Community Feedback to Inform Syphilis and HIV Prevention and Intervention Strategies

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Purpose and Overview

The Syphilis Prevention Coordinator of the Minnesota Department of Health (MDH) sought to engage community members with experience selling or trading sex, survivors of sexual exploitation or trafficking, and sex workers to gain their feedback on the most effective outreach strategies and messages for distribution of information on prevention, testing, and intervention for syphilis and HIV. This report summarizes feedback from 36 community members to inform marketing and communications materials, community partnerships, and other outreach strategies to be adopted by MDH.

Evaluation Questions

This project was guided by the following evaluation questions:

- What HIV and syphilis testing, treatment, or education services are community members aware of that are trusted and liked by community members?
- What sexual health resources are available that feel responsive and appropriate for their community?
- What barriers do people in the community encounter when seeking responsive and appropriate sexual health services?
- How and through what means should testing and awareness information and services be made available?
- Do participants perceive HIV or syphilis as problems in the community? If so, why? Why not?
- Do survivors/sex workers feel compelled to 'out' themselves to medical providers? If so, how does that impact the care they receive?

Methods

Advisory Team

Firstly, Rainbow Research convened a small advisory team consisting of two individuals who identify as sex workers as well as one individual who identifies as a survivor of sexual exploitation. The advisory team reviewed and revised the primary evaluation questions to ensure they were reflective of the issues and interests of community members related to HIV and syphilis prevention and treatment. Additionally, members of the advisory team reviewed focus group questions to ensure they were

appropriate for the target populations, assisted in identifying survivors of sexual exploitation/trafficking and sex workers to participate in focus groups, and co-facilitated focus group conversations. Lastly, they reviewed findings and assisted with recommendations. The individuals on the advisory team were compensated for their work as project consultants.

Focus Groups

Feedback was gathered through four focus groups conducted in Minneapolis and St. Paul in partnership with Breaking Free, a nonprofit serving survivors, and the Minneapolis Sex Worker Outreach Project (SWOP-MPLS), a grassroots organization that promotes the human rights of people selling sexual services through education, outreach, and harm reduction. Due to differences in experiences, stigma associated with identifying involvement in commercial sex, and the illegal nature of sex work, we convened one focus group advertised specifically with individuals identifying as sex workers. Additionally participants completed a brief optional anonymous demographic survey. All participants received $40 in cash as a thank you for their time. The focus group questions were designed to avoid triggering conversations and re-traumatization: no questions about someone's specific experiences were asked; participants were assumed experts in their communities and were asked about recommendations from that perspective, yet allowed to share personal experiences as they desired.

Analysis

All focus groups were recorded, transcribed and analyzed using NVivo qualitative analysis software. A content theme analysis across all methods was conducted which provided the major themes, quotes and recommendations included herein. All identifying information has been removed.

Participants identified with a variety of experiences within commercial sex, including survival sex, sexual exploitation/trafficking, and sex work as well various parts of the market: online escort, street-based, etc. The method of data collection and analysis was not designed to describe differences in opinion or feedback by experience, but rather was designed to be inclusive of a broad spectrum of identities and lived experiences. Additionally, as most demographic questions allowed for multiple-choice answers, percentages of responses will add up to greater than 100%, as signified by the qualifier, "duplicated".

Findings

Findings from this evaluation are organized into the following sections: description of participants, perception of syphilis and HIV, experience with testing, additional barriers, and safe spaces. In the final section of the report we provide a summary of recommendations for consideration to increase access to testing and treatment services, educate providers to address stigma and reduce barriers, and work with trusted people to increase awareness.

Participant Demographics

Overall, 36 sex workers, survivors of sexual exploitation or trafficking, or people with experience selling or trading sex participated in four focus groups. Of those, 31 completed optional demographic forms. The majority of participants (90%) were female identifying. Approximately half (48%) identified as African American, Black or African. Participants ranged in their experiences with selling or trading sex; most commonly participants identified with the experience of online escort (58%) and survival sex (42%), as summarized below. 39% identified as a sex worker; 36% identified as a survivor of sexual exploitation. One participant was currently pregnant. Full details are below in Tables 1 through 5.

Table 1: Participants by Race/Ethnicity

Participants by Race/Ethnicity, duplicated; 31 Total Participants						
TOTAL	**African/ Black / African American**	**White/ European American**	**Indigenous/ Native American**	**Multiracial**	**Asian/ Asian American**	**Latinx**
Count	15	14	3	3	2	1
Percentage	48.4%	45.2%	9.7%	9.7%	6.5%	3.2%

Table 2: Participants by Sexual Orientation and Gender Identity

Lived Experience by Sexual Orientation & Gender, duplicated; 31 Total Participants					
Total	**Lesbian, Gay, Bisexual, Pansexual, Queer**	**Female-identifying**	**Trans**	**Gender expansive/ non-binary**	**Male-identifying**
Count	10	28	2	1	0
Percentage	32.3%	90.3%	6.5%	3.2%	0.0%

Table 3: Participants by Age

Participants by Age; 31 participants	
Range	21-56 years of age
Average	34 years of age

Table 4: Participants Self-Identification in Commercial Sex

Self-Identification in Commercial Sex, duplicated; 31 Total Participants					
	Survivor of sex trafficking	**Survivor sexual exploitation**	**Sex Worker**	**Prostitute**	**Independent Provider**
Count	8	11	12	8	6
Percentage	25.8%	35.5%	38.7%	25.8%	19.5%

Table 5: Additional Lived Experiences in Commercial Sex by Market Sector

Lived Experience, detailed, duplicated; 31 Total Participants								
	Online Escort	**Survival Sex**	**Street-based**	**Stripping/ Erotic Dancing**	**BDSM/ Dominatrix**	**Massage Parlor**	**Brothel-based**	**Pornography**
Count	18	13	11	11	8	7	6	5
Percentage	58.1%	41.9%	35.5%	35.5%	25.8%	22.6%	19.4%	16.1%

Perceptions of Syphilis and HIV

Overall participants were unaware of syphilis as a problem or syphilis treatment, and perceived syphilis as a disease of the past. Participants were more aware and concerned about HIV, herpes, hepatitis C and chlamydia. During most focus groups, confusion was expressed about the harms of syphilis and the treatment: participants were unsure if syphilis was curable or not, if syphilis caused blindness, or whether syphilis could turn into AIDS[1]. However, the focus group in which the majority of people identified as sex workers expressed knowledge and understanding of syphilis and the corresponding treatment. Participants from that focus group reported syphilis being a lower concern for them because it was so easy to cure.

> *"I thought it was like Polio, it was gone."*
>
> *"What I thought was going around, I was more so, you know AIDS, herpes, chlamydia, you know what I mean? I would never have thought, you got syphilis. It's just not- You wouldn't hear nobody talking about that, you know people that I hang around with."*
>
> *"Syphilis doesn't really concern me because I know that there's a pretty easy medication, and it's preventable, or not preventable, but after you get it, it's a pretty easy fix."*

Conversely, overall, participants **reported consistent concerns about HIV as something people were aware of and talked about.**

> *"I think a lot of young people think that it's just AIDs. Or only think that, that's the only thing, you know, the worst thing you can get. That there are other diseases out there and there are other ways to ... If you don't know about it, it can become worse."*

[1] This question was raised in reaction to the MDH pamphlet that says syphilis can increase risk of HIV; people were unclear how HIV and syphilis were related or interacted.

Experience with Testing

Participants reported a range of personal practices in getting tested for STIs. Some reported their health care was only through limited access to the emergency room; some had consistent relationships with medical providers, while others reported utilizing ad-hoc testing services in drop-in programs or treatment centers. Trans identifying participants reported having a practice of getting tested each time they received hormone treatments. While a few individuals reported that their provider gave them the tests they requested, **the vast majority of participants across all groups reported that they had to highly self-advocate for STI testing, particularly for syphilis.** Merely asking to be tested for all STIs was insufficient and medical providers did not freely suggest syphilis testing if not directly asked. Participants reported many experiences where they asked to be tested for all STIs and were actively discouraged from doing so by their provider who in most cases attempted to dissuade them, saying things like 'you don't need this.' Other participants reported that providers would only test them for multiple STIs if they were actively showing symptoms, disclosed participating in anal sex, or knowledge that a partner was positive with one of the STIs, so people learned to make up symptoms and otherwise lie to their provider in order to convince them to do the tests. Additionally, participants reported that providers make many assumptions about their identities in providing them (or in this case, denying them) medical care including assuming monogamy, assuming sexual orientation, or assuming the type of sex acts they were engaged in and using those assumptions as the basis for recommending that full STI testing was unnecessary. Conversely, some participants reported when they asked for a full run of STI tests without symptoms, they feel shamed by the provider insinuating that they must be doing something out of the normal if they want that. Additionally **some expressed they did not know what they were being tested for or what to ask for from their provider. Those who did, had to be very assertive to get their testing needs met.** In the same way, participants reported being denied and talked out of receiving Truvada for PrEP, which they wanted as a preventative against HIV.

> *"They won't test until you break out or until there's some symptoms."*
>
> *"I lie, I've been like I'm itching, scratching, smelling just so I can get all my tests done without having to have symptoms."*
>
> *"I don't know how they test [or what they test for]. That's not my job to know."*
>
> *"No one ever asked me about syphilis."*
>
> *"At doctor's appointments, I found myself confused […]I think it was like a pap smear appointment, or something. I was confused, because I'm like, "This ain't all the STD's they have." […] Because it was only like, two or three that I had been tested for. And I must not have asked for the right thing, I must have probably just said I need to be tested for STD's or something. But, yeah. I was confused about that, too."*
>
> *"It's funny though the one that I have found that they are most hesitant on testing you for is syphilis. And usually, in my experience, a few places I've been won't even do it unless you say that you've had […] anal sex."*
>
> *"[Syphilis is] always the one for sure that they are like, no we're not gonna do that one."*

"I feel like people are usually like, oh [syphilis] that's really rare, you don't need to be tested for that."

"Even if you say I want the full screening you would then have to specifically ask the doctor for HIV test, which if you feel ... I accidentally forgot to ask, I knew I had to ask that, and I didn't 'cause I feel like that sequence of questions makes you nervous."

"If you go in, and you say I want an STD testing, they're only gonna test you for gonorrhea and chlamydia, at least that's been my experience, you have to ask, no I also want HIV, I also want syphilis, you have to specify, and they'll be like well I don't think you need that, or they'll say, you were just tested a month ago, that wouldn't make sense-"

"I have to fight with the doctors to get the full panel, and they'll be like, well if you're not really sleeping with new people all time... […] they try, and convince you not to. […] They're like well you don't really need that, and it's like, I have a right to do that if I want to, even if I hadn't had sex, fuck let me take the test."

Reporting through the anonymous optional survey paralleled the experiences described in the focus groups. Participants most commonly reported having received a STI test for chlamydia and gonorrhea in the past year (74%), followed by HIV (65%). A little less than half of the participants reported receiving a STD test for syphilis in the past year (45%). A little over half (58%) reported that they had received both a blood and urine test if they had ever asked specifically to be tested for all STIs. (Table 6.)

Table 6: Experience with STI Testing

Participants Reporting STI Testing in the Past Year, 31 Total Participants		
Test	**Count**	**Percent**
HIV (Blood Test)	20	64.5%
Syphilis (Blood Test)	14	45.2%
Chlamydia & Gonorrhea	23	74.2%
If you have ever asked a provider to test you for all STIs, did the provider:		
Provided Blood & Urine Test	18	58.1%
Blood Test Only	3	9.7%
Urine Test Only	2	6.5%
"I don't remember"	5	16.1%
Never asked	2	6.5%

Questioning Process of Providers

In the context of needing to advocate for testing, participants reported medical providers also being intrusive in their questioning process and undermining of clients knowledge of their own bodies and decision-making skills, as evidenced by providers refusing services directly asked by clients.

"I had got a pelvic inflammatory infection […], that I had had a miscarriage. […] By the time I got to the hospital, I almost died, because the infection had went in my body so tough. But it was the fact that they said, "Well, you got gonorrhea," hold up. No, I ain't got no gonorrhea. I know what

I got. But I don't like it when the first thing you do, is you come in and they tell me you got a disease. Everybody is not a dirty person."

"Nine times out of ten, if I go in the hospital, I know what's wrong with me because it has happened before, and it's a reoccurrence into my body. You know."

"I just think we all know our own bodies, especially if we've been in this lifestyle, or used to be in it, we're always gonna be checking for something. I know I was, I was just nervous because I know I had been sexually active with different men, I was paranoid almost."

Participants reported feeling anxiety in anticipation of being asked the barrage of questions regarding number of sexual partners or type of sex acts, and many of the questions and language used as screening for sexual exploitation were triggering.

"They're not very sensitive, or empathetic."

"It's hard to do already, even if you haven't been assaulted, it's just kind of hard to even go get tested anyway because if you have been having sex, and you are scared of maybe the person that you had just had sex with, you're nervous as hell."

"I was put in this precarious situation, and I was trying to explain that to the healthcare professional, I said, I told them, I said, 'I don't want to give details. I'm telling you that this was the situation, and that I've kind of had to do these things.' And the healthcare professional continued to push me, and continued to ask…[…] I gave the details that were medically necessary, and I said, 'I don't wanna talk about this', and they kept pushing me, and they were like, do you trade sex for money? Are you safe? And I'm like, I just said I don't want to talk about it, can you please just test me?"

Most participants reported not wanting to self-disclose their experience in selling or trading sex because it's stigmatizing and for fear of judgement from providers. Some reported already feeling stigmatized by medical providers due to being HIV positive or disclosing drug use. A few people reported disclosing involvement in selling or trading sex on impulse when the questioning route became too intense or uncomfortable for them and reported that when they had disclosed, it didn't improve the health care provided.

"Women that are in the life, judgment is number one, but we're judged constantly by our johns, our tricks, are, yeah whatever, always so the last person we want to be judged by is somebody that we're asking for help. That's the number one fear it's like, oh don't look down on me because I do this but this is how ... You know? I don't want to deal with that."

"They think like, 'piece of shit', like okay. And then sit over there, you know?"

"The way that they go about it, I feel like is just so aggressive, and you don't know what you get out of disclosing. We don't know the benefit of doing that. What are they giving us? We don't have that."

"Even after they do all this prying, and asking me extra questions, they never offer resources like how you said. They don't offer the proper resources, or resources that may even be of use, or they don't offer pamphlets."

"They're just clicking on a computer." "You're just writing down everything that I'm saying? And incriminating [me]?"

"I mean, after I disclosed, nothing happened differently, and I felt really silly like why did I just say that? And also I don't think it was relevant. I told you why I was medically there, that should've been reason enough."

Additional Barriers

Participants reported the lack of personal identification, health insurance, or ability to pay as main barriers overall in being able to access any form of health care, including STI testing. Additionally transportation and childcare were mentioned as barriers. Many participants with pimps said they had no ability to access routine medical care and had only very limited access to emergency medical treatment at the decision of their pimp, especially if medical services required money. Some involved in street based survival sex reported the needs and opportunities of the immediate moment took precedent (eg. an opportunity for a trick, urges to use substances, or other immediate needs) meant seeking health care services like testing was not prioritized or realistic.

"There's a lot of people that don't have insurance or even just an ID."

"It's like this: people try to make it seem like it's real easy to walk to the Red Door and get some condoms. But when you out there, and you on drugs, you're not fitting to walk to no damn Red Door to get no condoms. It's just that simple. It's just going to be as is, you going to do what you want, to get that one. […] But what if a trick pull up, and you're two blocks away from the Red Door? You going to get in that trick car and probably say, 'Well, I'll go to the Red Door later.'"

Safe Spaces

Amidst these barriers, a few organizations, namely HCMC HIV Clinic, Family Tree Clinic, Red Door Clinic, and Planned Parenthood were named as safer and more affirming medical providers[2]. However, participants explicitly noted that none of these medical services are always safe and affirming; these providers however were more likely to respond in affirming and respectful ways than other mainstream clinics. Some utilized medical services in connection to drop in centers like SafeZone (Face to Face), Youthlink, and Salvation Army Harbor Light. Safe and affirming spaces were described as having the following characteristics:

- **Discrete locations**. Specifically for Red Door, their location amidst other services provides relative obscurity about what particular service a client is seeking out.
- **Responsive to client requests**. As described above, participants were frustrated when providers did not provide the medical services specifically asked by clients. Conversely, participants felt respected when providers administered the tests or treatment requested by the client without objection or discouragement.
- **Free, multiple options for payment: sliding scale, option to pay in cash**. As lack of health insurance is a barrier, providers that accept cash payment, sliding scale options, or offer free

[2] University of Minnesota Physicians' Smiley's Family Medicine Clinic and Community-University Health Care Center were also named as positive medical experiences, but with less frequency.

services were preferred. Some participants with insurance still preferred options that didn't involve their insurance for confidentiality reasons.

- **Outreach based**. Providers such as the Aliveness Project and other groups that go out and provide free testing at treatment centers, jail, and other community locations.
- **Stigma free, not-judgmental treatment**. Places that also provide needle exchanges, ongoing treatment for HIV, and hormone therapy were specifically highlighted as being more likely to be non-judgmental.
- **Personably engaged, relatable**. Participants appreciated providers who talked to them without using medical terminology, but talked in the same way they did and could relate personally to their experiences.

  "What I liked about it is, they understood stuff about me right away. Drug, and or ... they're familiar with issues that people in the area face. So you don't feel like you're having to explain your situation as much. Or, put on the spot as much, I find."

- **Options for same day, walk in treatment.**

  "I honestly go to Red Door just because getting tested gives me so much anxiety that I can't schedule an appointment, they have the walk-in, and so I just walk in."

- **Questions asked by providers lead directly to improvement of treatment or services**. In contrast to being asked intrusive questions that do not impact what services are being offered, participants appreciated providers who were able to change the course of what services they provided based on how people answered questions.

  "Well I from my experience, I knew that whatever answers I gave, they were able to provide some sort of a response. I mean, I've been in other situations where I'm like, 'Why are you asking me all these questions? Because you're not going to be able to help me, so why are you being so invasive?' But in that situation, I felt like they did respond to it. So, that's where it was helpful."

Recommendations

Participants recommended efforts to educate providers and clinics on how to be more trauma-informed, sex-worker positive, and client responsive, regardless of how clients identify or disclose. Additionally participants recommended partnering with survivors, sex workers and trusted community locations to increase access to testing, treatment, and education by focusing on direct outreach supplemented with online-based messaging.

Increase access to testing and treatment services

1. **Partner with sex workers and survivors to directly administer STI tests and lead awareness and outreach efforts.** Participants advocated for models that pair medical providers with paid survivors or sex workers (peer outreach models) to provide medical care or create avenues to train survivors and sex workers to gain the skills necessary to provide testing.

   "I would rather listen to a person who has been through what I went through because like, experience of that. Give you more of a motivation to do this, take care of your body. […] You can relate to them. You feel more comfortable."

2. **Focus on street outreach**. Participants reflected that there was an insufficient amount of outreach to people involved in street-based selling or trading of sex. Participants recommended street outreach that combines free STI testing with additional services such as condom and dental dam distribution, needle exchange, distribution of related prescription medication (ie. birth control, PrEP, etc.), and domestic violence and mental health counseling. In particular, participants imagined the creation of a mobile medical clinic (ie. converted bus), co-staffed by survivors and sex workers, that could travel between locations with high numbers of people involved in street-based sex exchange such as the Central Library in Minneapolis, Lake Street, and Franklin Avenue that would have a constellation of services as well as a shower. Individuals involved in street-based sex exchange and survival sex have the greatest barriers to accessing treatment and testing. Provide financial incentives for people to get tested.

3. **Strengthen the practice of providing STI testing at community-based locations**. Participants recommended increasing the frequency of testing provided at locations such as Breaking Free, Youthlink, Harbor Lights, Salvation Army, SafeZone, substance abuse treatment centers, methadone and suboxone clinics, and jails. Additional community locations such as churches[3], grocery stores, or pharmacies (CVS, Walgreens, Target) parallel to how those locations encourage flu vaccinations.

4. **Partner with currently trusted locations** (ie. Red Door, Family Tree) to host sex-worker positive days or days for people with experience selling or trading sex and their allies. On these days, ensure practitioners are equipped to be responsive to client requests. By opening it up to allies, people don't need to self-disclose involvement for services. Incorporate additional elements of joy, pleasure, self-care, and community (ie. live music, dancing, art) so testing practices are linked with self-care and celebration, not as a negative connotation of disease.

5. **Focus on youth and young adults.** Many participants reported they began selling or trading sex as teenagers and recommended focusing on testing and education with youth.

Educate clinicians and providers on ways to decrease stigma and barriers to services

1. **Educate providers and increase accountability** for doctors to provide all STI tests when requested.

2. **Educate providers and clinics on practices that decrease stigma** in both messaging and care. Make continuing education focused on trauma-informed care and sensitivity to this population mandatory. Hire survivors and sex workers to design and implement trainings. Work with providers to ensure questions being asked and language is not offensive or triggering; the participants in this process recommended removing the question of how many partners someone has had as triggering and intrusive.

   "[They asked] 'Do you feel safe? Have you ever sold sex for drugs?' And I answered no, but it was just the way that it escalated, I wouldn't ever feel comfortable saying yes."

[3] Specifically, ICCM Inner City Church was named as a church that caters to individuals in recovery, is located downtown, and has a culture of judgement-free support.

3. **Work with providers to decrease existing barriers (costs, childcare, transportation, IDs, etc.).** For example, participants recommended providers allow option for treatment without identification and using a consistent alias that would allow clients to have continuity in their treatment without self-identification. Availability of free and low-cost services and medication is crucial.

   "More free services, like for those who don't have insurance."

   "I think no matter what happens, if you have a sexually transmitted disease, no matter what it is, if you don't have medical [insurance], you should be able to get your medication. If a person has herpes, you should be able to get your medication. If a person has HIV, or a person has AIDS, you should be able to go in the store. It's not like you're asking for a beer, or Tylenol."

4. **Determine best practices in medical care for people involved in commercial sex that respect and honor clients' self-knowledge.** Participants were unsure of the right frequency for being tested or what their unique sexual health care should be. Once that is determined, medical providers should be able to offer a specific menu of services that clients can request without requiring them to self-disclose. Participants wanted medical providers to offer something. For example, if a patient is having sex with multiple partners, here is the risk, and here is the medical option to consider. Let people know what their options are and allow them to choose what service would be best for them. Trust peoples' knowledge of their own symptoms.

   "I wish they would go about it in a way that's like, do you need some resources like this? In a way that it was open-ended so, here is something that we have, if this is something that applies to you, but you don't need to tell us [disclose your sexual history]."

Utilize trusted sources to raise awareness and educate on sexual health best practices

- **Utilize social media and online platforms in partnership with trusted sources.** Participants largely reported being unaware of syphilis as a problem and its symptoms. While some advocated for mass messaging techniques such as posters on buses, others expressed concern that mass messaging might further stigmatize those involved in selling or trading sex, propagating the message of people as vectors of disease. Overall participants advocated for partnering with specific community leaders and people known within the community (ie. informal leaders in the sex worker community, survivor communities etc.) to build and disseminate messages on social media that raise awareness of syphilis as an issue, prevention, how to recognize symptoms, and best practices for testing. This same avenue was recommended to increase sexual health awareness and education overall.

  "We had an alumni member by the name of [name], her name was [name] on Facebook and she is a prominent makeup artist here in Minnesota. She is Breaking Free crazy. So she has fund raisers for Breaking Free, she tells her story online, and she is an online make up sales person, and networking agent, so when she does things like that to promote make up demos or things like that, it starts and ends with Breaking Free. So I pay attention to her because I'm in the industry with her. So when I see her doing that stuff, then I'm like, oh yeah let me get back to this. Let do this, you know."

  "Everybody got Facebook."

- **Offer workshops that promote sexual health and well-being specifically for people involved in commercial sex and survivors, led by survivors and sex workers.** Participants had many questions about symptoms of STIs, best practices to reduce harm, and reported overall seeing the need for opportunities in person and online (for those who can't or don't want to participate in person) to ask safe people questions in a nonjudgmental space that promotes community. Participants recommended hosting these conversations with existing trusted spaces (ie. clinics), and groups (ie. Breaking Free, SWOP, etc.).

  "I wish they would offer more sexual education because there is some younger people, not even younger people, but just people that don't know about certain types of sex. Some people have never experienced anal sex, and what they should do after, or maybe that you had anal sex, and that it hurt you so bad that you should go get checked on, and you probably did mess something up you know, and they're not open, they're scared to talk about stuff. But they wanna ask you all those type of questions."

  "As someone who doesn't always practice using condoms with oral sex, I want to be able to know how to be able to get some insight into what does chlamydia look like, or what does herpes look like, or what do these different things look like instead of someone just telling me, oh you should be using a condom. I know I should be, but I don't always."

  "I'm saying like specifically like for the game, in that specific lifestyle, those type of women to just come and talk to the girls who were exposed to that, and say this is what you need to do, you need to take care of your body. If you still want to be in this lifestyle, you need to make sure that you're doing this, this, and the third to prevent syphilis, to prevent HIV, something you know to help prevent it from happening."

Conclusion

Participants largely reported being unaware of syphilis as a problem and were less likely to report having been tested for syphilis in the past year than chlamydia, gonorrhea, and HIV. Additionally, those who sought testing services at clinics reported needing to highly self-advocate to receive syphilis testing amidst clinicians actively discouraging them from doing so. While some clinics are more commonly described as safe and respectful, participants reported that overall clinics have a long way to go to provide responsive, stigma-free, trauma-informed care which is a main barrier to people seeking STI testing and treatment. This will require education and training to health care providers. At the same time, increases in direct outreach with free medical and sexual health services to people involved in street-based sex exchange or survival sex as well as increasing free testing at trusted community locations would address additional barriers to testing. Regardless of strategies adopted, sex workers and survivors must be included in paid leadership positions as outreach workers, providing testing services or partnering with clinicians, as designers and distributors of media messages, and as sexual health trainers and facilitators to providers and clinic staff[4]. Social media, online avenues to ask questions, and in-person workshops specifically for and by people involved in commercial sex and their allies were recommended as avenues to increase sexual health education and STI awareness.

[4] St. James Infirmary in San Francisco is one example of a health care model for and by people involved in commercial sex. https://stjamesinfirmary.org/