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The Impacts of Intersecting Stigmas on Health and Housing Experiences of Queer Women Sex Workers in Vancouver, Canada

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ABSTRACT

The objective of this study was to qualitatively explore how queer women sex workers' experiences of stigma impacted health and housing access in Vancouver, Canada. In-depth semi-structured interviews were conducted with 56 queer women sex workers in Vancouver, Canada between June 2012 and May 2013. Participants described sexual stigma in the form of discriminatory comments about their sexuality, and in the form of barriers to housing and complexities in maintaining their relationships in supported housing environments. Enacted stigma was also experienced, particularly drug use-related stigma, in healthcare settings. Consequently, some participants reported felt stigma in the form of hiding their sexuality and relationships to mitigate stigma and to gain access to services. Participants experienced a variety of stigma related to drug use, housing insecurity, and sexuality; thereby demonstrating the intersecting dimensions of stigma and structural oppressions in the lives of the queer women sex workers.

KEYWORDS

Sex work; queer; stigma; gender; housing; healthcare; substance use; bisexual

Introduction

While the sex work literature has focused primarily on heterosexual women, there is a shortage of research into the lives of queer women sex workers (those who identify as lesbian, bisexual, queer, non-heterosexual, or who have sexual relationships with women). The literature on gender, sexual identity and sex work has generally concentrated on men sex workers and transgender individuals (Matthen et al., 2016), with a near-complete paucity of data on lesbian and bisexual sex workers (Smith & Laing, 2012). This, despite data indicating that queer women may be overrepresented in the sex industry (Iversen, Dolan, Ezard, & Maher, 2015; Lyons, Kerr, Duff, Feng, & Shannon, 2014).

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While the data on the experiences of queer women sex workers is sparse, there is literature indicating that certain groups of queer women are burdened with stigma operating at both individual and structural levels, and which contribute to significant health inequities. For example, compared to their heterosexual counterparts, lesbian and bisexual women and girls face barriers to healthcare (Bjorkman & Malterud, 2009), while also being at higher risk for health disparities including substance use and mental health disorders (Germanos, Deacon, & Mooney-Somers, 2015). Queer women across a number of studies have reported higher levels of depression and anxiety (Persson, Pfaus, & Ryder, 2015) and lesbian and bisexual women have also been found to report higher rates of self-injury, suicidal ideation, suicide attempts compared to heterosexual women (Kerr, Santurri, & Peters, 2013). Additionally, queer women and girls experience higher rates of physical and sexual violence than heterosexual women (Button, O'Connell, & Gealt, 2012). Queer women, particularly those who have a strong connection to their queer identity, have reported using alcohol as a way to cope with discrimination (McNair et al., 2016). Structural factors contributing to these health outcomes among queer women include homophobia and economic barriers.

Research has also documented economic barriers and high rates of poverty among queer women (Dilley, Simmons, Boysun, Pizacani, & Stark, 2010). Among bisexual populations research has demonstrated that poverty is associated with symptoms of depression and experiences of discrimination, particularly for Indigenous persons (Ross et al., 2016). Queer women and youth are more likely to report homelessness (German & Latkin, 2015; Lyons et al., 2016). Taken together, this background suggests there are multiple stigmas at play for queer women sex workers and yet little research has examined how stigma impacts access to safe, non-judgmental healthcare and housing. Thus, the objective of this study was to qualitatively explore how stigma shaped the experiences of queer women sex worker when accessing health and housing services in Vancouver, Canada.

Theoretical framework

There is increasing attention to the role social and structural factors, including stigma and violence, play in shaping health outcomes (Lazarus et al., 2012; Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005). As such, this work is guided by theoretical perspectives on stigma where stigma is understood to have structural (e.g., heterosexism; economic arrangements) and individual (e.g., felt and enacted stigma) expressions (Herek, 2007). Stemming from Goffman's (1990) seminal work on stigma, stigmatization is understood a social process by which marginalized individuals or groups are labeled with negative characteristics that contribute to harmful outcomes (Link & Phelan, 2001). Stigma occurs at different levels and manifests in

a number of ways, including individual levels of enacted stigma characterized as incidents of discrimination (e.g., rejection, violence) and felt stigma defined as modifying one's behaviors to prevent experiencing enacted stigma. (Herek, 2007; Scambler & Hopkins, 1986). Sexual stigma, defined as "the stigma attached to any nonheterosexual behavior, identity, relationship, or community," also operates at structural and individual levels, and refers to a range of ways sexual minorities are devalued (Herek, 2009, p. 67). Using this framework permits exploration of how intersecting individual and structural experiences of stigma impact health and housing access.

Study setting

This study was undertaken on unceded Coast Salish Territories[1] in the Downtown Eastside neighborhood (DTES) of Vancouver. The DTES is a vibrant community, which like the rest of the Greater Vancouver area, is characterized by an unaffordable housing market (Grigoryeva & Ley, 2019). The neighborhood has a range of services available for individuals who are burdened with social and health inequities. This study is also situated within the context of colonialism characterized by practices such as displacement from land, forcibly removing children from homes and into residential schools, and high rates of criminalization (Truth and Reconciliation Commission of Canada, 2015).

Additionally, queer women sex workers' experiences are situated within the context of recent changes to Canada's sex work laws. In December 2013, as a result of challenges by sex workers, three sections of Canada's sex work laws were ruled unconstitutional for violating sex worker's rights (Sampson, 2014). In 2014, the Canadian government implemented sex work legislation called the *Protection of Communities and Exploited Persons Act* (PCEPA). This legislation reenacted similar laws and also criminalizes the purchase of sex and the advertisement of sexual services for the first time in Canadian history. Consequently, there are concerns that the PCEPA will contribute to even greater harm to sex workers (Krüsi et al., 2014). Thus, this study is situated within a historic context of violence against sex workers and Indigenous peoples, and an evolving sex work legal framework (Krüsi, Kerr, Taylor, Rhodes, & Shannon, 2016); all of which shape the experiences of stigma among queer women sex workers.

Methods

This study draws upon data from semi-structured interviews with 56 queer women sex workers. The first author conducted the interviews between June 2012 and May 2013 at research offices in Vancouver. Participants were recruited from an open prospective cohort of sex workers (An Evaluation of Sex

Workers Health Access) and three open prospective cohorts of individuals who use drugs (The At Risk Youth Study, Vancouver Injection Drug Users Study, and AIDS Care Cohort to Evaluate Access to Survival Services). The cohort methods have been described in detail elsewhere (Shannon et al., 2007; Strathdee et al., 1997; Wood, Hogg, & Lima et al., 2008; Wood, Stoltz, Montaner, & Kerr, 2006). Nine additional participants were referred to the study by other participants using snowball sampling. Eligibility included a) identifying as a woman who is queer, lesbian, bisexual, non-heterosexual, or who does not identify with a category but has sexual relationships with women, b) having exchanged sex for money, c) residing in Metro Vancouver, and d) being 14 years of age or older. Interviews lasted approximately an hour and no participants declined to be interviewed or left the study. All participants provided written consent and were paid CDN$20 per interview. This study holds ethical approval through Providence Health Care/University of British Columbia Research Ethics Board and pseudonyms are used to protect the identity of participants.

Interview data were analyzed using a theory- and data-driven approach (DeCuir-Gunby, Marshall, & McCulloch, 2011) guided by a framework that positions health as an outcome of social, structural, and environmental contexts (Fredriksen-Goldsen et al., 2014; Shannon et al., 2008). The first author, who identifies as a queer White cisgender[2] woman, conducted the coding along with a participant who identifies as a lesbian and an Indigenous woman. The first stage of coding was conducted by the first author and involved a line-by-line analysis of emergent themes and recurring phrases in the interview transcripts. Next, coded sections were read repeatedly and interpreted in comparison with the other transcripts and additional data-driven codes and sub-codes were analytically created during this stage of coding using an inductive approach (Thomas, 2006). As a third stage of coding, the first author and the research participant met to read and interpret the data in a process called participatory analysis, which is described in-depth elsewhere (Lyons et al., 2017). At each participatory analysis session, the data associated with a first-level code (e.g., housing) was printed and we analyzed the text together. We validated the codes, corrected any coding errors, and discussed key findings. The 4 one-on-one analysis sessions, which lasted approximately 1 hour, were held at research offices. Transcripts and coded data were repeatedly drawn upon and analyzed to form the themes of this paper. ATLAS.ti (version 7) was used to manage the data analysis.

Results

Participants ranged in age from 20 to 62 years of age, with an average age of 40.8 years. Thirty (53.6%) participants identified as White, 20 (35.7%) were of Indigenous ancestry, 3 (5.4%) identified as Black, 1 as Asian, and 2 did not

identify with a category. Given that Indigenous persons comprise approximately 4% of the population of Canada (Statistics Canada, 2013), Indigenous persons were vastly overrepresented in this study. Only 8 (14.3%) participants had secure, independent housing (e.g., apartments) while the majority (n = 19, 33.9%) lived in supported housing buildings or were homeless (n = 14, 25%). Ten participants (17.9%) lived in single room occupancy hotels notorious for small, unsanitary, and unsafe conditions (Lazarus, Chettiar, Deering, Nabess, & Shannon, 2011) and 5 (8.9%) lived in subsidized housing (e.g., BC Housing). All participants were cisgender and 36 women (64.3%) identified as bisexual, 11 (19.6%) identified as lesbian or gay, 7 (12.5%) did not categorize their identity. One participant identified as queer and one identified as heterosexual but had relationships with women. The majority of participants (n = 38, 67.9%) were currently engaged in sex work and the majority (n = 49, 87.5%) were currently using drugs.

Participants described a range of enacted stigma in their daily lives related to their sexuality, drug use, and area of residence. Women experienced sexual stigma in the form of discriminatory comments about their sexuality/relationships with women, and in the form of barriers to housing, and complexities in maintaining their relationships in supported housing environments. They also reported enacted stigma related to drug use in healthcare settings. In response, some reported hiding their sexuality, relationships and drug use to access services.

Sexual stigma in supported housing and residential addiction treatment environments: "We eventually got caught and got kicked out"

As indicated, the majority of participants lived in supported housing of some kind. These housing arrangements raised particular issues for queer women in this study. Lydia (White, bisexual) was living with her partner in a supported addiction treatment housing environment. While the staff and other residents knew they were partners there were rules about how they could interact in the house:

> "Everybody knows. But uh we're not allowed to do anything like openly. It's against the rules there to be openly, together. … Can't do anything in common space. Kicked out for it … Yeah. It's pretty strict."

They were allowed to be in each other's rooms but they were required to sleep in their own rooms and when asked how staff responded to them as a couple, she responded, "They're okay with it. As long as we don't break the rules." Ava (White, bisexual) described how staff at the same building tried to separate her and her girlfriend:

> "No I don't think [they know]. But they know we're really close. They know we're really close and that we spend a lot of our time together. Sometimes they try to separate us."

The consequences of maintaining a relationship were severe, including losing one of the few options of secure housing and access to a treatment program.

Queer women in recovery houses and housing shelters also had rules placed on their relationships. Willa (White, lesbian) met her girlfriend at a shelter and while they "kept a low profile" from staff, they were not allowed in the same room together and they "would get kicked out" if caught breaking the rules. Phoebe (White, bisexual), who also met her girlfriend at a women's recovery house, described what happened when staff discovered their relationship:

> "It's actually like against the rules and … I guess it just became apparent like how we felt about each other, so we got put on restriction, but then she would like, sneak into my room, and we eventually got caught and got kicked out."

The women were prohibited from spending alone time together: "we couldn't be around each other unless it was like five other bodies around us as well, um, which made it like nearly impossible and very frustrating." In another example, Tamara (White, didn't identify) had to hide her relationship with a woman in a recovery house.

> "We weren't supposed to be in a relationship. … Because we were in the recovery house. And then once we were found out, we weren't allowed to hang around with each other or somebody had to be with us. We had to have, like a third wheel kind of with us and stuff like that and she ended up leaving. And then I ended up leaving with her, like the following day."

In many residential addiction programs clients are forbidden from engaging in intimate or romantic relationships. While this requirement may have contributed to experiences of sexual stigma, the participants in this study felt they were targeted in particular because of their sexuality and relationships with other women.

Barriers to housing

Participants reported difficulties in renting housing due to their sexual identity. Jasmine (Black, didn't identify) discussed the challenges in accessing housing with women partners compared to her men partners, "I just found it hard to find a place with two women instead of a woman and a man." In other instances, participants had difficulty accessing housing due to intersecting stigmas related to poverty, sex work and drug use. Isla (Indigenous, bisexual) described having to use a different address when she had housing interviews, "I use a friend's address so that way I don't get categorized as junkie, drug addict or someone that lives in the downtown eastside." In other cases, women discussed sex work-related barriers to housing:

> "Basically we don't want you because you're a sex worker. Just straight up forward. … We've had a few women in the building but we don't take, women of your kind. I went to rent to rent a room when I first moved here at the [an SRO hotel] And they wouldn't rent to me. And I wasn't even a sex trade worker. I just moved here. You know? And they're like no you're probably a sex trade worker, we don't want you." (Lydia, White, bisexual)

The examples demonstrate the intersections of several individual and structural dimensions of stigma related to sexuality and the criminalization of sex work and drug use. In the context of inaccessible housing, the threat of losing housing due to criminalization and/or for their relationships with women had harmful consequences for queer women sex workers.

Sexual stigma: "It's just the dirty looks, the talking, the whispering"

Participants experienced sexual stigma in the form of derogatory comments and looks from strangers and acquaintances about their sexuality and/or relationships with women. As Isla (Indigenous, bisexual) noted, "It's just the dirty looks, the talking, the whispering." Lee (Indigenous, lesbian) also described the stigmatizing looks from others, "Sometimes they just look at us like. And I'm like we're not living in the fifties anymore, you know we're allowed to come out." Comments included anti-queer labels such as "you fucking dyke" (Rae, White, bisexual) and other comments as described by Zara (Black, didn't identify):

> "Oh yeah, you lesbians and this and uh, muff-diver, uh, whores, and you deserve each other can you dive in the trash bitches, you know, go fuck each other to death, and oh shit like that, you know, because they're jealous. Yeah, or they try to tell you um, oh she's better looking than you or why're you doing, why're you with her? Oh, just every little negative thing."

The comments were sometimes sexualized as illustrated by the following example:

> "Always some kind of comments. Can I come home with yous guys? … Is just the sexual innuendos and stuff like that. You know? What do yous guys do? Tell me what yous guys do. It's like buddy it doesn't have nothing to do with it." (Tamara, White, didn't identify)

Many participants that experienced this kind of sexual stigma noted that these comments were usually perpetuated by outsiders, and generally they felt more accepted in their neighborhood than other areas of the city. Lydia (White, bisexual) explained, "Some people laugh or point fingers but, not really, not downtown. … You get the outsider that will say things." While the sexual stigma that participants faced around being queer were persistent in the data, some participants discussed not feeling discrimination based on their sexuality; however the stigma and barriers they faced were related to

living in poverty, sex work and/or drug use, particularly when they accessed health services.

Healthcare settings

Healthcare settings, primarily hospitals, were areas where participants reported consistent stigma and discrimination. Most often, the discrimination was related to drug use (or assumed drug use). Jade (Black, bisexual) felt healthcare providers treated her differently because she used drugs, "It's like, if you don't give a shit about your health, why should we? That's pretty much the attitude you get right." In another example, Sara (White, bisexual) discussed negative treatment in a hospital,

> "You're already an addict in their eyes. And I find them to be really biased there and um, judgmental. So I did not ever deal with those people there … I had an altercation there with some of the nurses and the doctors there. … They were treating me poorly. … And assuming that I was a drug addict and all these things."

There were also incidents of discrimination related to sexual identity in healthcare settings. Roxanne (Indigenous, gay) discussed being denied access to her partner when she was in the hospital: "I've taken her to so many hospitals and … I've been refused to be able to go in and see her. Go to emerg and be told that I can't, I'm not family." She described finding ways to sneak into her partner's hospital room, including saying they were sisters; however "But then you're holding hands or you're hugging or she's comforting you when you're in pain and then its like, I thought you guys were sisters." In another example, when Charlie (White, lesbian) went to the hospital with pneumonia she faced discrimination about her sexuality:

> "I says, "I'm very fussy. I like women doctors more than I do men." And they says, "You got a reason?" I says, "I've been assaulted and abused by men so much, and I'm gay." "Well, if you're gay, why don't you go to a hospital that deals with gays?" Whoa, I walked right out of [the hospital] then, and I never walked back."

Felt stigma: "We're not gonna advertise it"

The primary way participants managed stigma was by not disclosing their sexual identity, or only disclosing to certain individuals. For example, Geneieve (White, bisexual) said, "I never discuss it" and Carey (Indigenous, bisexual) stated, "We just kinda keep it to ourselves. We're not gonna advertise it." Dakota (White, bisexual) felt comfortable disclosing her bisexual identity to other queer sex workers, but not to heterosexual women sex workers. Jadene (Indigenous, bisexual) explained:

> "Everybody knows I'm pretty secretive and that I don't want other people to know. … And, I basically told the girls that I was with, if you're gonna be with

> me then it has to be with me and when I'm not with you I'm not with you right? And I made that very clear at the very at the very beginning and they see me on the street, they can say hi but that's all they can say."

These are examples of felt stigma, where participants modified their behaviors because there was an expectation of enacted stigma if others were aware of their sexual identity.

These practices of managing stigma were most pronounced when accessing housing. Many participants did not report problems accessing housing because they presented as friends or family. Julie's (White, gay) girlfriend would access housing and tell the landlord they were cousins. As Patty (White, bisexual) stated, "I think most people probably assumed we were just roommates." Nat (Asian, lesbian) reported not having issues accessing housing as a lesbian woman "because when I trying to rent a place I always rent a place that is single person."

Discussion

This study captures the unique experiences of queer women sex workers and their experiences of intersecting stigmas associated with sex work, drug use, poverty, and sexuality. Experiences of sexual stigma occurred in participants' daily lives, and through their healthcare and housing experiences.

While research demonstrates queer women are overrepresented in the sex industry in Vancouver (Lyons et al., 2014), women sex workers generally work in heterosexist environments where sex work is assumed to be heterosexual activity undertaken by heterosexual sex workers and clients (Cole, Jeffreys, & Fawkes, 2015). It is within this context that participants in our study experienced sexual stigma in their daily lives and engaged in felt stigma, particularly in housing and healthcare settings, to prevent additional sexual stigma. Sexual stigma contributes to health disparities among sexual minorities (Lick, Durso, & Johnson, 2013), in part by constraining access to appropriate care, and as demonstrated by these findings, also contributes to discrimination in health and housing services.

The strict rules in supported housing environments that regulated queer women's relationships resulted in loss of housing and access to treatment programs. Because of the severe consequences, many participants hid their sexuality and their relationships. Disclosure of sexual identity is a stressor unique to queer women sex workers and in this study the primary way participants managed stigma was by not disclosing their sexual identity, or by presenting as heterosexual. These strategies can be understood in the context of felt stigma and while these strategies provided opportunities (e.g., housing) for queer women in our study, research also indicates that not disclosing one's sexual identity can contribute to negative health

outcomes among queer women (Velkoff, Forrest, Dodd, & Smith, 2016). For example, queer women who had lower levels of sexual orientation disclosure (defined as whether and to what degree an individual has divulged her sexual identity to others) were more likely to report more symptoms of depression and anxiety (Persson et al., 2015). Queer women sex workers in this study are not alone in engaging in stigma management. In a large study of sexual minority women in Australia, less than half had a regular general practitioner that knew their sexual identity (Germanos et al., 2015). Thus, hiding one's sexuality and/or relationships may impact queer women sex workers' health and social well-being.

Other studies of sex workers in Vancouver have found sex work-related stigma to be a barrier to healthcare access (Lazarus et al., 2012) and there is an association between identifying as a gender and/or sexual minority and barriers to accessing health care (Socías et al., 2016). In a Canadian study, 28.6% of the bisexual women sampled reported their healthcare needs were not addressed in the last year (Tjepkema, 2008). Sex work-related stigma also contributes to the criminalization of sex workers (Krüsi et al., 2016). There is also research supporting the findings found here that women from this neighborhood experience stigma in hospital settings. For example, in a study of women who use drugs in Vancouver, nearly three-quarters of the sample described stigma as a consistent part of accessing healthcare, with the most severe stigma occurring in hospital settings (Salmon et al., 2009). Additionally, research in this setting has found that Indigenous people living in Vancouver's downtown eastside neighborhood experience systemic and structural racism in when accessing healthcare services (Goodman et al., 2017).

The majority of sex workers in our study had a history of drug use and reported drug use-related stigma in healthcare settings. While there is a gap in the literature addressing queer women sex workers' experiences accessing healthcare services, there is literature documenting the discrimination people who use drugs encounter, including stigmatizing attitudes and behaviors from healthcare providers (Lloyd, 2013; Voon et al., 2013). In a Canadian hospital setting patients who used drugs reported judgments from nursing staff, the stigma of being labeled as a drug user, and fears of not having their health concerns addressed (Pauly, McCall, Browne, & Parker, 2015). Indigenous people who use drugs in Vancouver have described extensive racism, including threats from security, not having their health concerns taken seriously, and negative assumptions of drug use that resulted in poor clinical care, in healthcare settings (Goodman et al., 2017). These findings are similar to those in this study and demonstrate the insidious character of drug use-related stigma in healthcare settings.

Indigenous women comprised 35.7% of the sample in this study and were therefore highly overrepresented. Indigenous persons experience heightened structural vulnerabilities, including those related to racism and housing

disparities, due to historic and current practices of colonialism (Bingham, Leo, Zhang, Montaner, & Shannon, 2014; Hunt, 2015). For example, indigenous youth in British Columbia have high levels of housing instability which enhances vulnerability to health inequities including sexual violence (Jongbloed et al., 2015). In Canada there continues to be a crisis of murdered and missing Indigenous women (Patrick, 2016) and it is clear that structural factors related to racism, colonial practices, gender, and class are central contributing factors (Monchalin, 2016; Oppal, 2012). Data from the US has demonstrated that Indigenous queer women face stigma related to their sexuality, Indigenous ancestry, as well as their gender (Walters, Evans-Campbell, Simoni, Ronquillo, & Bhuyan, 2006). For example, Indigenous queer women report exceptionally high rates of sexual and physical violence (Lehavot, Walters, & Simoni, 2009). Therefore, future research would do well to examine how sexuality, gender, and colonization intersect for queer women sex workers.

Given the great heterogeneity of sex workers and queer women the study findings may not be generalizable to other queer sex workers or other sex work settings. This study focused on the experiences of queer women sex workers and future research is needed to examine the perceptions of health and housing service providers to better understand how to address stigma.

Policy implications and conclusions

Participants in our sample experienced a variety of intersecting stigmas related to housing insecurity and sexuality; thereby demonstrating the multiple dimensions of stigma in the lives of the queer women sex workers. As such, our study underscores the need for improved policies at the health and housing levels that are inclusive and relevant to the lives of queer women. It is also vital to implement peer-based hiring strategies in health and housing services, and to ensure staff and service providers receive appropriate training to foster environments free from stigma related to poverty, drug use, sex work and sexuality. The findings also suggest the decriminalization of sex work and drug use could improve health outcomes for queer women sex workers, particularly those who are marginalized and those who are Indigenous given the overrepresentation of Indigenous person in Canadian jails and prisons (The Correctional Investigator, 2014). Canadian sex work laws continue to criminalize sex workers and sex buyers and therefore, the PCEPA is reproducing the harms of previous sex work legislation (Krüsi et al., 2014; Sterling & van der Meulen, 2018). Thus, it is recommended that Canada move toward the decriminalization of sex work, for example the New Zealand model (Armstrong, 2014), to prioritize the safety and health of queer women sex workers.

Notes

1. Coast Salish territories encompass a number of Indigenous peoples, including the territories of the Musqueam, Squamish, and Tsleil-Waututh people. This territory is unceded, which means Indigenous peoples never surrendered this land (Hunt & Holmes, 2015).
2. Cisgender refers to a person whose gender feels congruent to their assigned sex at birth.

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