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# The Subjective Experience of Social Stigma on Mental Health among Cisgender Women Sex Workers in Colombia



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# The Subjective Experience of Social Stigma on Mental Health among Cisgender Women Sex Workers in Colombia

**Abstract**

This phenomenological study elucidates the subjective experience of social stigma on mental health among cisgender women sex workers in Colombia. Two themes emerged from the thematic analysis: (1) institutional stigma, insensitivity of healthcare providers and abuse of power by the police force, and (2) behavioral stigma, disagreement with the social classification of the occupation, family abandonment, conflict with work identity, social isolation, societal disapproval of the occupation, and unequal social treatment. These findings highlight the need for a holistic approach consistent with unmet needs and the high vulnerability to deterioration of mental well-being due to social stigma against this group.

**Keywords**

cisgender women sex workers, mental health, qualitative research, sex work, social stigma.

## Introduction

Stigma is socially and culturally constructed as an attribute that discredits, belittles, and devalues human identity and dignity at all levels of the social structure (Link & Phelan, 2001; M. S. Ryan et al., 2019). This is the case for cisgender women sex workers (CWSWs), who exchange sexual services for money or goods, and they experience and confront the consequences of stigmatizing labels from friends, family, and social institutions due to disapproval and disagreement with their sexual behavior and work involvement (McMillan et al., 2018). Additionally, the majority of CWSWs engage in their occupation in spaces where other social issues are prevalent, such as drug and alcohol use and distribution, crime, human trafficking, and a lack of judicial protection for individuals involved in sex work (SW), which increases the risk of operating in secrecy and experiencing sexual and gender-based violence (Aldridge et al., 2018; Bungay & Guta, 2018).

Analyzing and addressing sex work from a health perspective is controversial for academics, scientists, and health providers due to the marginalized status and moral, religious, and cultural rejection promulgated in various social settings and discourses (Strega et al., 2021). The profiles of the people involved are diverse, ranging from low, middle, and high-income earners. Factors related to the initiation of SW also vary, the most prominent in the existing scientific literature being those related to social inequality, which limits opportunities for access to education, employment, and housing for socially vulnerable groups and minorities (Hengartner et al., 2015; Khezri et al., 2020).

CWSWs may have lived through adverse experiences such as domestic and sexual violence and live in circumstances of high social vulnerability such as poverty, low education, low mental health (MH) literacy, and few job opportunities coupled with the psycho-emotional demands of undignified working conditions and dealing with occupational identity in a society that marks and stereotypes sexual behaviors away from normative sexual codes (Khezri et al., 2020; Parcesepe et al., 2016). Additionally, CWSWs may experience psychological consequences and unfavorable emotional reactions that potentiate mental

states such as mood disorders, anxiety, post-traumatic stress disorder, and depression, the most reported in the scientific literature (Jewkes et al., 2021; Krumrei-Mancuso, 2017; Puri et al., 2017; Stockton et al., 2020).

On the other hand, some CWSWs have difficulty coping with and promoting their MH due to a lack of practical strategies and skills, a dysfunctional family and social support network, a lack of a welcoming environment, and a lack of community-based MH promotion and care. As a result, some CWSWs turn to alcohol and psychoactive substances as an alternative route, increasing their vulnerability to contracting sexually transmitted infections (STIs) through increased risk of exposure to non-consensual risky sexual practices as well as deteriorating MH and mood, which in turn support suicidal behaviors (Ongeri et al., 2023; Roshanfekr et al., 2015).

MH is understood as a state of emotional, psychological, and social well-being that allows the individual to cope with the circumstances of the environment in which he or she interacts, not just the absence of illness (World Health Organization, 2022). In this sense, promoting MH and addressing clinical disturbances in cognition, emotion regulation, and behavior of subjects should be assumed as a fundamental human right enabling the individual to learn to live well and develop their potential to contribute to their community environment (Aldridge et al., 2018; Beattie et al., 2020). This state of mental well-being is unattainable for most CWSWs due to internal factors within the individual and external factors such as barriers related to undignified and unfair working conditions and social inequality due to barriers stemming from stigma and social discrimination (M. S. Ryan et al., 2019; Zehnder et al., 2019).

Given the above, and considering the lack of empirical studies in Colombia, we set out to elucidate the subjective experience of social stigma on MH among CWSWs in Colombia.

## Methods

### *Study Design*

We conducted a qualitative study framed in the constructivist research paradigm with a hermeneutic phenomenological methodological approach (Neubauer et al., 2019). Therefore, the subjective experience of social stigma in MH among CWSWs was structured and interpreted as part of their naturalistic and embodied reality, derived from the interaction with SW according to the socio-health, cultural, political, and legal circumstances in how the occupation is addressed in Colombia (Neubauer et al., 2019). During the development of the study, we incorporated the criteria of quality and methodological rigor for qualitative research, such as credibility, dependability, confirmability, transferability, and reflexivity (Stenfors et al., 2020).

The criterion of reflexivity was conceived and incorporated transversally as a critical and reflexive dialogic strategy of the overlapping dimensions related to personal, interpersonal, methodological factors and contextual characteristics of SW, which influenced the decisions and course of the research (Olmos-Vega et al., 2023). Allowing to elucidate the study phenomenon as part of the natural experience of CWSWs, who navigate among the unfavorable social circumstances and categories implicit in the exercise of SW.

The elaboration of the manuscript was guided by the COREQ criteria of Tong et al. (2007).

### *Participant Selection*

Purposive sampling (Campbell et al., 2020) was used to select participants who were required to self-identify as cisgender women aged 18 and over and current sex workers willing to share their experiences lived voluntarily and honestly. Children, transgender women, cisgender or transgender men, and non-current sex workers were excluded from the study.

The first author employed four strategies to contact and voluntarily invite CWSWs, as detailed in Table 1.

Finally, 34 CWSWs participated in the study, 16 in the in-depth interviews, and 18 in two discussion groups with nine participants each. All participants who met the eligibility criteria and voluntarily agreed to share their lived experiences were interviewed.

Participants ranged in age from 18 to 62 years; most were heterosexual, single, of low-income, of Colombian nationality, and with incomplete primary and secondary education, as shown in Table 2.

*Context of the Study*

The fieldwork was carried out in the urban centers of Bogotá Capital District and the city of Barranquilla, the capital of the Department of Atlántico in Colombia, see Figure 1. In this country, SW is not illegal when it is carried out voluntarily by persons over 18 years of age, but activities that promote the exercise of this occupation, human trafficking, and child sex procuring are illegal.

*Data Collection*

The fieldwork consisted of in-depth face-to-face interviews and discussion groups conducted between July 2021 and March 2022. These data collection techniques were facilitated face-to-face by the first author, who previously introduced himself and indicated to the participants the purpose of the study.

Data saturation was reached in the 16 individual interviews. Eleven were conducted in Bogotá and five in Barranquilla in a flexible schedule for CWSWs, averaging 65 minutes in a single encounter. It was unnecessary to repeat the interviews among the participants, as doubts and discrepancies arising from the experience narrated were clarified during the interview.

Interviews were conducted in a comfortable space, free of distractions, without third parties, and in an atmosphere of empathy and trust, usually in a room provided by the organization's president or in the residence where the CWSWs provided their sexual services.

Following data saturation, two discussion groups were conducted to enrich the analysis and validate participants' subjective experience of MH (Jayasekara, 2012). Each discussion group consisted of nine CWSWs and took place on the dance floor of a brothel provided by its owner during non-business hours for SW in the city of Barranquilla, each lasting 90 minutes. These in-depth interviews and discussion groups were guided by a thematic script constructed following the steps detailed in Figure 2.

Indeed, the guiding instrument contained open-ended questions with a flexible nature that allowed for rephrasing, reordering, and clarification of the questions, encouraging participants to speak openly about their subjective MH experience of engaging in SW, as shown in Table 3.

The in-depth interviews and discussion groups were recorded in MP3 audio on a smartphone's digital recorder. In parallel, a field diary was kept with contextual records and nonverbal expressions of CWSWs during and after the interviews and discussion groups.

The audio recordings were transcribed verbatim into Microsoft Word, and the quality of the transcripts was checked by comparing the transcribed information with the audio recordings and their consistency with the proposed interview script. In addition, CWSWs were informed and assured of the possibility of checking the veracity of the transcripts; however, none accepted the proposal.

*Ethical Considerations*

Participants were invited and informed verbally and in writing in plain language about the details of the study, data management, and ethical considerations. After clarifying doubts and agreeing to participate in the study, they signed an informed consent document, and each CWSW received a copy of this and an information sheet. During the research, the confidentiality of data and anonymity of participants were ensured through the assignment of pseudonyms. This research is part of the first author's doctoral thesis, which is being developed in the Doctoral Programme in XXXX at the University of XXXX. The thesis is being directed by the second author, whose research project was previously approved by the Bioethics Commission of the same university with the number XXX.

*Data Analysis*

The textual information was imported into the ATLAS.ti software version 22 for Windows. This technological tool facilitated qualitative data storage, organization, coding, and synthesis.

The reflective thematic analysis proposed by Braun & Clarke (2021) was used, with an inductive approach in the coding of the data looking for patterns of shared meanings related to the subjective experience of social stigma in MH among CWSWs, following the six steps proposed by Braun & Clarke (2006), which are detailed in Figure 3.

The quality and credibility during the thematic construction of the subjective experience of social stigma in MH from the naturalistic perspective of CWSWs were ensured through an analytical, cyclical, dialogic, and continuous process between the research team and the participants. Triangulation of data sources (Patton, 1999) was also incorporated, such as field notes that facilitated a contextual interpretation of the experience derived from the interaction with SW and socio-cultural dynamics (Fetters & Rubinstein, 2019) and information gathered in the discussion groups.



**Results**

From the data's reflective and inductive thematic analysis, two general themes emerged with their respective subthemes that elucidate the subjective experience of social stigma in MH among CWSWs in Colombia, as detailed in Figure 4.

*Theme 1. Institutional Stigma*

*Subtheme 1.1. Insensitivity of Healthcare Providers.* The CWSWs stated that when they have required medical attention and have disclosed their SW to health personnel, the therapeutic relationship has been lost due to inadequate and insensitive treatment, lack of ethics and confidentiality, and the association of the occupation with the presence of STIs. This situation has generated in CWSWs a sense of rejection, disgust, and discrimination towards them, negatively affecting their self-esteem.

*For example, an injured female sex worker from Santa Fe neighborhood arrives, one of those women who walk around almost undressed. The rejection of the health staff is like running into a wall! I've heard them say: 'Those are the consequences of where they come from; be careful with them; they may have HIV (Human Immunodeficiency Virus)!'* (Elda)

*The attitude of the medical staff changes one hundred* percent*! It is not to improve my self-esteem but to worsen it. I feel rejected and perceive that the person feels disgusted towards me. There is a sense of mistrust in the relationship, and it is as if sex workers are carriers of venereal diseases such as the HIV.* (Dafne)

On the other hand, some participants indicated that they prefer to avoid attending early detection programs for diseases such as cervical cancer because they have felt that health personnel perform cervical cytology with distrust, rejection, and discrimination, generating discomfort in the care received.

*I have often felt discriminated against because the nurses don't want to touch me; they say to each other, 'You do the cytology on her.' Also, some patients hear what one is talking about with the doctor in the consultation, and they turn away; I feel too lazy to go to the doctor because they see me and discriminate against me too much.* (Discussion group two, Yilda)

*Subtheme 1.2. Abuse of Power by the Police Force.* CWSWs agreed that the police force had been a perpetrator of verbal, physical, emotional, and sexual violence due to previous experiences where police have terrorized them during or after their occupation. Transporting them in vehicles to the police station to steal their money, assault them, or put them to work in cleaning or unpaid and non-consensual sexual services.

*I have heard of female colleagues who have worked all day, tired and all, and in the evening, the police come to pick them up. They are taken to the police station. There, they steal their money, sexually abuse them, and wash them. The police are a determining factor of violence!* (Elda)

*The police are sometimes daring or rude because they come to the brothels and mistreat us.* (Frida)

Participants also perceive the public health strategy to prevent STIs in the relationship with the police as unfavorable. In the case of not carrying laboratory reports of syphilis, HIV, and vaginal smears that accredit them to provide sexual services, they stated that the police officers took this as a pretext to take them against their will and access free and unprotected sexual services.

*When they force us to carry our lab reports for serology, HIV, and vaginal swabs, if we don't have them on hand when the police arrive, they put us in the patrol car so that we give them free sexual services without protection, or they make us wash the police station.* (Bruna)

*Theme 2. Behavioral Stigma*

*Subtheme 2.1. Disagreement with the Social Classification of the Occupation.* The participants have lived stigmatizing experiences related to naming the occupation and the people involved, expressing their disagreement with the term prostitution as having a social and cultural meaning that excludes, degrades, belittles, and discriminates against the person. Furthermore, they consider that prostitution disassociates the person from human rights and promotes the association of the occupation with criminal activities. In contrast, they consider the term SW to have a more dignified and less exclusionary representation.

*Since ancient times, the word prostitution has been used to degrade, belittle, and discriminate. The term prostitution goes against a person's principles; it is like not being part of a country's political constitution as a human being and being part of the crime.* (Dafne)

*The word prostitution is ugly, and it means lying on the street. But, for me, SW is a more decent word, and prostitution is a slur.* (Katia)

Likewise, SW was assumed voluntarily and thought of as a life option by the CWSWs in this study, providing them with the minimum economic resources for housing and personal and family

sustenance; therefore, they recognize the need for the various social environments and discourses to promote the human dignity of people involved in SW.

> *The word prostitution degrades human dignity and promotes more social rejection with this expression. We are not prostitutes because it was a voluntary life choice, and no one is forcing me. My family lives and eats from this activity.* (Fiona)

*Subtheme 2.2. Family Abandonment.* CWSWs expressed the complexity of experiencing hunger, thirst, and homelessness for themselves and their children while mediating between SW and maintaining family relationships, incorporating strategies ranging from denial of the occupation to identification with another socially accepted occupation. Thus, disclosing their work to the family has negatively affected the relationship, linked to a lack of acceptance for going against the values and patterns of upbringing promulgated and instilled by their parents. This exclusion and family rejection have led to feelings of loneliness and abandonment among CWSWs.

> *When they discovered I belonged to the SW community, they stopped talking to me and never called me again. I haven't been going to my family's house for 25 years; I isolated myself from everyone.* (Hada)

Some participants recognize that family and partners benefit from the income from SW but do not actually accept their occupation, especially in the case of intimate partners who, in addition to monitoring and controlling their income, encourage them to continue SW only to satisfy their needs.

> *In SW, the family is seen as the leading economic exploiter and stigmatizing and discriminating agent, but they never accept where the money comes from*. (Zoe)

*Subtheme 2.3. Conflict with Work Identity.* Some CWSWs find it difficult to accept their occupation as a job, generating discomfort when accepting it publicly due to the same social stigmatization, which

translates into feelings of fear if their social environment discovers the work they do, adopting mechanisms to protect their identity, such as the use of pseudonyms or denying their connection to SW when seeking health care.

> *The fact that a woman sex worker does not identify as a sex worker fosters social stigma and barriers to accessing sexual and MH care. In our community, some colleagues use masks and pseudonyms when the media interview them and deny being sex workers when they go to the doctor, so tell me what health workers can do to guide them.* (Dafne)

Most participants who conceal their occupational identity and are interviewed by the media for public reporting on SW issues prefer not to participate in interviews or request to distort their voice, mask their face on camera, and use pseudonyms out of fear and shame of being recognized as part of the SW community.

> *We use masks and pseudonyms when visualizing our problems because we fear our identity will be revealed to society.* (Cloe)

*Subtheme 2.4. Social Isolation.* Participants related the distancing and fragmentation of social and family relationships to the disclosure of their occupation; they have been stigmatized, rejected, and excluded from activities by acquaintances, family, and neighbors, resulting in feelings of contempt and loneliness, causing them to isolate themselves.

> *SW has affected my family relationships and social life; for example, the neighbor doesn't invite me to his birthdays or anything because I work in this, especially in a village where everyone knows what I do.* (Fiona)

> *I am very distant from my family since they found out that I am a sex worker. It's not that I don't want to visit them; I feel criticized and rejected by them.* (Magdalena)

CWSWs also experience anticipated stigma due to previous experiences of stigma, discrimination, and social rejection, generating feelings of doubt and persecution, especially when traveling on public transportation.

*When I go on public transport, I feel that people look at me as if they know I am a sex worker. People kind of already know. Sometimes I ask myself, 'Do they know I'm a sex worker?' Because they look at me funny, even if I'm not naked.* (Crésida)

*Subtheme 2.5. Societal Disapproval of the Occupation.* Most participants have experienced social segregation due to the pejorative and derogatory labeling of SW. Therefore, they agree that it is a difficult job to cope with because of the negative emotional impact of the antipathy and social rejection they face daily. This situation has limited their access to rental housing and social integration, confining them to live close to areas with significant social problems.

*Prostitution is not easy! I tell you what, no matter how much I want to cope with the occupation, I can't. People look at me as something worthless! It's not easy for me!* (Cloe)

*They look at me ugly, or they don't talk to me. It's not easy for me to look for a house to rent because they ask me: 'What do you do for a living?' I answer: SW, and they say: 'Oh, no!'* (Ariel)

In addition, participants have perceived that they are looked down upon and treated as criminals, being linked to and attributed social and legal responsibility in criminal activities, without considering the possible involvement of clients in these social problems that may arise.

*People see us as criminals or the scum of society when the crime comes more from the client than the sex worker herself.* (Dafne)

On the other hand, participants perceive that the media has focused on misinforming society about the different experiences of SW, linking the occupation only to negative and criminal behavior without

delving into the real problems or experiences of those involved, thus fostering stigma and discrimination towards them.

> *The media always show the worst side of SW, highlighting only the negative to make an impact with their news. The same media discourse makes society see us as the worst of humanity, increasing the stigma and discrimination towards our population.* (Tea)

*Subtheme 2.6. Unequal Social Treatment.* Participants reported that treatment by family members and society is always derogatory, with offensive words and belittling and rejecting attitudes that dishonor their human dignity, generating feelings of inequality compared to other women not involved in SW.

> *We are not seen as housewives but as trash, like a dog that is shown an object.* (Katia)

On the other hand, most of the participants indicate their unease about the inequality they experience as sex workers, as they consider that, like any other job, their occupation should be regulated and normalized because they lack equal labor rights and opportunities in terms of social security, generating negative feelings due to stigma and unequal treatment.

> *SW is not regulated, we do not have the same rights or social security benefits, we do not have the same rights as any other worker in terms of protection or recognition of our work; we do not have the guarantee that when we decide to do this work, the stigma and discrimination will end.* (Dafne)

Similarly, for CWSWs, the decision to undergo a voluntary termination of pregnancy has become a controversial issue linked to social imaginaries that stigmatize, discriminate, and criminalize the person who undergoes the procedure, ignoring the actual circumstances and reasons that precede the decision.

> *When we decide to terminate a pregnancy voluntarily, we are often seen as murderers, the whores who eat children.* (Aura)

## Discussion

CWSWs have lived under a stigmatizing gaze and experience disparity and social segregation, leading to feelings that disrupt their MH. Health workers are no strangers to this contribution. Health care provided to CWSWs is sometimes permeated by aversion, discomfort, fear, or disagreement about their occupation, evidenced by inappropriate questions and unempathetic and inflexible attitudes. Lack of sensitive and humanistic health care leads to self-doubt, rejection, isolation, and low self-esteem among CWSWs. Previous studies agree that CWSWs avoid health services or hide their occupation due to unequal, abusive, and insensitive treatment, preventing timely diagnosis and treatment of both physical and mental illnesses (Dourado et al., 2019; P. Ryan & McGarry, 2022; Singer et al., 2021). Other authors found that some health entities and personnel create barriers in the care of CWSWs, such as the total denial of care or increased waiting time for timely access to medical consultations, medications, or screening tests for STIs, and similar to what was expressed by the participants in our study, the lack of privacy and confidentiality in health care was highlighted (Muhindo et al., 2021; Nyblade et al., 2017).

The situation of CWSWs finds no relief in the area of law enforcement, as interactions with police expose them to abuse of power in which officers belittle them and trample on their rights, robbing, raping, or arbitrarily arresting them, articulating their discourse as a strategy to maintain public order and control. As with several studies, police were found to generally apply excessive violence against CWSWs, regardless of whether SW is legalized or not, using police raids as an excuse to control drug addiction, human trafficking, or pimping (Aristegui et al., 2022; Decker et al., 2022). This disparity on the part of the police has remained in the imagination of CWSWs, generating mistrust, which translates into avoidance of the police to prevent altercations. Struyf (2022) mentions four factors associated with the fear that sex workers feel when interacting with the police force, highlighting the fear of punishment, mistreatment, public exposure, and fear of police impunity, causing sex workers to accept and hide

situations of physical, mental, verbal, or sexual violence experienced with their clients, due to the lack of actions that promote and guarantee their rights.

The CWSWs in this study claim that there is a need to stop using the term prostitution to refer to their occupation due to the hostile denotation society gives to the phenomenon; however, in some countries, the term prostitution is still used in legal debates and advocacy groups such as the New Zealand Prostitutes Collective (Benoit et al., 2018). Some scholars and feminist groups refer to the occupation as SW, assuming it to be a trade that grants labor and economic rights to those who engage in it (Benoit et al., 2018). The participants of this study have adopted this classification of their occupation, as it shows that SW is not always forced or part of a criminal system, as the term prostitution has been treated for years, generating discomfort in those involved, as the words prostitution and prostitute attach their occupation with social conflicts and labels such as being indecent, animals, or deviant, taking away all the privileges that a normative job has in society such as being included and accepted as human beings. Similar to Hansen and Johansson (2023), who mention that the term prostitution throughout history has been linked to negative, impure, and unpleasant sexual behavior; in contrast, the term SW allows sex workers to free themselves from stigma and social discrimination.

Likewise, the participants' accounts evidence the constant struggle to eliminate the social labels of prostitute, whore, or slut, and thus prevent the same population of sex workers from being affected by the stigmatization and discrimination associated with these pejorative denominations that affect their self-esteem and mental well-being. Given this situation, Benoit et al. (2017) argue that social and stigmatizing labels become embedded in the psyche of sex workers, causing them to adopt them as part of their lives and accept that they are deserving of segregation and exclusion because of their occupation. On the other hand, a study conducted in Brazil with a sex worker indifferent to self-identify as a prostitute demolishes the belief that the meaning of prostitution is always seen as something negative since her

struggle is for the visibility, support, and prevention of infection by the HIV of the collective of female sex workers in Brazil, rather than for the shame of being called a prostitute or not (Calabria, 2022).

Social stigma towards SW can disrupt the family dynamics and coexistence of CWSWs, especially in family and social dynamics where sex is seen as taboo and the exchange of sex for money is sinful and immoral, causing CWSWs to feel rejected and abandoned. Furthermore, previous studies show that female sex workers are more excluded, judged, and abused by their families for doing their work, increasing feelings of loneliness that affect their MH, manifesting in suicide attempts and mental illnesses such as depression and anxiety (Ruegsegger et al., 2021; Zhang et al., 2017). On the other hand, another study showed that family networks, acceptance of the occupation, and economic redistribution among family members reduced symptoms of depression in female sex workers, as they felt supported and listened to in environments that favored dialogue and healthy coexistence (Nabunya et al., 2021).

The stigmatization experienced by CWSWs becomes an unfavorable factor for the appropriation of their work role, motivating them to hide their occupation out of shame, which causes them to isolate themselves from society, thus reducing their social circle so as not to be identified in the scenarios where SW is practiced. According to McCausland et al. (2022), CWSWs implement these defense mechanisms to divide their personal life from their occupational life, living a double identity and thus affecting their MH by having feelings of guilt for living amid lies established to hide their occupation from their social circle. In addition, women immersed in SW end up isolating themselves, undermining their MH by not having an adequate psychosocial support network. The study by Reynish et al. (2022) found that concealment of occupational identity is a control measure exercised by CWSWs to protect themselves from the negative impacts of stigma; however, this concealment leads to increased psychological distress, stress, and difficulties in seeking care and help for their mental and physical health, which is related to the data found in our study.

One of the consequences of the social stigma attached to SW for the participants in this study is the loneliness they experience because they avoid disclosing their occupation, which leads to social isolation that affects their self-esteem, confidence, and the establishment of social relationships. According to Pinedo González et al. (2021), loneliness generates a combination of unfavorable factors for CWSWs, such as increased vulnerability to violence, low perceived MH, and dissatisfaction with life, affecting their emotions; this causes loneliness to arise due to emotional and social isolation as a response mechanism to discrimination, stigma, and exclusion. Also, social isolation is a precursor to risk factors that increase morbidity and mortality from cardiovascular and mental illnesses, risk behaviors for HIV, and suicides in contexts where poverty or family difficulties are common (Febres-Cordero et al., 2018).

Stigma and social discrimination towards CWSWs construct stereotypes to reject and marginalize, negatively labeling their sexual behavior and assuming them to be immoral, dirty, perverse, and criminal women. Previous studies show similar results where CWSWs are singled out and judged by societies as drug addicts and deviant women, which, coupled with the social context of inequality, poverty, and low education in which most CWSWs live, makes them susceptible to significant problems such as difficulty in renting housing or accessing credit to meet their needs, affecting their physical, mental, and social health, and placing them in a position of greater vulnerability to STIs due to the same political, social and economic inequality (Braga et al., 2022; McCausland et al., 2022; Rock et al., 2023; Stockton et al., 2023).

Finally, participants expressed that for years, society has excluded them and denied them the right to equal rights by negatively classifying their occupation, linking their behaviors and lived experiences with immorality, and treating them unequally and inhumanely for the aberration of SW. As a result, CWSWs feel categorized as vulgar and sick women of the streets, in contrast to non-sex workers, who are socially perceived as good, submissive women of the home. Previous studies have also confirmed that the stigma and discrimination experienced by CWSWs exclude them and render them socially and

politically invisible, generating inequalities that interconnect with social identities related to gender, race, class, and education, resulting in false classifications of good and bad women that demean the integrity and dignity of CWSWs and, in turn, justifies their social marginalization with the immorality attributed to the occupation (Benoit et al., 2018). Similarly, social exclusion leads to other negative processes that result in the deprivation of rights, opportunities, resources, and civic participation, generating greater inequality in the population of CWSWs by preventing them from accessing the opportunities that all people have within a social context, such as social security, housing, and health, which affects their physical, mental, and social health and reduces their quality of life and life expectancy (Tweed et al., 2021).

*Relevance for Research and Healthcare Practice*

This research showed that CWSWs are a socially vulnerable group historically marked by social stigma, highlighting the need to (1) strengthen MH care aimed at this group with diverse unmet needs and high vulnerability to deterioration of mental and sexual health; (2) improve humanized therapeutic communication that generates trust and empathy with the characteristics and needs of this group; (3) disassociate the imaginary of always associating SW with social problems to avoid judging CWSWs because all people have the right to have their dignity respected and, therefore, to be provided with comprehensive health care that facilitates preventive self-care alternatives to mitigate the damage to MH derived from the occupation and social stigma; (4) sensitize current and new generations of health professionals in general and nurses in particular to the fact that SW is part of a social reality that will continue to exist as long as social inequality prevails; and (5) to add health research that helps to understand the actual MH needs and the contextual approach to care that promotes mental well-being for this socially vulnerable group, considering that the deontological duty of health professionals is humanized and holistic care beyond the moral judgment of whether this occupation should or should not exist in societies.

*Limitations*

The findings of this study should be interpreted with the following limitations in mind: (1) the results lack statistical significance to be extrapolated to the rest of CWSWs due to the qualitative nature of the study; (2) the need for previous studies on the object of study at the local level limited the comparability of the findings; (3) it is possible that CWSWs withheld sensitive information or gave socially desirable responses when elucidating their subjective experience related to occupational stigma on their MH due to the social and cultural significance of SW; (4) the study was conducted with CWSWs in a very vulnerable socio-economic situation; therefore, it did not reflect the subjective MH experience of those in a more favorable social position; and (5) the researchers' nursing background may have influenced the analysis and interpretation of the data.

**Conclusion**

The subjective experience of CWSWs elucidates the repudiation of a society that labels their occupational role as immoral and repulsive because of its association with unhealthy practices, criminality, and violence, which isolates them from social contexts and renders their support networks ineffective in meeting their psycho-emotional needs. In addition, health professionals often lack the skills and strategies to provide and ensure humane, empathetic, individualized, and respectful care. Consequently, it causes CWSWs to hide their work identity or avoid contact with health services for fear of victimization, moral judgment, and violations of their human integrity, which increases the risk of mental and sexual morbidity and mortality.

In sum, the social stigma experienced by CWSWs makes them feel impure, segregated, and abandoned from family and social dynamics, increasing feelings of low self-esteem, self-doubt, fear, frustration, and sadness, which alters their MH and increases the risk of suicide. Health professionals must be sensitive to this reality to attempt to open communication with CWSWs, allowing for a humanized therapeutic relationship that develops in mutual trust.

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**Declaration of Conflicting Interests**

The authors declare that they have no conflict of interest.

**Availability of data and material**

Data will be made available upon explicit request to the corresponding author for privacy protection reasons.

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**Tables & Figures**

**Table 1.** Strategies for Contacting and Inviting Participants.

| Strategy | Description |
|---|---|
| 1. | Communication via telephone and email with the president of the only organization of CWSWs in Colombia, whose contact details were obtained from the organization's website and to whom the characteristics of the study were explained in person; she was subsequently interviewed, and in turn, she facilitated the contact for the voluntary participation of five CWSWs who were part of the organization, thus completing the first six participants interviewed individually. |
| 2. | The other ten CWSWs were contacted and invited face-to-face and interviewed individually at a time and place of their convenience through walks through streets and |

parks in the city centers of Bogotá Capital District and Barranquilla, specifically where CWSWs are most commonly contacting their clients.

3. The snowballing technique was applied among the participants when the face-to-face invitation in the streets and parks was unsuccessful.
4. The 18 volunteers in the two discussion groups were contacted with the help of the president of the organization of CWSWs in Colombia and with the collaboration of a CWSW representative in the city of Barranquilla.

**Table 2.** Socio-demographic Characterization.

| Characteristics | In-depth interviews (n=16) | Discussion groups (n=18) | (N=34) n | % |
|---|---|---|---|---|
| Age in years | | | | |
| 18-28 | 2 | 2 | 4 | 11.76 |
| 29-39 | 2 | 7 | 9 | 26.47 |
| 40-50 | 3 | 5 | 8 | 23.53 |
| 51-61 | 6 | 3 | 9 | 26.47 |
| >62 | 3 | 1 | 4 | 11.76 |
| Sexual orientation | | | | |
| Heterosexual | 13 | 17 | 30 | 88.24 |
| Homosexual | 1 | 0 | 1 | 2.94 |
| Bisexual | 2 | 1 | 3 | 8.82 |
| Education | | | | |
| Illiterate | 1 | 2 | 3 | 8.82 |
| Incomplete primary school | 6 | 9 | 15 | 44.12 |
| Completed primary school | 1 | 0 | 1 | 2.94 |
| Incomplete secondary school | 4 | 5 | 9 | 26.47 |
| Secondary school completed | 2 | 2 | 4 | 11.76 |
| Technologist | 1 | 0 | 1 | 2.94 |
| Professional | 1 | 0 | 1 | 2.94 |
| Religion | | | | |
| Atheist | 1 | 0 | 1 | 2.94 |
| Catholicism | 11 | 13 | 24 | 70.59 |
| Protestantism | 4 | 5 | 9 | 26.47 |
| Age (in years) of initiation | | | | |
| 12-22 | 8 | 8 | 16 | 47.06 |
| 22-33 | 6 | 7 | 13 | 38.24 |
| 34-44 | 0 | 2 | 2 | 5.88 |
| > 45 | 2 | 1 | 3 | 8.82 |
| Length of time in sex work (in years) | | | | |
| 1-10 | 6 | 8 | 14 | 41.18 |
| 11-21 | 0 | 4 | 4 | 11.76 |
| 22-32 | 7 | 3 | 10 | 29.41 |
| >33 | 3 | 3 | 6 | 17.65 |
| Marital status | | | | |

| | | | | |
|---|---|---|---|---|
| Single | 13 | 12 | 25 | 73.53 |
| Married | 0 | 1 | 1 | 2.94 |
| Divorced | 2 | 1 | 3 | 8.82 |
| Cohabiting | 1 | 4 | 5 | 14.71 |
| Place of residence | | | | |
| Bogotá | 11 | 0 | 11 | 32.35 |
| Barranquilla | 5 | 18 | 23 | 67.65 |
| Migrant | | | | |
| Yes | 4 | 9 | 13 | 38.24 |
| No | 12 | 9 | 21 | 61.76 |

**Table 3.** Interview Script.

| | Stimulus questions |
|---|---|
| 1. | From your point of view, what is your opinion of sexual services? |
| 2. | What does it mean to you to be a sex worker? |
| 3. | In your emotional, family, and social life, do you freely recognize yourself as a sex worker? Why? |
| 4. | When you need health care, do you identify as a sex worker? |
| 5. | What is the social reaction when you identify as a sex worker (with family, health professionals, and others)? |
| 6. | Does your family know that you are involved in SW? |
| 7. | How do you view the treatment of healthcare officials and staff toward those who identify as sex workers? |
| 8. | What has been your experience when you have needed health care? |
| 9. | How would you like to be treated when you go for health care? |
| 10. | How do you think your clients treat you? |
| 11. | Have you experienced hostile attitudes when disclosing your occupation to anyone? |
| 12. | Do you think that having an STI creates difficulties in communicating with another person? Why? |
| 13. | How do you prefer to be referred to as a sex worker or a prostitute? |
| 14. | What does it feel like to be a sex worker? |
| 15. | What do you expect from SW in the long term? |
| 16. | Has it been a challenge to cope with the fact that you are a sex worker? |
| 17. | Do you find SW easy? |
| 18. | How do men perceive you when they discover your occupation? |
| 19. | Have you experienced abuse as a sex worker? |

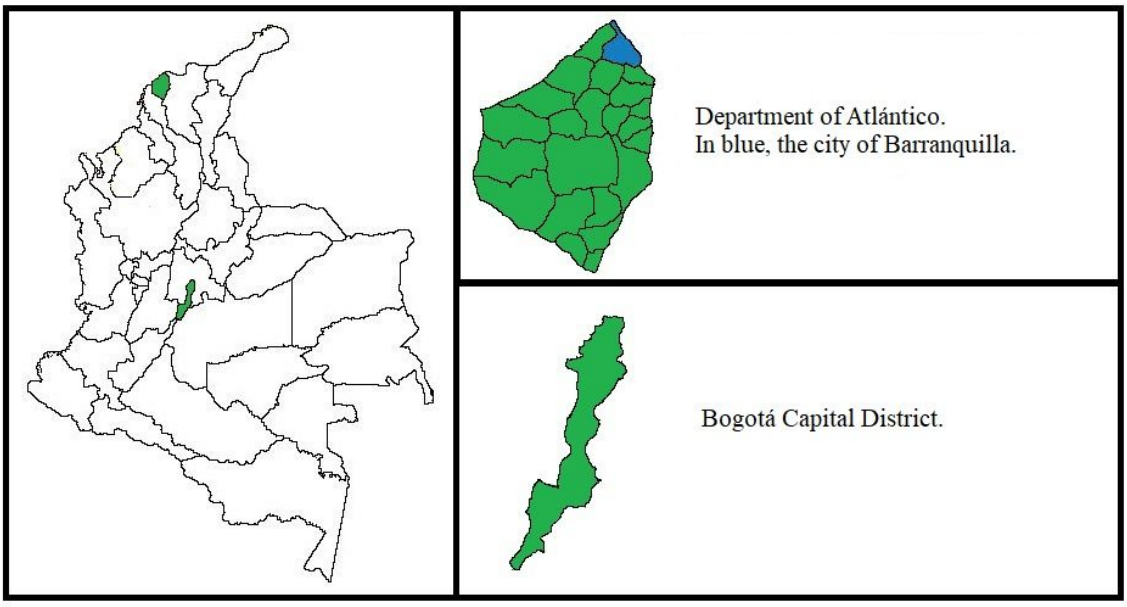


**Figure 1**. The geographical Location of fieldwork.

Note: Own elaboration (2023). The geographical location of the fieldwork.

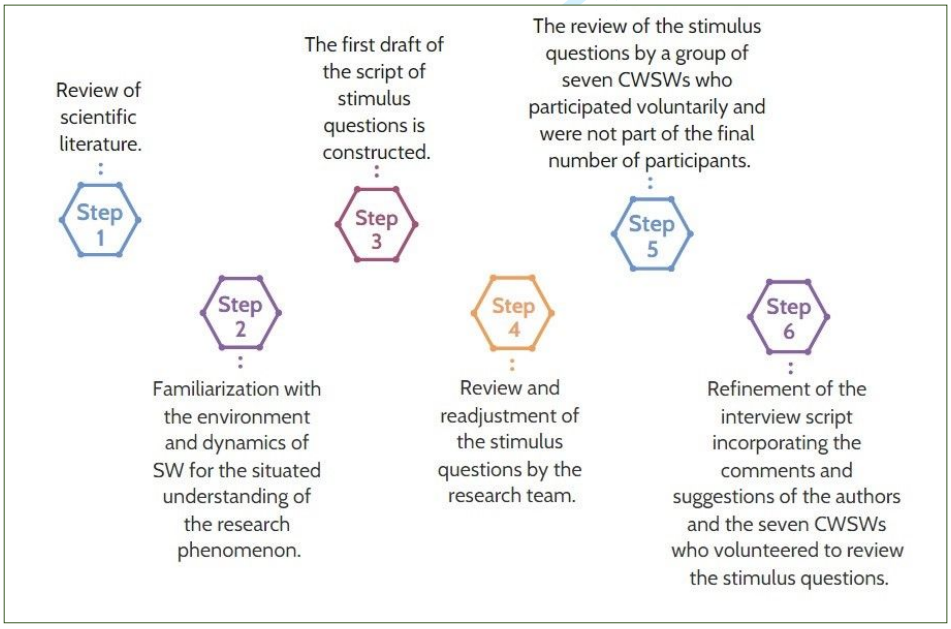


**Figure 2.** Steps for the Elaboration of the Interview Script.

Note: Own elaboration (2023).

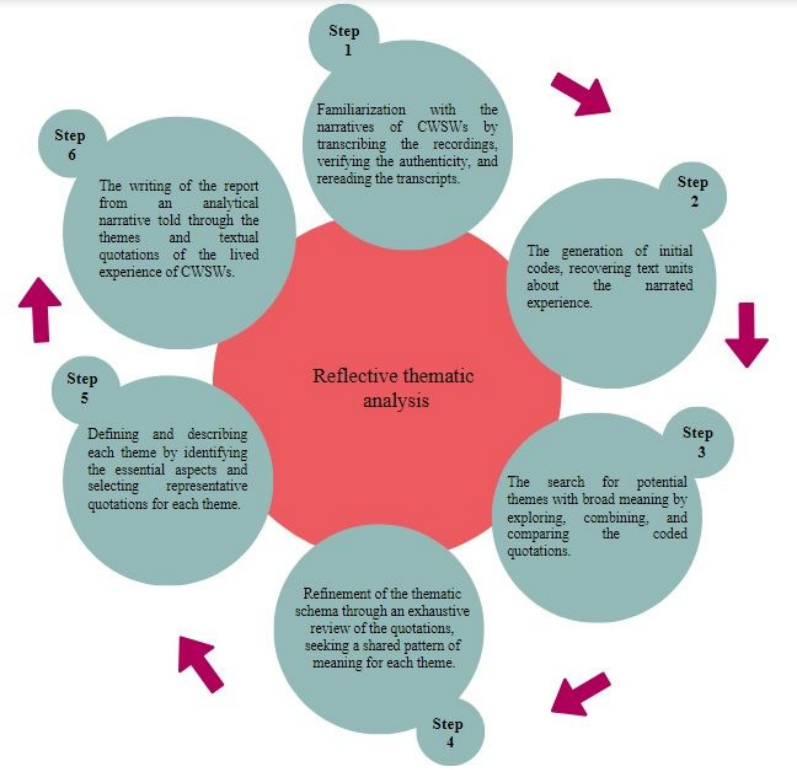


**Figure 3.** Reflective Thematic Analysis.

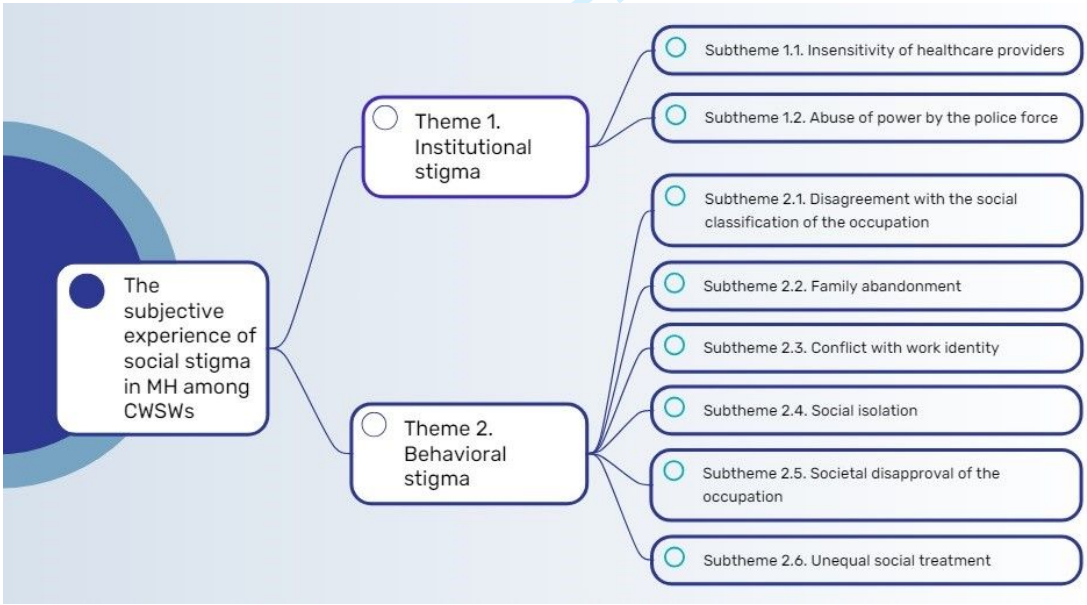


**Figure 4.** The Subjective Experience of Social Stigma in MH among CWSWs.