Final Report

Title of research (in English)

Pregnancy and childbirth among women working in sex: Developing a model for best reproductive health care practice

Title of research (in Hebrew)

הריון ולידה בקרב נשים בזנות: פיתוח מודל למתן שירותי בריאות מיטביים

פרופ' עינת פלד, פרופ' יעל בנימיני, גב' יעל גור, ד"ר זהר סהר-לביא

Executive Summary- Hebrew

רקע מדעי: נשים בזנות הן אחת האוכלוסיות המודרות ביותר בהקשר של שירותי בריאות בכלל וביחס לשירותי בריאות בתחומי ההיריון והלידה (שבה"ל) בפרט. רבים מניחים כי נשים בזנות הנן רווקות, שאינן מעוניינות בילדים ושהן מנסות להימנע מהריון. אולם מחקרים מוכיחים שהריון ולידה נפוצים בקרב נשים בזנות בעולם ובישראל. בישראל, ההערכה היא כי מתוך כ-10,000 נשים בזנות, 70 אחוזים הנן בגילאי 18-40, וכ-70 אחוזים הנן אימהות (Santo & Carmeli, 2016).

על אף הצורך בשירותי בריאות סביב הריון ולידה, הוצע כי נשים בזנות מתמודדות עם חסמים רבים בצריכת שבה"ל, בהם סטיגמה, חסמים כלכליים, גילוי מאוחר של ההיריון והעדר מידע (למשל: Parmley et al., 2019). תחום המחקר הבוחן את צרכיהן של נשים בזנות סביב הריון ולידה הולך ומתפתח, אולם קיימת התייחסות מועטה למודלים מעוגנים בנתונים סביב מתן שבה"ל לאוכלוסייה זו. מחקרים אודות החוויות והתפיסות של נשים בזנות עצמן ביחס לשבה"ל וכן אודות תפיסותיהם של אנשי רפואה ביחס לנושא הנם מועטים. כמו כן, אין בישראל קווים מנחים לשבה"ל עבור נשים בזנות.

מטרות המחקר: 1. להבין את התנסותן של נשים בזנות בישראל בהריון ולידה. 2. להבין את תהליכי ההיעזרות של נשים בזנות ולמפות גורמים מעכבים ומקדמים בקבלת סיוע רפואי הולם במצבי הריון ולידה. 3. לפתח מודל אמפירי מעוגן בנתונים למתן שבה"ל מיטביים לנשים בזנות בישראל.

שיטות המחקר: מחקר איכותני זה נשען על גישת התיאוריה המעוגנת בנתונים (Grounded Theory) (Corbin & Strauss, 2015). איסוף הנתונים התקיים באמצעות 48 ראיונות עומק חצי-מובנים שנערכו עם עובדות במוסדות רווחה המיועדים לנשים בזנות המסייעות להן סביב הריון ולידה

(n=15), עובדות במוסדות בריאות בשירותים המספקים מענה לנשים בזנות סביב הריון ולידה (n=20), וכן נשים בזנות אשר קיבלו שירותי בריאות במצבי הריון ולידה (n=13). הדגימה הייתה מגוונת מבחינת נשות המקצוע וסוגי השירותים וכן מבחינת נשים בזנות (מאפייני הזנות, גיל, מוצא אתנו-לאומי ומעמד אזרחי). הראיונות הונחו על ידי מדריך ראיון ונערכו פנים אל פנים, בטלפון ובזום. המחקר אושר על ידי ועדת האתיקה של אוניברסיטת תל-אביב ונערך תוך הקפדה על כללי האתיקה. הראיונות הוקלטו, תומללו ונותחו בהתאם לגישת התיאוריה המעוגנת בנתונים. צוות החוקרות כלל נשות מקצוע בתחום הסיוע לנשים בזנות וכן אישה עם רקע של זנות.

ממצאים ומסקנות: 1) מערכת מורכבת של גורמים מעכבים ומקדמים מעצבת מתן שבה"ל לנשים בזנות: אלו ממוקמים ברמה החברתית (כמו סטיגמה), במערכות הבריאות והרווחה, ברמה הבין-אישית וכן ברמת האישה. 2) תהליכי היעזרותן של נשים בזנות בשבה"ל הנם **בלתי לינאריים**, וכן מאופיינים בהעדפת שירותים **לא פורמאליים** על פני שירותים פורמאליים, רפואה **פרטית** על פני ציבורית, ו**שירותי חירום** כגון מיון על פני שירותים מכוונים-מניעה בקהילה. תהליכי היעזרות אלה מתעצבים על רקע: א. הכרות עם ארגונים ייעודיים לסיוע לנשים בזנות (או העדרה); ב. פער בין אופי מערכת הבריאות (ביורוקרטיה, המתנה) לבין צרכי האישה (מצבים אקוטיים, צורך במענה "כאן ועכשיו"); ג. ניסיון קודם ובלתי מיטיב בצריכת שבה"ל, המשפיע על ההיעזרות בהווה. 3. הגורמים המעכבים והמקדמים מתן שבה"ל מיטביים לנשים בזנות פועלים באופן משולב: לרוב מדובר במספר גורמים הפועלים יחד ומסבירים היעזרות או הימנעות מפנייה לשבה"ל. 4. **סטיגמה** כלפי נשים בזנות מהווה חסם מרכזי ורב-ממדי: סטיגמה ברמה החברתית משליכה על יחסם של נותני.ות שירותים כלפי נשים בזנות, על טיב הטיפול המוענק להן, על אופי הקשר של נותני השירות עם האישה, וכן על בחירת האישה האם וכיצד להיעזר בשבה"ל. 5. תהליכי ההיעזרות מתעצבים עבור קבוצות שונות של נשים בזנות על רקע הקשרים תרבותיים-חברתיים.

השלכות למדיניות והמלצות למקבלי ההחלטות: נשים בזנות ישולבו בתכנון ובמתן שירותים. פרוטוקול התערבות במצבי הריון ולידה עם נשים בזנות יכלול מספר רכיבים: 1) קווים מנחים לתכנון התערבות. **טיפול רגיש-טראומה:** אימוץ הפרוטוקולים הקיימים אודות טיפול רגיש-טראומה, כולל העזרות בתוכניות לידה ובחדרי לידה מודעי-טראומה; העדפת מתן טיפול ע"י נשים; מתן הסברים

לפני בדיקות, במיוחד גופניות; העדפת אולטרסאונד נייד (ללא בדיקה וגינאלית) במהלך הלידה ועוד. זאת, תוך התייחסות לצרכים ייחודיים של נשים בזנות, כבוד לכוחותיה ולבחירותיה של האישה, יחס אמפתי והעדר שיפוטיות. **הריון ולידה כ"חלון הזדמנויות" לזיהוי צרכים ויצירת קשר:** במהלך בדיקות הריון, בוועדה להפסקת הריון וכן בלידה - איתור גורמי סיכון וצרכים פסיכו-סוציאליים והפניית האישה לגורמי סיוע רלוונטיים; במקרה שישנו גורם מלווה - קיום שיחה ראשונית עם האישה לבדה; תליית הסברים במגוון שפות אודות סימני זיהוי לניצול רגשי, פיזי ומיני. **חיזוק קשרים בין-ארגוניים ובין-מקצועיים:** בפרט, חיזוק ההכרות בין ארגונים ייעודיים לא.נשים בזנות בקהילה ובין שבה"ל.

2) קווים מנחים להנגשת שירותים. **שיפור והנגשת *שירותים קיימים* לאוכלוסייה הכוללת:** כולל, בין היתר, שיפור והנגשה של שירותים מודעי-טראומה בהריון ולידה, הנגשת קורסי הכנה ללידה בקהילה לנשים במצבי הדרה, הרחבת סל הבדיקות למחלות מין בהריון לכלל הנשים בישראל. **זאת לצד פיתוח ושיפור *מענים ייחודיים* לנשים בזנות:** כולל, בין היתר, הפניית משאבים להרחבת שבה"ל ייעודיים לנשים בזנות בקהילה**,** הרחבה ופיתוח של מענים שיינתנו ללא עלות או בסבסוד, יהיו זמינים בטווח רחב של שעות ולא יצריכו קביעת תור מראש. **"אף אישה לא יולדת לבד" - פיתוח מערכי ליווי סביב הריון ולידה:** מערכי ליווי בשלבי ההיריון, ההכנה ללידה, בלידה וכן ליווי רגשי ופיזי לאחר לידה; הנגשת שירותי דולה לנשים במצבי זנות והדרה; פיתוח מענים לאימהות בזנות וילדיהן.

3) קווים מנחים להכשרת צוותים. **רפלקטיביות:** עידוד מודעות א.נשי צוות ביחס לעמדותיהם כלפי זנות, ולידה ואימהות במצבי זנות. **מתן מידע על נשים בזנות:** כולל, בין היתר, סוגי ומאפייני זנות, צרכים מגוונים על רקע מגדר, מוצא, מעמד, תחלואה כפולה וכו'; צרכים רפואיים במצבי הריון ולידה בקרב נשים בזנות; מחלות מין; טראומה ופוסט-טראומה. **הכשרות על ידי נשים עם רקע של זנות.**

4) הנגשת מידע לנשים בזנות. **מידע אודות בריאות האישה**: עבודה פסיכו-חינוכית אשר תנגיש מידע אודות בריאות מינית, הריון ולידה, תוך שימוש בשפה מכבדת ותוך רגישות תרבותית. **מידע והתנסות בצריכת שירותים:** התנסות פרקטית בצריכת שירותי רפואה. **שימוש במדיה ובאמצעים טכנולוגיים:** הנגשת מידע באופן ויזואלי ובשפה נגישה.

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Comprehensive scientific report - English

Pregnancy and childbirth among women working in sex: Developing a model for best reproductive health care practice

Scientific Background

Israel has a robust, relatively efficient public system of healthcare, yet disparities persist based on socioeconomic factors and a geographic maldistribution of resources (Clarfield et al., 2017). Israeli women working in sex (WWS)[1] are among the most marginalized populations in regard to healthcare in general, and reproductive health care (RHC) in particular. RHC pertains to information, education, and services surrounding reproductive tract infections and sexually transmitted infections, abortion, family planning, prenatal care, safe births, and postnatal care (World Health Organization [WHO], 2004).

WWS's often unplanned pregnancies are not necessarily unwanted (du Plessis et al., 2019). Reports of RHC for WWS center mainly on the prevention of pregnancies or, if this failed, the termination of these pregnancies. At the same time, despite high rates of pregnancy terminations and miscarriages, most WWS experience full term pregnancies and bear children.

Early and regular prenatal care is essential to ensure the health of WWS and babies, as WWS often live in highly stressful conditions. Prenatal anxiety and stress have been linked to low birth weight, preterm birth, worse fetal neurodevelopmental and child outcomes, and poor maternal mental health postpartum (Dunkel Schetter & Tanner, 2012). The latter can impair attachment and parenting, and consequently impair infant emotional, cognitive, and physical development (Pisoni et al., 2014). Maternal prenatal stress and exposure to violence may also lead to a range of short and long-term child physical and mental health problems (Beydoun & Saftlas, 2008; Manzari et al., 2019; Sosnowski et al., 2018; Toso et al., 2020).

Despite their complex needs, WWS encounter significant challenges in seeking

[1] We use the term *women working in sex* (WWS) (Showden, 2011) to refer to women who exchange sex for money in various settings (e.g. street, brothels, discrete apartments, spa and health clubs, and strip-clubs). Shawden suggests that many of the terminologies employed by researchers and activists (such as prostitution, sex work, sex trafficking, and survival sex) are associated with a particular ideological or theoretical position regarding the phenomenon, often not held by the woman herself. The term 'WWS' allows more room for the women to define the particular meaning and context of their work in sex.

and receiving RHC services. Supporting them involves unique considerations, yet little is offered in the way of evidence-based models of RHC to this population. The available research mostly outlines risks and barriers attributed both to the women themselves and to social systems and professional services available to them. Only a few studies have focused on the particular experiences and perceptions of WWS and of health professionals, related to seeking and providing RHC, pregnancy and birth-related services to WWS. Moreover, little understanding exists of how these experiences vary for WWS of diverse groups, nor of how they are shaped within the context of specific healthcare systems, such as the Israeli one.

Therefore, this qualitative Grounded Theory (GT) (Corbin & Strauss, 2015) study aimed at offering a comprehensive understanding of the barriers and enabling factors to providing best RHC to WWS, and developing an evidence-based conceptual model of best RHC practice with Israeli WWS, based on the perspectives and experiences of both WWS and RHC professionals.

Pregnancy and childbirth among WWS

Some of the most common myths about WWS is that they are single, do not want children, and try to avoid pregnancy (Strathdee et al., 2015). In contrast, the evidence shows that pregnancy and childbirth are common experiences among WWS in general and particularly in Israel. A recent national survey (Santo & Carmeli, 2016) estimated the number of Israeli WWS at 10,000, of whom 70% are 18 to 40 years old and 70% are mothers to children, yet no data exist on the annual number of pregnancies among Israeli WWS. Globally, the majority of WWS are mothers (Willis et al., 2016). Data from low- and middle-income countries as well as from high-income countries suggest that the incidence of pregnancy in general and unintended pregnancy among WWS is high (Ampt et al., 2018; Duff et al., 2011; Simoes et al., 2017; Twahirwa Rwema et al., 2019).

The main risk factor for unintended pregnancy among WWS is failure to use effective contraception (Ippoliti et al., 2017). Additional risk factors include substance abuse, a large number of clients, and exposure to sexual and physical violence (Marlow et al., 2014; Oza et al., 2015). Pregnancies have been found to be more likely among younger women, with low income, those who have an emotional partner, and who had given birth, miscarried, or terminated a pregnancy (Duff et al., 2018; Weldegebreal et al., 2015).

Access and utilization of RH services by WWS

Antenatal and postpartum healthcare are important for maternal health and infant development of all women, but particularly crucial in this population due to the coinciding risk factors, such as substance abuse, STIs and HIV, and to their work conditions. Pregnant WWS typically continue working and report concerns about HIV infection during pregnancy, fear of violence from clients and worries about their safety in general (Parmley et al., 2019; Sloss & Harper, 2004). In addition, they often do not know who the father is and cope with the pregnancy with little support (Yam et al., 2017). Most seem to continue sex work due to their current and anticipated postpartum financial needs (e.g., Becker et al., 2012). Their work practices are often incompatible with pregnancy and particularly with parenting, creating difficulties in recommended practices such as breastfeeding (Parmley et al., 2019). The various risk factors lead to poor pregnancy outcomes, such as higher rates of stillbirths and serious health problems, including neonatal deaths, low birthweight, prematurity, and neonatal abstinence syndrome, as well as developmental problems seen in the children (Willis et al., 2016).

However, WWS' access to health services is limited and thwarted by many barriers (Oza et al., 2015). The bulk of available research in this domain, based on the perspectives of WWS regarding their general experience with health services, uncovers (dis)enabling factors. Stigma was found to be the main and most detrimental barrier to health care access and utilization among WWS (e.g., Beckham et al., 2015; Benoit et al., 2019; Dourado et al., 2019; Jeal & Salisbury, 2004; Katz et al., 2016; Lasater et al., 2019; Lazarus et al., 2012; Luchters et al., 2016; Ryan et al., 2019), requiring them to employ stigma-related coping strategies when accessing health care services (Ma & Loke, 2019). Other factors suggested to impact access of WWS to health services are: low education and ethnic/racial minority status (Toquinto, 2017), late discovery of the pregnancy (Parmley et al., 2019), perception of providers' judgmental behavior and lack of willingness to treat them (Toquinto, 2017; Wahed et al., 2017); the setting of sex work (e.g., street-based vs. massage parlors; Jeal & Salisbury, 2007), health or service information, social support, appointments and waiting time, quality of healthcare, available and affordable services, and healthcare policy (P. H. X. Ma et al., 2017; Wahed et al., 2017).

Need factors as perceived by WWS, mentioned above, include specific health and safety concerns related to their pregnancy, particularly as most of them continue

to work. The complementary view of WWS's needs as understood by healthcare providers, seems to play an important role in WWS's access to health services and their utilization. Yet, there is a dearth of research on the experiences and perspectives of health professionals regarding helping WWS, with the exception of victims of sex trafficking (Chaffee & English, 2015; Dovydaitis, 2010). Even so, gynecologists seem to be ill-trained to identify sex exploitation and its consequences (Geynisman-Tan et al., 2017). Two studies of nursing and medical students suggested they had little knowledge of WWS (Ma & Loke, 2020; Nakagawa & Akpinar-Elci, 2014).

Very little is known about the access of WWS specifically to RHC services and to supportive interventions related to pregnancy and birth. In a study of WWS with HIV diagnosis, over half reported no communication with health providers about their pregnancy. A significant association has been found between having spoken to a health provider about HIV in pregnancy and a more positive perception of their provider; and, participants were less likely to speak with a provider if they had a history of drug use or current alcohol use (Cernigliaro et al., 2019). WWS who are mothers may have more exposure to healthcare because of seeking antenatal/perinatal services yet this was not found to lower their fear of seeking services or their avoidance of health services (Papworth et al., 2015).

The Israeli context of RHC practice with WWS

Being paid for sex in Israel is legal as an adult. Nevertheless, 'prostitution' is highly stigmatized in Israeli society, as evident in cultural, political, academic, and media discourses on the topic (Almog, 2010). In recent years, there is a noticeable impact of the view of paying for sex as a form of violence against women in both the public and professional discourse (Peled & Krumer-Nevo, 2013), which led to a new law that criminalizes paying for sex — coming into effect in July 2020 and being enforced since December 2020. A survey conducted in 2014 estimated that 12,000 people in Israel were 'in prostitution', 95% of whom were women and 11% minors. The settings where women get paid for sex are varied, though it is estimated that about half of WWS in Israel work at brothels and discrete apartments, whereas only 7% are involved in street prostitution (Santo & Carmeli, 2016).

All Israeli citizens are entitled to universal public health services covered by the Israel National Health Insurance Law. Legal residents of the country are entitled to a defined basket of health services (Clarfield et al., 2017). Thus, most WWS in

Israel are entitled to free basic RHC services. As in other countries, RHC services in Israel are impacted by cultural norms. Specifically, Israeli society has a strong pronatalist orientation and attaches great importance to family, marriage, motherhood, and raising children (Fogiel-Bijaoui, 2005; Granek & Nakash, 2017). Accordingly, Israeli national health insurance covers expansive universal antenatal and postpartum health and mental health services, and pregnant women are granted many rights. Terminations of pregnancy require approval from a pregnancy termination committee on specific grounds established by law. In practice, virtually all requests to terminate a pregnancy on these grounds are approved (Granek & Nakash, 2017). Abortion of unwanted pregnancy of WWS may be justified based on several of these grounds, including: the woman is unmarried or the pregnancy is not from the marriage, the pregnancy resulted from an illegal act, or the continuation of the pregnancy is liable to endanger the life of the mother or cause her physical or emotional harm.

No data exist on the actual use of health services in general and RHC services in particular by WWS in Israel. While public Israeli RHC is generally of good coverage and quality, it is not available to women who are not citizens or legal residents. Moreover, studies revealed vast socioeconomic inequalities in health indicators and in Israel's healthcare system due to economic and cultural barriers (Horev & Avni, 2016). Several psychosocial support services for WWS in Israel were established in recent years, mostly at the geographic center of the country, yet only two mobile clinics provide medical services to WWS.

Theoretical framework

This study makes a heuristic use of the theoretical models of help-seeking processes (Cauce et al., 2002) and of the Behavioral Model of health services use (BM) (Andersen & Newman, 1973) to further the understanding of access and utilization of RHC among WWS. The theoretical concept of help-seeking was used in numerous studies on women exposed to violence, health issues, and stigma (e.g., Ali et al., 2017; Lelaurain et al., 2017; Schnyder et al., 2017) and facilitated the exploration of RHC-related experiences and perceptions of WWS. Help-seeking is about communicating with other people to obtain help in terms of understanding, advice, information, treatment, and general support, in response to a problem or a distressing experience (Rickwood et al., 2015; Saint Arnault et al., 2018). The multifaceted macro-level help-seeking model proposed by Cauce and colleagues

(2002) – based on the models of Pescosolido's (1992) and Andersen and Newman (1973), centers on both individual and social systems and outlines three interrelated, non-linear steps: problem recognition, the decision to seek help, and the selection of a help provider. It involves various pathways associated with personal, attitudinal, experiential, and structural factors that shape persons' engagement along the help-seeking process.

The BM (Andersen & Newman, 1973) views utilization of health services as an individual behavior associated with personal characteristics of people, which are influenced by societal factors (e.g. norms) – directly and through health system factors, resources, and organization. This model has been widely used to study healthcare use (see review, Babitsch et al., 2012) and has also been applied to pregnancy care (Okonofua et al., 2018). We used it to explore how RHC professionals contextualize their experiences of providing help to WWS within social and health system settings.

Research objectives

The aims of the study were:

(1) To understand RHC experiences of Israeli WWS.

(2) To understand RHC help-seeking processes of WWS, and identify barriers and enabling factors to receiving needed RHC.

(3) To develop an empirically grounded evidence-based model of best RHC practice with Israeli WWS.

Methodology

Sample and recruitment. This qualitative study utilized GT method, aimed at developing data-embedded theoretical models, while using varied data sources to facilitate a multidimensional understanding of the studied phenomenon (Corbin & Strauss, 2015). Data were collected through 48 semi-structured interviews with: (1) practitioners in social services directed at WWS (n=15); (2) practitioners in healthcare settings (n=20); and (3) WWS in various sex work settings, who received RHC, pregnancy and childbirth-related medical services (n=13).

As per GT *theoretical sampling* principles, the preliminary sampling plan was adjusted during the course of the study based on the evolving conceptual model produced through simultaneous data collection and analysis (Corbin & Strauss,

2015). Recruiting the participants was done via convenience sampling based on the researchers' personal and professional contacts and snowball sampling, based on participants' referrals (Patton, 2015). We aimed at a sample that reflects heterogeneity in terms of geographical locations and demographic characteristics of the services and of WWS. A research assistant who is a former WWS assisted in developing the interview protocol and in the recruitment phase.

Data collection. The interviews were conducted between June 2021 and July 2022. All interviews were conducted by the first author in Hebrew, except for one interview conducted in Arabic and translated to Hebrew by a research assistant. The interview protocol comprised questions regarding WWS' experiences and needs surrounding pregnancy and childbirth, covering RHC needs ranging from prevention to postpartum phase (see Figure 1). The questions focused on barriers and enabling factors to RHC utilization, and the relationship between service providers and WWS. Twenty-five interviews were conducted via Zoom, 12 via phone, and 11 face-to-face, according to interviewees' preferences. All interviews were recorded and transcribed verbatim.

Participants**.** *WWS.* 13 WWS were interviewed. Women's ages ranged from 21-40 (mean = 28). Ten were Jewish, and three were Arabs. They all hayoungd children who lived with them, except two who had partial custody and were under child protection supervision. Two were pregnant at the time of the interview. All reported they do not work in sex at the moment except for one. *Service providers.* Thirty-five service providers were interviewed. All were women. Their ages ranged from 26-68 (mean = 44). Thirty-three were Jewish, one was Arab, and one was Christian. Practitioners in social services directed at WWS included 11 social workers, two NGO directors, and two activists in organizations for WWS. Practitioners in healthcare settings included 12 social workers, two doulas, two obstetricians, a psychiatrist, an internal medicine doctor an oncologist, and a nurse. Social services directed at WWS included state-funded and semi-funded organizations and NGOs, and provided services for adults and young adults. Healthcare organizations included community HMOs and hospitals. The organizations offered services to a diverse WWS client population (i.e., in terms of gender, sexual orientation, age, citizenship status, nationality, ethnicity, and setting of working in sex).

Data analysis and trustworthiness. Data analysis was conducted using MAXQDA software and followed the analytic steps of GT (Corbin & Strauss, 2015): (1) in an

open coding all data were coded to identify themes and concepts; *axial coding* included grouping and regrouping, resulting in *focused codes* that represented the most significant and frequent barriers and enabling factors. Finally, *theoretical coding* was used to organize and integrate the analysis into a coherent analytical framework organizing the relationships between ideas, themes, and concepts. The entire research team discussed the analysis outcomes at various stages to deepen understanding and support credibility.

Ethical considerations. The study was approved by Tel Aviv University IRB. Extra care was taken to ensure the ethical tenet of "do no harm" in this sensitive study (Peled & Leichtentritt, 2002). We made an effort to guarantee safe, private, and pleasant conditions for the interviews. The participants and organizations' names and identifying information were changed to attain confidentiality.

Findings

We have identified a multi-layered model of barriers and enabling factors that are linked with the provision of RHC for WWS (see figure 2). The model entails numerous barriers and only a few enabling factors. Barriers range from societal factors such as stigma through factors within the healthcare and welfare systems, informal interpersonal relationships, and women-related factors. The barriers and enabling factors vary for WWS of differing social statuses, identities, and sex work settings.

Against this backdrop, WWS' help-seeking processes were described as non-linear, including a general preference for **informal** rather than formal services, **private** rather than public services, and **an emergency** rather than prevention-oriented ones. Further, a few primary aspects seem to modify WWS' help-seeking processes: (a) women's acquaintance with specialized services for WWS (or its lack); (b) gaps between the capacity of the Israeli health system (due to characteristics such as bureaucracy, long waiting times) and the nature of WWS' needs (acute, require a "here and now" response); (c) previous negative experiences of WWS in RHC utilization, which impact their present help-seeking.

In the following sections we condensely elaborate on each of the barriers and enabling factors that appear in the model.

Barriers

Social structure and norms

***Stigma*.** Societal stigma towards WWS was described as including a range of perceptions of WWS – from deviant and dangerous to powerless and traumatized. Either way, prevailing perceptions questioned WWS' agency. Stigma induced WWS hesitance to seek RHC and caused them to hide their background if they did utilize services. Some WWS experienced the impact of intersecting stigma and discrimination, such as addiction-related stigma and racism.

The healthcare system

Structure. *Limited resources***.** Healthcare policy that resulted in limited staffing and long shifts negatively impacted the quality of care provided, especially for women with multiple needs (such as WWS with addictions). *Limited accessibility.* The healthcare system was described as inaccessible for WWS, by being 'too bureaucratic' and including long waiting times for appointments. ***Service providers.*** *Lack of knowledge regarding WWS.* lack of acquaintance with WWS' health needs, lack of awareness of existing community-based services, lack of guiding principles for care of WWS and lack of familiarity with women with lived experiences all hindered adequate response of healthcare providers to WWS. *Burnout.* The combination of limited resources in the healthcare system, and the complex needs of (some) WWS, were described as contributing to personnel's burnout, which in turn manifested in practitioners' stress and inability to provide good care. At times, these were accompanied by frustration and hostility that could be directed toward WWS. *Emotional difficulties.* Healthcare providers' emotional challenge in providing care for WWS – even if unconscious – may hinder their ability to provide good RHC. They may feel rejection or aversion, partly as a result of prejudice towards WWS and specifically towards those who are mothers. For some MDs, emotional difficulties arise when treating WWS who underwent multiple abortions– that might augment impatience and serve as a barrier to good care. ***Patient-provider relationship*.** *Provider's identity.* Providers' ethnicity and gender were viewed as impacting the nature of the patient-provider relationship and potentially hindering WWS' help-seeking. For example, due to the stigma surrounding WWS in the Arab community, an Arab WWS might fear that an Arab service provider will reveal her identity to family/community members. Likewise, an Arab service provider might be at risk if her family knew she was working with WWS. Regarding gender, receiving treatment

from a male doctor was a primary barrier for WWS' utilization of RHC. This was explained in light of early sexual abuse or as related to the context of working in sex.

Negative and stigmatizing attitudes. Some WWS encountered criticizing, condescending and suspicious attitudes from providers, which manifested verbally and physically. These included replacing a pregnant WWS' doctor without notifying her, intervening in the latter's decisions regarding pregnancy and childbirth, repeated questions about the baby's father (especially when absent) or speaking "over the woman's head" directly to her accompanying figure. Some participants described these experiences as typical "to all Israeli women". Still, if hospital staff, such as midwives, knew about WWS' background, they might see her as less responsible regarding to her body, which can lead to making decisions over her body during childbirth. Such attitudes explained some WWS' preference for private rather than public services.

The welfare system

Inadequate services for WWS. The lack of adequate support for WWS within the welfare system was described as negatively impacting WWS' health needs and hindering their RHC utilization. The welfare system was viewed as 'splitting' between the best interest of the child and that of WWS. This manifested for example, in a lack of specialized services for young WWS who become mothers. Often, when youngsters who were accompanied by an organization for marginalized youth became mothers, they were referred to social services that focused on their child's needs. Such a split, along with WWS' negative previous experiences in the welfare system, impaired WWS' trust in social services and was linked to a general fear of systems. Moreover, participants emphasized that WWS' practical and emotional postpartum support is an overlooked need.

Informal interpersonal relationships

Pressure from partner/client/pimp. For WWS who lived with a partner, an abusive relationship that included physical or emotional violence served as a barrier to help-seeking. This barrier was mainly prevalent around the decision to abort/keep the baby. At times, WWS' partners/clients pressured them, including by using physical power, to abort the baby. Moreover, for some women who traded sex for housing and economic support, keeping the pregnancy served as means to maintain such support. Finally, involvement of a pimp pressured some WWS to undergo an abortion so they could go back to selling sex as quickly as possible.

Women-related factors

Trauma-related barriers. Various traumatic experiences in WWS' life – including sexual, emotional and physical violence in their childhood and/or while working in sex – were linked with women's increased distrust in the healthcare system, especially in authoritative figures. Also, Complex PTSD (CPTSD) and its symptoms were explained as hindering some WWS' ability to deal with bureaucracy. At times, trauma and its psychological consequences were linked with self-neglect, which caused some women to seek care only in emergency cases. Further, the birth itself was described as traumatic, putting WWS at high risk for postpartum depression. ***Cultural barriers.*** Socio-cultural taboos surrounding sex work, pregnancy and childbirth served as a barrier for some women from ethno-national minority background. For example, Arab WWS who wished to conduct an abortion often feared societal rejection as well as physical harm from members of their community, which hindered care seeking or made them reach out for services in far geographical locations. Likewise, for Eritrean asylum seekers, the taboo surrounding sex in general served as a barrier for acquiring knowledge on RHC, using contraception and conducting abortions. ***Economic barriers.*** Poverty and the lack of access to bank accounts and credit cards due to existing debts and account confiscation, served as a prominent barrier for obtaining RHC by WWS. This manifested for example in the need to pay in cash for the pregnancy termination committee, or to pay the national health insurance via a standing order. ***Demographic barriers.*** First, the intersecting identities of adolescent and young WWS were described as enhancing WWS' difficulties in obtaining RHC. Moreover, living in the geographic periphery of Israel meant having limited access to good RHC – for example due to scarce women gynecologists or long travel distance to services. Finally, the lack of legal status for migrant and asylum seeking WWS heavily limited RHC utilization. For example, unauthorized migrant care workers feared that approaching RHC will cause their deportation. ***Addictions.*** The findings revealed distinctive barriers for addicted WWS. Being an active user often related to difficulties in planning ahead and attending treatment. Moreover, addiction was related to delayed realization of the pregnancy and irregular utilization of pregnancy services. It further had negative consequences on the baby's health, which required early detection and specific medical treatment. Also, WWS with an addiction often left the hospital right after childbirth, to go back to use, which hindered their and/or their baby's healthcare.

Loneliness. The lack of support from family and friends often created emotional and physical loneliness. Practically, having no accompanying figure halted WWS' utilization of RHC services. For some, the lack of a good relationship with their mother, was linked with missing knowledge regarding pregnancy and childbirth. Moreover, loneliness was heightened due to WWS' fear of disclosing their working in sex to family, friends and service providers, and was viewed as a barrier for seeking help postpartum. ***Lack of knowledge.*** WWS' often lacked knowledge regarding sexual health, pregnancy and childbirth, as well as regarding RHC services. This was viewed as linked with late pregnancy discovery and with some WWS' tendency to utilize Emergency Department services even when not necessary. ***Fear from "systems".*** WWS' often distrusted and feared 'systems', specifically the welfare system. Many WWS had previous negative experiences with the welfare system, where they felt 'unseen' by professionals who were supposed to take care for them, or had theirs/their relatives' children taken to out-of-home placement. Such negative perceptions and experiences had further impacted their relationship with the healthcare system: fearing that their child would be taken away, women refrained from checkups during pregnancy or did not report their emotional needs (for example postpartum depression) and health needs (for example drug use). Fearing "the system" had further implications for childbirth: Some WWS chose to give birth at home, while others who went to a hospital, did not disclose being a WWS. Keeping "the secret" could impair the desirable natural development of childbirth and lead to multiple interventions, which in turn increase the risk of postpartum depression. ***Perceptions regarding pregnancy.*** WWS' perceptions of the pregnancy as wanted/unwanted (or both) were described as impacting RHC utilization. For example, WWS who view pregnancy as a "way out" of working in sex, may feel more anxious about their child being taken away, and therefore avoid RHC utilization or hide their identity as WWS. Also, some WWS who continued sex work while pregnant, linked their feeling guilty about potentially harming the baby with comprehensively utilizing RHC. ***Body perception.*** Alienation and negative body perception – which some WWS linked with early abuse – along with fear of the pregnancy and the bodily changes it involves, hindered pregnancy discovery and checkups.

Enabling factors

Existing trauma-sensitive approach in healthcare services. The fact that some RHC services in Israel already implement a trauma-sensitive approach was described as enabling WWS' access and utilization of RHC. For example, participants mentioned that a patient's asking for a female rather than a male doctor was already familiar to health service providers. **Inter-professional and inter-organizational cooperations.** Existing cooperations were described as enabling good RHC for WWS, for example as they enhance the continuity of care for women before and after childbirth. **A good patient-provider relationship.** A relationship of trust and respect between WWS and healthcare providers supported the provision of good RHC. Good relations included providers' reaching out to WWS, accessibility beyond fixed working hours and a non-judgmental attitude. A good relationship enabled better health outcomes – for example when installing an IUD, which could require more than one session – and could increase the chances of WWS attending a second session. Further, receiving care from a provider that is a woman with lived experience was described as enabling the creation of close and trusted relations **Accompanying figure.** The presence of an accompanying figure and good relations between them and healthcare providers, were described as central for enabling good RHC. Accompaniment of WWS often occurred by members of specialized services for WWS. These services' views regarding working in sex – generally either perceiving sex work as traumatizing or as a respectable occupation – were described as impacting decisions regarding RHC utilization, such as keeping the pregnancy or not. **Support system.** Receiving support from family and friends often enabled better access to RHC services. **Women's strengths.** WWS' own strengths and resilience supported their ability to seek and receive good RHC. Such strengths included for example women's ability to mobilize others to assist them and women's ability to learn about her rights and/or demand them.

Policy implications and recommendations

Based on the findings we offer guidelines for best practice in delivering good RHC for WWS (see figure 2), for interventions that target the healthcare system as well as WWS. We recommend including women with lived experiences in the different stages of planning and providing RHC services for WWS.

The healthcare system

Guidelines: *Trauma-sensitive approach.* Policy makers and healthcare practitioners should adopt a trauma-sensitive approach as best practice for RHC of WWS. This includes: utilizing existing birth centers and preparation for birth tools; providers' sharing information and decisions with WWS; providing explanations before physical checks; avoiding the presence of male personnel (as much as possible), preparing staff for working with CPTSD symptoms such as dissociation, and using mobile ultrasound devices instead of vaginal checks in childbirth. This, while adhering to WWS' unique needs as described below. *Empathy, respect, nonjudgment***.** Providers should adopt a humane, non-judgmental and respectful approach towards WWS, including sensitivity to words used and to the tone of speech. This also means recognizing WWS' agency and choice: some women may not favor a trauma-sensitive service, but rather want doctors' focus on their medical needs in a non-judgmental manner. Further, sensibility to stigma is required, especially in unusual medical situations. For example, if a WWS caught an antibiotic resistant bug while being hospitalized, she may need to be isolated and handled while service providers use gloves. As she may feel rejected on the base of being a WWS, attentive explanations from staff members are required in advance. *Pregnancy and childbirth as a "window of opportunity".* RHC utilization by WWS should be seen as an opportunity to identify psychosocial needs surrounding violence, addictions, mental health etc. Pregnancy termination committee and childbirth were highlighted as main such opportunities. In case WWS has an accompanying figure, providers are advised to conduct a first intake with the women alone. Also, explanations regarding exploitation and existing services should be posted in clinics, preferably in women's WC, and in various languages. *Cooperation.* Strengthening inter-organizational cooperations between healthcare providers and specialized services for WWS is vital.

Enhancing health services' accessibility: The findings indicate two main complementary approaches for improving RHC accessibility. The first is *improving accessibility to general health services.* As many WWS do not disclose working in sex and thus avoid specialized services that might identify them, improving general RHC services could indirectly benefit WWS. For example, by enhancing trauma-sensitive services, community-based and free of charge preparation for birth courses and doula services for marginalized women, and by introducing a comprehensive STI/HIV test for all pregnant women. A second approach includes *developing and*

enhancing specialized services for WWS. As many WWS are familiar with specialized services and find them accessible, widening the scope of existing RHC services for WWS is needed. This may include expanding resources such as personnel and medical checks within community-based services. Also, specialized services should offer as many treatments as possible in one place to "strike while the iron is hot", flexible opening hours, free of charge services, and walk-in services, allowing WWS to reach-out without scheduling appointments. *"No women gives birth alone".* Developing a structure for accompanying WWS during pregnancy, childbirth and postpartum. This includes enhancing the accessibility of (free) doula services for marginalized women and WWS; offering physical and emotional postpartum support at women's house, parenting guidance and concrete assistance, including developing unique services for young mothers in marginalization.

Healthcare providers training: *Reflexivity.* Training should include healthcare providers' reflection on their perceptions regarding WWS and regarding pregnancy and childbirth (in general and in relation to WWS). *Knowledge.* Educating healthcare providers should include knowledge regarding existing services for WWS and regarding WWS. This includes the varied settings, intersecting identities and experiences of WWS**;** trauma, PTSD and CPTSD; addictions and their implications for pregnancy and childbirth; identifying abuse (sexual, physical and other); sexual health and health needs of WWS. *Trainings by women with lived experience.*

Intervention with WWS

Making knowledge accessible: *Knowledge on reproductive health.* Providing psycho-education on reproductive health to WWS in a direct, eye-to-eye and context and culture aware manner. *Enhancing knowledge of and experience in service utilization.* Practical assistance and hands-on experience in active utilization of services. *Utilizing media and technology***.** using short, visual and media-based tools to transfer knowledge.

Discussion and conclusion

This qualitative study explored help-seeking processes, barriers and enabling factors to RHC utilization by WWS based on the experiences and perceptions of service providers and WWS in Israel. The findings exposed a multi-layered network of barriers and enabling factors, which served as a base for developing an empirically grounded evidence-based model of best RHC practice with Israeli WWS.

The findings indicate that stigma is a central and multidimensional barrier to accessing good RHC for WWS in Israel: societal stigma toward WWS impacts and is reflected in service providers' attitude towards WWS, impairs providers' quality of care and the nature of the patient-provider relationship. Further, societal stigma may impede women's decisions to seek help or prevent them from disclosing health needs related to working in sex. This is the first study that documents the impact of stigma toward WWS on the delivery of healthcare services in Israel. Similar findings were reported in studies conducted in low-, middle- and high-income countries, demonstrating the pervasive nature of stigma as encumbering WWS's right to RHC (e.g., Beckham et al., 2015; Benoit et al., 2019; Dourado et al., 2019; Jeal & Salisbury, 2004; Katz et al., 2016; Lasater et al., 2019; Lazarus et al., 2012; Luchters et al., 2016; Ryan et al., 2019). Even in New Zealand, where prostitution is decriminalized, research suggests that while most WWS have regular sexual health checkups and access to their GP, their checkups may be compromised since they hide their occupation from the GP (Abel, 2014).

The study has several main contributions. First, it points to the salient role of the social determinants of health (SDH) in constructing WWS' unequal access RHC (Commission on Social Determinants of Health [CSDH], 2008). SDH includes WWS' childhood, geographical, economic and cultural conditions shaped by unequal social policies and financial arrangements. Second, it demonstrates the central role of a positive and supportive relationship between WWS and healthcare practitioners in facilitating good RHC surrounding pregnancy and childbirth. The ability to create such relations was enhanced when WWS had an accompanying figure– typically a professional/volunteer from a specialized service for WWS, especially when these were continuous and long-term relations of trust (Eyal-Lubling et al., 2022). In contrast, negative experiences in encountering a healthcare provider impaired WWS' future RHC utilization. The need for an accompanying figure throughout pregnancy and childbirth is enhanced in the context of fragmentation of RHC services in Israel: these are divided among community-based clinics (for reproductive care, pregnancy and postpartum) and hospitals (for childbirth), typically with little or no contact between them (Khoury & Weisman, 2002).

Third, the study reveals the unmet health, emotional and practical needs of WWS postpartum. This gap is especially alarming given WWS's increased risk for postpartum poor maternal mental health (Dunkel Schetter & Tanner, 2012). It should

serve as a call for developing postpartum services that provide emotional and practical assistance. Such services should also be directed towards WWS who underwent abortions and stillbirths or gave birth but did not raise their children. Moreover, the study indicates the role that the welfare system plays in impairing WWS' access to RHC, specifically, WWS' fear of having their children taken to out-of-home placement. Such fear halts some WWS' from reporting their health needs, attending pregnancy checkups, or staying at the hospital right after giving birth. While this barrier was only scarcely addressed previously, mainly in relation to drug-using WWS (e.g., Toquinto, 2017), the current study reported this barrier also concerning non-using WWS.

Finally, our model's guidelines for best RHC practice contribute to existing recommendations for confidential, non-judgmental, trust building, adherence to principles of trauma-informed care, and cultural sensitivity (Benoit et al., 2019; Cernigliaro et al., 2019; Hemmings et al., 2016), and emphasize the need for direct involvement of WWS in the development and implementation phases of RHC interventions (Ferguson et al., 2017; Hemmings et al., 2016; Lazarus et al., 2012; Marlow et al., 2014). This includes taking into account WWS' agency and considering the diverse identities, settings, and self-determination of WWS. Further, we call to emphasize the component of healthcare service providers' training: Beyond the need for knowledge regarding WWS, training should include reflective aspects regarding providers' perceptions of WWS, their pregnancies and childbirths, viewing these perceptions as consciously and unconsciously impacting service delivery.

Interestingly, the findings did not reveal implications of the law that criminalizes paying for sex – which came into effect in July 2020 and has been enforced since December 2020 – on RHC of WWS. It could be that the law is still relatively new; hence its possible implications are yet to be revealed, or that it is not linked by professionals and WWS with RHC utilization.

To conclude, the study's results contribute to bridging RHC gaps for a highly marginalized group of women—WWS, by enabling the inclusion of their voices and perspectives in research about them and facilitating the adaptation of services to their needs (Shdaimah et al., 2017), with the hope of improving WWS maternal health indicators and their children's health and developmental trajectories.

Figure 1.

Reproductive health needs of WWS

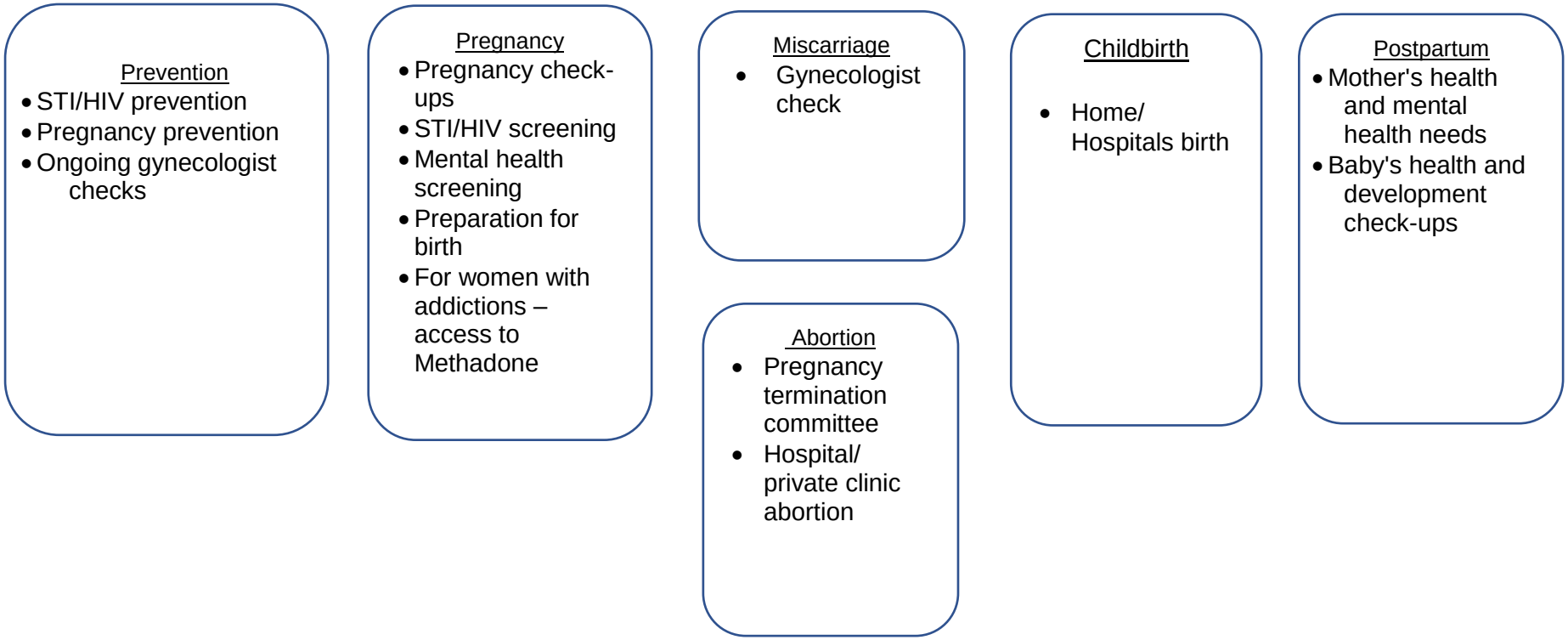
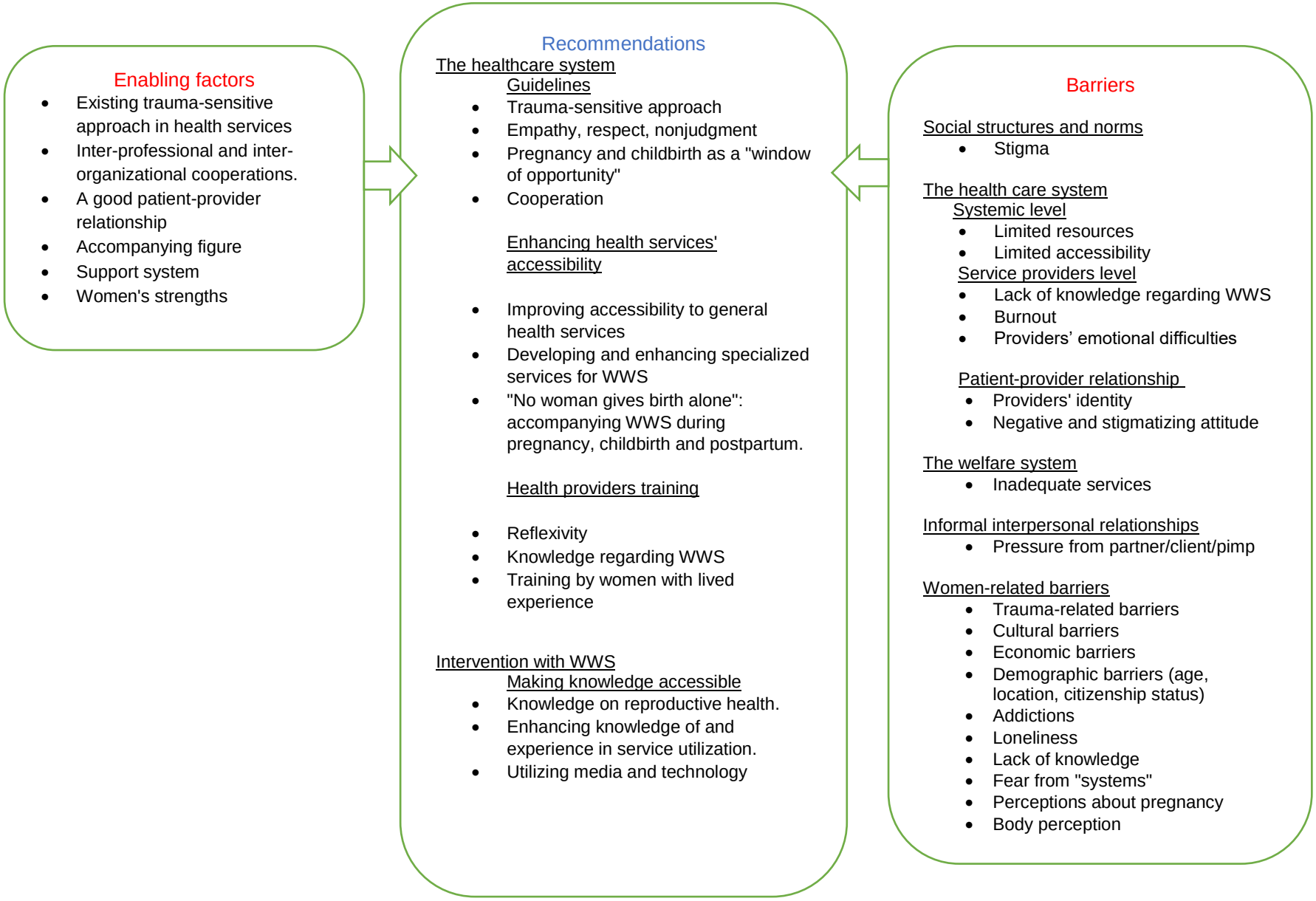


Figure 2.

A model for best RHC practice with Israeli women working in sex



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