs aged 19–42 years, who were chosen based on the inclusion criteria of the research: to have sex work experience, willingness to participate and ability to respond in Farsi. We employed a snowball sampling strategy. In the beginning, the study participants were referred by a social worker (n = 3), and then a snowball strategy was used to find additional eligible participants. We asked our interviewees to introduce new participants to us, mostly based on our codes and emerged categories identified from the initial interviews. This method has been used to find hidden TWSWs.[19] Participants were invited to read and sign an informed consent form prior to interviews. Interviews were conducted in a quiet and private room to the participants' convenience, coordinated with participants to select these environments, and if she was not satisfied, another place was selected for the interview based on her preference. At the visit time, all issues related to the research ethics were explained to her, and she was informed of the full participation requirements. The researchers explained that no names or addresses of the participants were mentioned at the publication of findings and all their personal information was protected.

Semi-structured one-on-one interviews were conducted face-to-face. Two authors conducted the interviews. Author one is a PhD student with experience conducting qualitative research and interviews. Author two has a PhD, is an assistant professor who is competent for women's studies and has conducted several qualitative studies.

Interview topic guide

The interview guide had three parts: initial open-ended questions, intermediate questions and ending questions. The initial open-ended questions asked about the understanding experiences of the participants, with questions like: 'How do you experience sexual healthcare services provided by public health facilities?', 'Can you talk to me about your experience in accessing sexual health services?', 'Can you explain it?'. The interviewer followed with probing, intermediate questions, such as 'How did you manage the situation?', 'What decision did you make?'. Ending questions, such as, 'Is there something else you think I should know in order to understand [what you have just described to me] better?' were used to conclude the interviews. All interviews lasted between 45 and 60 min. The determination of the sample size was guided by the theoretical saturation criterion, which led to the cessation of data collection once the interview responses became repetitive and no new data were obtained.[20] Participants were given the option to follow up via email if they had additional information they

wanted to relay after the interview. Of the 22 participants, three of them sent follow-up emails.

During the interview, field notes were written, and participants' postures, such as body language, pause and silence, and emotional reactions were recorded (e.g. some participants appeared to be furious about sexually violent experiences).

Data analysis

A model of thematic analysis developed by Braun and Clarke was applied in the current study.[18] After listening several times to each interview, the first author transcribed each interview verbatim. Data analysis started after the transcription of the first interview. Both the first and the second author did the main coding. Initially, interview transcriptions were coded separately, and then codes were compared during regular meetings of the research team. Coding had two phases: initial and focused coding. Initial coding was begun after the first interview. The codes were simple and used a lower level of abstraction. After initial coding, focused coding occurred, identifying codes according to frequency and significance. The codes with higher frequency and higher importance formed the focus codes. In this study, an inductive process gave rise to a series of codes and categories which were subsequently developed into themes and sub-themes. Almost all participants experienced all kinds of acts of violence, so violence became a theme, and various aspects of violence, such as physical, psychological and sexual, were sub-themes.

Result

The demographic information of the participants in the study is presented in Table 1. Four themes and 11 sub-themes are presented in Table 2.

Table 1. Participants' demographic information.

Characteristics	Frequency
Age (years)	
Mean	28
Minimum	19
Maximum	42
Marital status	
Single	12
Married	2
Divorced/widowed	8
Highest education	
Elementary	8
Diploma	6
College	8
Economic status	
Low	11
Average	7
High	4
No. of clients or sexual partners per week	
Mean	4
Maximum	11
Minimum	2
Record of recent use of drugs	
Yes	19
No	3

Table 2. Themes and sub-themes of transgender women sex worker experiences.

Themes	Sub-themes
Violence experiences	Physical violence
	Psychological violence
	Sexual violence
Contextual barriers to health	Discrimination
	Cost
	Providers' knowledge
	Lack of post-surgical care
Socioeconomic difficulties	Financial difficulties
	Lack of social support
HIV/STI risk practices	Condomless sex and risk of HIV and STIs
	Drug use

STIs, sexually transmitted infections.

Violence experiences

Participants commonly reported violent experiences, often related to being a sex worker or transgender. The reported forms of violence included physical, psychological and sexual violence.

Physical violence

Physical violence was one of the most commonly reported forms of violence amongst participants. One participant said, 'When people realise that we are sex workers, they treat us rudely, and sometimes they give us beatings. They know that I'm a trans and I live alone, and my family has rejected me, and I have no one to support me, and no one will hear from me or ask how I am. That is why they allow themselves to do anything they please' (P1). Another participant expressed 'I remember that a client bit my back so hard that I could not sit in a chair for a long time' (P5).

Psychological violence

Participants reported experiences of someone insulting or making fun of them, which led to significant psychological harm. One participant expressed, '. . . I remember one of the sex clients saved my phone number [with the contact

name] as 'an illegitimate bitch" (P8). 'It is very common for people in the street to insult me or call me by the worst demeaning names. Sometimes I feel worthless' (P4).

Sexual violence

Most participants described experiences of sexual violence in their lifetimes, which often started at an early age. One participant said, 'I was raped so many times, by my relatives, sex clients and friends. I think the first time it happened I was 13 years old when one of my classmates raped me' (P7). Another participant explained: 'Sometimes I accepted the invitation of a client to go to his home, but when I went to the house, he forced me to have sex with several people despite my desire' (P12).

Contextual barriers to health

Participants experienced obstacles to accessing SH services. These barriers to health included discrimination, cost, providers' knowledge, and lack of post-surgical care.

Discrimination

Participants reported instances of stigma, discrimination and poor access to SH. 'When providers find that I am trans, they ignore me, and they are reluctant to give me the services' (P9). Another participant reported avoiding health services due to fear about criminalisation: 'I have been bleeding from the stitches for a long time [due to gender-affirming surgery]. I didn't go to the hospital for treatment because I was afraid that the doctors would report me to the police and I would get arrested' (p2).

Cost

Participants who had fully medically affirmed their gender often encountered difficulties in receiving gynaecological care due to inadequate insurance coverage, compelling them to seek services from unlicensed providers. One participant said, 'Some screenings like anal cytology are not covered by insurance and we have to do them in the private sector' (P9). The financial cost attached to gender affirmation and lack of coverage by health services appeared to be the main reason some participants engaged in sex work: 'The costs of treatment and operations, and the supply of medicine are so staggering that sometimes I have to sell sex in order to pay for it, we don't have a specific trans-oriented centre or even any kind of insurance' (P5). As another participant put it: 'The cost of plastic surgeries is very high, we need to earn money to pay for it, and since there is no job for us, we earn it through sex' (P6). Participants also mentioned difficulties such as low quality care, inconvenient geographical locations and long waiting hours. One participant explained, 'So it's about a two-and-a-half-hour drive to the closest place that might have reproductive health care that is competent for trans people' (P7).

Providers' knowledge

The absence of knowledgeable and supportive staff with adequate experience with transgender health represented a significant obstacle to accessing health services. As one participant explained: 'I haven't ever met competent physicians, most of them just think of money and don't bother to care for us' (P13).

Lack of post-surgical care

A lack of post gender-affirming surgery care by competent healthcare providers was also an obstacle to accessing health services. One participant said, 'The doctor who has done my surgeries
[gender-affirming surgery] did not like to visit me after the surgery and I have had trouble with my urinary tract, but he wasn't willing to see me again and treat my problem. So I went to another specialist, but he said he couldn't do anything for me and I should go to my own doctor' (P5).

Socioeconomic difficulties

Participants reported social isolation and lack of acceptance in society, and from their families and friends. With high rates of unemployment, lack of career training and education, and discrimination in employment, many transgender women engage in sex work for survival.[21]

Financial difficulties

Financial challenges posed a major barrier to accessing health care facilities for many participants. Some participants reported losing their jobs upon disclosing their transgender identity, leaving them with limited options and leading them to engage in sex work. One participant said, 'When my employer identified me as trans they fired me. When I begged him for my job, he proposed having sex with each other, so I lost the job' (P11). Some transgender individuals resort to engaging in sex work as a means to meet their daily needs. 'I do not accept prostitution. I don't like to sell myself to others. I am willing to eat nothing at night, but I will not do this. But what can be done, I have no other choice . . . ' (p10).

Lack of social support

Study participants reported receiving little support from their family, friends and other transgender peers. One participant remarked, 'After my family knew that I got into this job, they never wanted to see me, I also lost all my old friends, I'm very alone' (P16).

HIV/STIs risk practices

Engaging in sex work can be associated with high-risk behaviours, such as substance use and condomless sexual practices. Limited knowledge about STIs, inconsistent condom use in diverse sexual relationships, lack of proficiency in using condoms during penetrative sex, as well as substance use, including injection drug use and needle sharing, are key

high-risk factors associated with the transmission of HIV and other STIs.

Condomless sex and risk of HIV and STIs

Participants engage in sex work to earn an income. However, these situations can increase the likelihood of higher risks for HIV, particularly when clients offer more money for condomless sex. One of the participants said, 'The majority of our clients don't like to use condoms or pay less if we wear condoms' (P8). As another participant explained: 'When clients pay you a large amount of money, and want to enjoy their time, the condom talk is meaningless' (P9). The capacity for participants to negotiate condom usage also appeared to be difficult based on social pressure or coercion: 'Once I went to a villa, I had to have an unsafe relationships with several men. I was familiar with; I knew they might have a disease, but I had no choice. If I did not do it, they might kill me, so I did it. After a while, I took a blood test. I realised I was HIV positive' (P20).

Higher rates of STIs are another risk participants face. One participant appeared to hold incorrect beliefs about STI risk with one partner: 'Because I love him, sex with him is safe, and I'm protected from any sexually transmitted diseases' (P18). Another participant had limited knowledge about the risk of STIs transmission: 'I had sex with someone that week, then there was something like a wart on his penis, then he told me no, it's a lump and it's nothing special. I don't know what he said, I was scared that maybe I had caught HIV from him. Does that mean I have to go for a test?' (p10).

Drug use

Participants reported drug use as a mechanism for coping with difficulties, such as depression, low self-esteem, peer pressure and the pressures of sex work, they were facing in their lives. Several of the participants explained that drug use was encouraged by clients: 'Some of our clients use street drugs to feel more pleasure from sex' (P17). Another explained: 'Having sex in parties where you use drugs is usual. In several occasions, I had unprotected sex at parties with total strangers. I did not meet them again; it was only for sex' (P1). Other participants used drugs on their own to manage their mental health challenges: 'I use drugs for relieving my pain and forgetting all the difficulties I face. It depends on the situation, but I usually consume every day, leading to suicidal tendencies' (P9).

Discussion

Participants in this study experienced difficulties in accessing SH services, which were consistent with previous research. The first and most frequent experience in sex work is violence. Sex workers are vulnerable to violence due to their marginalised social status, and this risk is even more pronounced among transgender individuals involved in sex work due to discrimination and transphobia.[3,18,21] Such violence can inflict significant harm and detriment to their health and well-being.[22] For instance, among female sex workers, sexual violence is consistently associated with increased STIs and HIV risk.[23–26] The high levels of violence in Iran can be attributed mainly to the low sociocultural acceptance of transgender people at a societal level. Better legal protection and education through different avenues such as school and social media, would help to improve this acceptance.

TWSWs may be at a higher risk of HIV transmission and they may be unaware of their HIV status, so increasing HIV testing and diagnosis can help to prevent the transmission of the infection to others.[27] One of the reasons for not testing may be the lack of easy access to these tests.[15] HIV testing and counselling should be routinely offered to TWSWs for prevention and early diagnosis. Also, the most frequently diagnosed STIs in TWSWs were chlamydia, syphilis and gonorrhoea. For example, the US Centres for Disease Control and Prevention does not currently suggest STIs screening practices for gender diverse people, but does recommend that health care providers assess STIs-related risks for their transgender patients based on current anatomy and sexual behaviours.[16] There are no guidelines relevant to transgender populations to apply in Iran.

Participants in this study described experiences of physical violence and bodily harm, psychological violence, verbal harm, forced sex, and not using protective and prophylactic devices during sex as some aspects of the violence. For TWSWs living with HIV and experiences of past or current violence, routine screening and management of mental health disorders may optimise health outcomes, and improve antiretroviral therapy adherence.[15,28] In this population, fear of repercussions, such as criminalisation of sex work, prevents reporting sexual violence to health care providers, and the consequence is limited access to health care.[19] Moreover, violence-related fear or stigma may further compromise access to health services. Sex workers in Iran practice in a context in which sex work is both criminalised and socially stigmatised. Health services, including transgender-friendly clinics and organisations promoting safe sex, have a key role to play in providing supportive and non-judgemental SH care to TWSWs, including HIV or STI screening.

This study reveals that discrimination, lack of providers' knowledge and the cost of health services are the most prominent obstacles to accessing comprehensive health. It appears that health care providers' knowledge does not follow recent best practice approaches in gender affirming and HIV care.[22,29] Our findings are similar to other contexts. For example, Ganju and Saggurti found that some transgender sex workers in India faced discrimination in health facilities, including being refused care.[30] Rather than access free government health care facilities, study participants opted for self-medication or paid services to avoid discrimination. According to Samudzi and Mannell, TWSWs in South Africa

are frequently maltreated by governmental health services, discouraging them from seeking assistance.[31] Participants in Underhill *et al.*'s study in the United States who engaged in sex work reported more medical mistrust and health care discrimination due to issues beyond behaviour or identity (i.e. homelessness, substance use, poverty etc.).[32] This context, along with fear of rejection, may reduce TWSWs' access to health services.[19] The knowledge and expertise of health care providers play a crucial role in facilitating access to the healthcare system. However, the absence of knowledgeable and supportive staff with adequate experience represents a significant obstacle to accessing health services.[22]

Stigma and discrimination related to employment and lack of accessible affirming care may increase the likelihood that transgender women engage in sex work for economic survival and gender affirmation. Criminalisation and stigmatisation of sex work and client demands around condomless sex can increase the vulnerability of TWSWs to problems with substance use, and HIV and STIs.[21] Similar to Fan *et al.*'s study, sexualised drug use is associated with a higher risk of condomless sex and, hence, a higher risk of HIV and other STIs.[33] Other research has shown that having a secure job and financial security can reduce the risk of HIV and other STIs.[22] Social exclusion reduces this group's ability to access health services and HIV prevention programs.[28] Studies have also revealed that condomless sex with clients was more likely among TWSWs at low socioeconomic levels, reinforcing that contexts of social disadvantage increasing exposure to HIV risk. Many TWSWs are pressured to engage in condomless sex, especially with clients that pay extra money for condomless sex.[3,19] Participants who reported condomless sex with clients also reported other experiences, such as coercive sex and sexual assault, and condom failure, which are linked to increased risk for HIV and STI transmission.[19] Those TWSWs who reported poor mental health and who use drugs to cope might not be concerned much about practicing safe sex or avoiding possible conflicts through introducing condom use, as previous studies reported. Also, some participants added that their clients asked them to use drugs for more sex enjoyment.[34] Bith-Melander *et al.* expressed that most TWSWs contracted HIV by having condomless sex with clients while under the influence of drugs.[35] Sex work provided the economic means to access gender-affirming care, including hormones, injections and surgeries. This has been observed in other studies, including that a more feminine appearance was reported to increase sex work earning power.[3,15,18,22] We found that transgender women who were involved in sex work were receiving less social support, experienced in the form of family conflict and rejection, and also loss of friendships.[33]

This study aimed to explore the experiences of TWSWs in accessing SH services. The findings of this study highlight the pressing need for interventions that target modifiable barriers to SH education and services. These interventions should aim to enhance knowledge, empower informed decision-making, improve access to services and promote better sexual well-being for TWSWs. First, culturally sensitive and inclusive SH education programs need to be specifically tailored for TWSWs. Partnerships between health care providers, community organisations and transgender advocacy groups are also important to address TWSWs' unique needs, concerns and experiences. Given the challenges for providers, implementing training programs for health care providers could enhance knowledge and understanding of transgender health issues, including SH. This would create safe and welcoming environments in health care settings by training staff members to address implicit biases, reduce stigma and provide affirming care for transgender individuals. It is vital that providers are equipped to deliver respectful, non-discriminatory and culturally competent care. Programs to support sex workers are also important. One study in Canada showed that peer education programs proved successful in enhancing sex workers' community empowerment in one urban setting by increasing their knowledge about health issues, sharing information about and building confidence in accessing services, and expanding capacity to disseminate this knowledge to others.[36]

Considering that sex work is illegal in Iran, law reform and accompanying policies to reduce structural inequalities and stigma would have a major impact on TWSWs' health. It seems that decriminalisation can improve relationships between sex workers and health care providers, increasing the ability to report incidences of violence and facilitating access to SH services. Further advocacy is needed for policy changes that prioritise the rights and well-being of transgender individuals, including access to gender-affirming health care and support for SH services.

Conclusion

Sex workers face challenging occupational risks, including sexual and physical abuse, mental health issues, and HIV and STIs. Considering the impact of TWSWs' health on the general public's health due to overall HIV and STI transmission, efforts to improve TWSWs may directly benefit the overall health status of the Iranian population due to reductions in the transmission of diseases. However, TWSWs generally face hostility and humiliation in SH care facilities. Discrimination is faced in terms of health care providers withholding services and medicine. Furthermore, TWSWs are victims of physical and sexual abuse.

Additionally, TWSWs face various barriers to accessing health care in the first place. Although these barriers include challenges applicable to all patients, such as limited financial resources and long distances to public health care facilities, they also encounter barriers specific to being transgender and a sex worker. Because TWSWs are often unmarried, administrative procedures that require a partner

make adequate health services impossible for these women. Finally, stigmatisation and discrimination cause TWSWs to either avoid public health care facilities, delay visits or seek care elsewhere. In addition to these structural barriers, TWSWs also face individual challenges that make accessing health care even more difficult. TWSWs may require further education around understanding of HIV and STIs, or may not perceive SH to be an important priority, or may not be sure of how to access supportive information or education. Moreover, negative past experiences cause the internalisation of stigma and poor mental health, which inhibit TWSWs from accessing SH services. As health is a major contributor to well-being, access to health care is a key determinant. However, this research shows that well-being is severely impacted by individual, interpersonal, structural and financial barriers to health care. In particular, these findings may help stakeholders facilitate behavioural intervention, counselling, and are needed to implement HIV and other STIs prevention among TWSWs. Targeted public intervention programs and research are desperately needed to support the health and well-being of TWSWs in Iran.

Limitations

Some potential limitations should be considered in our study. Regarding the recruitment methodology, we only considered TWSWs due to being a high-risk population. Another limitation was the snowball sampling method, which is not all TWSWs have an equal chance of being selected. This study was conducted in Tehran, certainly other TWSWs in other cities of Iran have different experiences. An additional limitation is the perspectives and potential biases of researchers. Experiences in sex work were self-reported and might be subject be social desirability bias during face-to-face interviews.

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Data availability. Data are not available in this qualitative study, because all interviews are confidential.

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