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Community-Based Responses to Negative Health Impacts of Sexual Humanitarian Anti-Trafficking Policies and the Criminalization of Sex Work and Migration in the US

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Abstract: System-involvement resulting from anti-trafficking interventions and the criminalization of sex work and migration results in negative health impacts on sex workers, migrants, and people with trafficking experiences. Due to their stigmatized status, sex workers and people with trafficking experiences often struggle to access affordable, unbiased, and supportive health care. This paper will use thematic analysis of qualitative data from in-depth interviews and ethnographic fieldwork with 50 migrant sex workers and trafficked persons, as well as 20 key informants from legal and social services, in New York and Los Angeles. It will highlight the work of trans-specific and sex worker-led initiatives that are internally addressing gaps in health care and the negative health consequences that result from sexual humanitarian anti-trafficking interventions that include policing, arrest, court-involvement, court-mandated social services, incarceration, and immigration detention. Our analysis focuses on the impact of the criminalization on sex workers and their experiences with sexual humanitarian efforts intended to protect and control them. We argue that these grassroots community-based efforts are a survival-oriented reaction to the harms of criminalization and a response to vulnerabilities left unattended by mainstream sexual humanitarian approaches to protection and service provision that frame sex work itself as the problem. Peer-to-peer interventions such as these create solidarity and resiliency within marginalized communities, which act as protective buffers against institutionalized systemic violence and the resulting negative health outcomes. Our results suggest that broader public health support and funding for community-led health initiatives are needed to reduce barriers to health care resulting from stigma, criminalization, and ineffective anti-trafficking and humanitarian efforts. We conclude that the decriminalization of sex work and the reform of institutional practices in the US are urgently needed to reduce the overall negative health outcomes of system-involvement.

Keywords: sex work; anti-trafficking; health; stigma; community responses; sexual humanitarianism; migration; transgender

1. Introduction

The criminalization of sex work and migration, and the resulting police encounters, arrests, incarceration, and system-involvement that take place under the guise of anti-trafficking efforts, have created troubling health disparities among migrants, sex workers, and people with experiences of trafficking in the US. These trends, combined with persistent stigma against sex workers and migrants, create formidable barriers for community members in accessing affordable health care and unbiased support.

This paper explores how policing, arrests, court involvement, court-mandated services, incarceration, immigration detention, and the broader carceral politics surrounding US anti-trafficking strategies (Bernstein 2012) impact sex workers' health. In it, we examine how efforts to "rescue" victims (Agustin 2007) and abolish sex work via anti-trafficking initiatives advance sexual humanitarian strategies that adversely impact the health and well-being of sex workers and trafficking victims alike. We also demonstrate how these trends have inspired sex worker-led initiatives to address their own needs, developments that highlight the importance of community-led health initiatives in addressing barriers to health care that sex workers face.

In the sections that follow, we situate our research within a larger body of interdisciplinary scholarship focused on sex work, humanitarianism, and contemporary anti-trafficking efforts, with particular attention to legal and health effects of humanitarian efforts. From there, we discuss our methods, research findings, and recommendations for future policy and institutional practices.

1.1. Sexual Humanitarianism and Anti-Trafficking

This research emerges within a sociopolitical context vexed by debates and ideological tensions surrounding prostitution (Weitzer 2010; Musto 2009). Since the early 1990s, sex worker rights-oriented feminists have recognized adult women's agency in consenting to sell sex. However, this has been challenged by neo-abolitionist feminists who view prostitution as "paradigmatic of a system of male power" and who seek to abolish it by removing the demand for, and provision of, sexual services (Scoular and O'Neill 2008, p. 13). Feminist debates surrounding sex work and sex trafficking are enduring and have been explored at length by many social scientists over the course of the last two decades (Jackson 2019; Weitzer 2010; Bernstein 2010; Musto 2009). Of note here is that abolitionist feminist attention to "trafficking" in the 1990s revived the "feminist sex wars" (Jackson 2019, p. 172). The revivification of neo-abolitionist feminist sentiments corresponds with earlier feminist concerns about women's exploitation in the sex industry. Such concerns informed negotiations about how to define "trafficking" in domestic and international law, including the 2000 UN Palermo Protocol (Ditmore and Wijers 2003).

In the 20 years following the adoption of the Palermo Protocol and the passage of the United States' federal legislation the Trafficking Victim Protection Act (TVPA), the effects of anti-trafficking laws have come into clearer view: laws often conflate sex work with sex trafficking and position trafficking as a crime control issue rather than a human rights violation (Haverkamp 2019, p. 69; Mai 2018; Musto 2016). Moreover, while conceptions of agency and exploitation are arbitrary, state actors wield tremendous discretionary power to determine whether a person's involvement in the sex industry is voluntary or coerced (O'Connell Davidson 2006 p. 9) and whether they are entitled to protection, punishment, or some combination (Musto 2016). By positioning sex workers as a priori victims of gendered violence (Farley 2006) whose protection hinges on abolishing the sex industry and "rescuing" sex workers from it (Agustin 2007; Ward and Wylie 2017), anti-trafficking efforts are justified on ideological and humanitarian grounds. Accordingly, interventions informed by neo-abolitionist sentiments are understood as the most logical response to addressing exploitation in the sex industry. At the same time, these trends emerge alongside the expansion of humanitarian rhetoric and interventions.

Defying neat or singular definition, humanitarianism is informed by a “do good” ethos (Ticktin 2014, p. 274; Richey 2018, pp. 2–3) that relies on moral claims to justify political engagement (Richey 2018, p. 2–3; Ticktin 2014, p. 281). Yet, humanitarian efforts to ameliorate the “distant suffering” (Richey 2018, pp. 2–3) of poor people, migrants, and a growing number of displaced people around the globe proves limited. In the same moment in which neoliberal globalization has gutted the welfare state, decimated labor rights, and exacerbated income inequality within and across borders, a growing number of people around the globe face a life encumbered by “uncertainty, debt, and humiliation” (Standing 2011, p. viii). Rather than address the structural inequalities that contribute to displacement and economic insecurity, humanitarian interventions address the suffering of a select few presumed to endure the most extreme forms of victimization (Mai 2018). Humanitarian actors’ attention to specific forms of suffering (Ticktin 2014, p. 282) and particular groups deemed worthy of saving are further shaped by race, gender, class, and age (Hesford and Lewis 2016, p. ix). Sexuality also constitutively shapes the contours of humanitarianism. For instance, calls to “save” sex workers and trafficking victims alike (Mai 2018) are based on ideological presumptions that involvement in the sex industry is so injurious that it warrants state and non-state intervention.

Drawing on insights from the aforementioned scholars, our suggestion is that “sexual humanitarianism”—a framework to describe how groups of sex workers and migrants are problematized, supported, and intervened upon by institutions and actors based on vulnerabilities commonly associated with sexual behavior and orientation (Mai 2018)—extends social science understanding on the politics and effects of humanitarianism. Sexual humanitarianism emanates out of the global rise of neo-abolitionist policies that frame all forms of sex work as sexual exploitation. Just as humanitarian interventions rely on moral claims to authorize governance schemes that support and control vulnerable populations (Ticktin 2014, pp. 274, 281; Fassin 2012), sexual humanitarianism leverages morality, affect, and normative ideas about sexuality in the service of heightened security (Amar 2013).

In the context of everyday sexual humanitarianism outlined above, anti-trafficking advocates, faith-based actors, and celebrities act as “norm entrepreneurs” (Majic 2018) in promoting commonsense ideas about how to fight sex trafficking. Such ideas may include endorsing policies that in practice aim to abolish the sex industry (Hoefinger 2016; Soderlund 2005; Anderson and Andrijasevic 2008) or restrict migration. In the United States, moral concerns about sex work have advanced alliances between the state, neo-abolitionist feminists (Ward and Wylie 2017), and Christian organizations (Bernstein 2010)—what Elizabeth Bernstein refers to as “carceral feminism.” Carceral feminist efforts utilize arrest, incarceration, prosecution, and court supervision to assist victims and privilege criminal justice responses to combat sex trafficking (Bernstein 2010; Musto 2019). Moreover, anti-trafficking responses can further exacerbate the vulnerability of marginalized groups deemed “at risk” of trafficking (Showden and Majic 2018; Musto 2016). That anti-trafficking efforts control the very people they aim to protect reveals the punitive dimensions of carceral oriented anti-trafficking efforts (Musto 2016, Musto 2019). Consider: migrant women deemed “at risk” of trafficking continue to face deportation and heightened state surveillance (Doezema 2002; O’Connell Davidson 2006; Plambech 2017). Meanwhile, LGBT sex workers, though recognized as particularly vulnerable to trafficking (Department of State 2014), are rarely legible to authorities as victims (Boukli and Renz 2019) nor offered supportive services and legal protection. Transgender sex workers of color have also been disproportionately targeted by carceral orchestrated anti-trafficking activities (Kempadoo 2001; Buist and Stone 2014; Fehrenbacher et al., forthcoming A) and are overrepresented in jails and prison, which further underscores the punitive dimensions of anti-sex trafficking efforts.

Harms are epistemic too and there is considerable distance between representations of “innocent victims” in contemporary anti-trafficking campaigns (Showden and Majic 2018) and the lived experiences of sex workers, migrants, and people that have been in trafficking situations. Not only does this demonstrate how contemporary anti-trafficking efforts are part of a longer history of neo-colonial humanitarianism where efforts to “save” the disadvantaged (i.e., ethnic, racialized and sexualized “Others”) by constructing them as victims incapable of making decisions about their own

lives is used to justify their subordination (Bex and Craps 2016; Sripaoraya 2017; Rostis 2015; Richey 2018). It also reveals how unnuanced experiences of sex work and exploitation can do more harm than good (Mai 2018).

Promisingly, this is beginning to change. Whereas sex workers were rarely consulted in the development of anti-trafficking interventions and their experiences were also commonly discounted (Kempadoo and Doezema 1998), contemporary researchers note the importance of working with people that have experienced trafficking. In a comprehensive review of trafficking studies funded by the National Institute of Justice over the last 15 years, Picarelli (2015) described the “value” and “untapped potential” for researchers working with survivors to better frame trafficking issues. Yet institutional and other barriers remain and need to be removed in order for researchers, practitioners, and survivors to successfully work together to address trafficking (p. 53).

1.2. Impact of Peer-to-Peer Interventions

A large body of research also exists highlighting how anti-prostitution and anti-trafficking policies negatively impact health. The link between repressive carceral policies and diminished health outcomes has been explored in research focused on HIV and sexual health (Anderson et al. 2016; Fehrenbacher et al., forthcoming B; Footer et al. 2019; Footer et al. 2016; Shannon et al. 2015), mental health (Benoit et al. 2015a; Maciotti et al. 2017) stigma (Krusi et al. 2016; Hughto et al. 2018), general health (Le Bail et al. 2019), and violence (Rhodes et al. 2008; Dewey et al. 2015). What these studies broadly highlight is a correlation between health disparities of sex workers and experiences of policing, arrest, detention, and incarceration.

In a meta-analysis by Platt et al. (2018) examining over 130 studies in 33 different countries over almost three decades, researchers found higher risks of condomless sex, physical and sexual violence from clients or partners, and HIV/STI infections amongst sex workers who had been exposed to repressive policing, compared to those who had not. Policing practices were also linked to the disruption of work environments, diminished support networks and compromised safety and risk reduction strategies, and limited access to health services and justice (Platt et al. 2018). In a separate longitudinal study featuring 221 transgender women in Boston and Chicago, researchers noted that participants were disproportionately affected by incarceration (38%), and incarceration predicted participants’ negative health outcomes and drug use over time (Hughto et al. 2018). The authors recommended multi-level interventions to prevent incarceration, and provide support afterwards, in order to address transgender women’s poor health (Hughto et al. 2018).

Yet accessing supportive services remains a challenge due to the stigma surrounding sex work. Indeed, people involved in the sex trades—including those with trafficking experiences—continue to struggle accessing quality, non-judgmental care. In a systematic review of 22 qualitative papers addressing barriers to accessing sexual health care for trans and male sex workers, for example, Brookfield et al. (2019) found that intersectional forms of stigma around sex worker status, sexuality, gender identity, HIV status, and internalized stigma were predominant barriers. Scambler and Paoli (2008) found that within female sex work in London, Bangkok, and Kolkata, norms of blame, shame, and labelling sex work as deviant created barriers to accessing effective health care. Even in quasi-criminalized prostitution environments like Canada, researchers find that occupational stigma persists. For instance, stigma surrounding sex work creates barriers for street-based sex workers in accessing health care (Lazarus et al. 2012).¹

In an attempt to overcome stigma-related hurdles to care, a variety of research and NGO initiatives have emerged to position sex workers and affected community members as peer health advocates, particularly in the context of HIV interventions. A large body of research exists highlighting the benefits of sex worker-led sexual health programs and the positive outcomes of peer-to-peer outreach in STI and HIV prevention programs (Benoit et al. 2017). In Songachi, Kolkata’s

¹ In another study in Canada, sex workers experienced stigma from their HIV status and sex work and faced structural racial, gender, and sexual inequalities that created formidable health barriers and limited their coping strategies (Logie et al. 2011).

largest red-light district (in India), a program that trained sex workers as peer educators run by the Durbar Mahila Samanwaya Committee managed to dramatically reduce HIV and STI transmission (Swendeman et al. 2015; Jana et al. 2004). Due to its success, the program grew and covered the entire Kolkata area by utilizing thousands of peer educators (Cornish and Campbell 2009). In Australia, a number of sex worker-led outreach organizations have continued to receive state funding since the mid 1980s, and their role in promoting health amongst sex workers has been widely acknowledged (Bates and Berg 2014). In New Zealand, the New Zealand Prostitute Collective (NZPC) was offered government health funds to run prevention programs in 1987 and is a leading organization in providing health and rights support for sex workers (Healy et al. 2010). In Cambodia, Hoefinger and Srun's (2017) work highlights the salience of intersectional approaches to shared movement building and political organizing now taking place among different marginalized groups of sex workers and LGBT+ communities in response to sexual humanitarian interventions. These efforts have resulted in policy changes and increased mutual support and social awareness around the violence and human rights violations that divergent, but sometimes overlapping, communities experience.

Sex worker-led outreach efforts are particularly effective. A collaborative report by World Health Organization (WHO), United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV/AIDS (UNAIDS), Global Network of Sex Work Projects (NSWP), and World Bank found that community services whereby sex workers take the lead in outreach and HIV prevention programs are both efficient and effective. There are significant benefits in terms of HIV outcomes, as these programs enable sex workers to address structural barriers and empower themselves by changing social norms and achieving a sustained reduction in their vulnerability that goes beyond HIV-related issues (WHO et al. 2013, p. 44).

According to a 2015 *Lancet* Article, "even modest coverage of peer or sex worker-led outreach and support could avert a further 20% of infections in sex workers and clients over the next decade" (Beyrer et al. 2015, p. 4). Importantly, comparative research in India and South Africa showed that, in order to be efficient, peer-to-peer programs need to be provided with sufficient funding, support, and resources (Cornish and Campbell 2009). Other studies have reported how, with the appropriate support, grassroots sex worker rights organizations around the globe have developed to become non-profit organizations, and in some instances, fully funded service providers offering services beyond HIV/AIDS and sexual health—including community and social support, peer-to-peer education, legal advice, counseling, and work transition programs—whilst also advocating against harmful anti-trafficking and anti-prostitution sexual humanitarian policies, and for labor rights and unionization (Majic 2014; Lutnick 2019; Healy et al. 2010; Garofalo Geymonat and Macioti 2016; Macioti and Garofalo Geymonat 2016; Jeffreys et al. 2011; Hardy 2010; Gall 2007; Chateauvert 2014; Smith and Mac 2018).

In the United States, political scientist Samantha Majic (2014) has documented how two non-profit organizations—California Prostitutes Education Project (CAL-PEP) and the St. James Infirmary (SJI)—have emerged as key providers of services for sex workers while also engaging communities in "claims-making activities" that more broadly center on promoting social change for sex workers (Majic 2014, p. 30). Alix Lutnick (2019) also describes how anti-trafficking and sex worker-led organizations have worked together to improve sex workers' access to justice by agitating for reforms that make them exempt from criminalization, for instance, when reporting a crime to law enforcement. This highlights how anti-trafficking approaches focused on harm reduction rather than sexual humanitarianism can support sex workers' rights and justice (Schwarz et al. 2017).

Fewer studies have looked at the work of sex worker rights organizations that address the specific vulnerabilities of migrant, trans, and sex workers of color in the context of the convergence of criminalization with anti-migrant policies and practices, institutional racism, and transphobia. Despite this, in Germany (Garofalo Geymonat and Macioti 2016) and Australia (Jeffreys and Perkins 2011; Bates and Berg 2014), state-funded sex worker outreach programs have been shown to employ trans and migrant sex workers to provide peer education, and culturally and linguistically sensitive health, work and legal advice and support to migrant sex workers, while simultaneously advocating for sex worker rights. The crucial role of grassroots organizing in mitigating the harmful

consequences of poverty, racism, and criminalization amongst marginalized groups, and women of color in particular, has also been thoroughly documented (Cohen and Jackson 2016; Erbaugh 2002; Gutierrez and Lewis 1994). Taken together, these trends underscore the critical importance of peer-led interventions that are attentive to sex workers' needs and which work to address barriers sex workers face in accessing health care needs.

Troublingly, in the United States, the very community-based, peer-led initiatives equipped to mitigate mental and physical health problems associated with policing, arrest, court involvement, immigration control, and incarceration, and capable of advancing appropriate services that best support sex workers' needs, are increasingly constrained, due in part to a repressive (Östergren 2017) carceral landscape that has only grown under the Trump administration. Indeed, sex workers' ability to access health care and appropriate services is markedly curtailed by the criminalization of both sex work and immigration. Despite considerable barriers, sex workers have developed strategies to navigate a health and social service landscape shaped by punitive laws by engaging in community mobilization efforts grounded in an ethos of "mutual care and advocacy" and operating independently from large, well-funded NGOs and sexual humanitarian networks. In the following sections, we present research on these trends and on how they have been experienced, resisted and responded to by sex workers, migrants and people with trafficking experiences.

2. Methods

This paper draws on 34 months of ethnographic fieldwork from March 2017 to December 2019 in New York City (NYC) and Los Angeles (LA) in the context of the international, multi-country Sexual Humanitarian: Migration, Sex Work and Trafficking (SEXHUM) Study (2016–2020). SEXHUM explores the relationship between migration, sex work, and trafficking in 8 cities within four countries: Australia (Sydney and Melbourne), France (Paris and Marseille), New Zealand (Auckland and Wellington), and the United States (New York and Los Angeles). The study aims are to examine the impact of anti-trafficking legislation and initiatives on the governance of migration and on the sex industry. It analyzes migrants' own understandings and experiences of agency and exploitation with the goal of producing new concepts and data reflecting the perspectives and priorities of people working in the global sex industry in order to develop more efficient and ethical policies and social interventions to address their needs. The data for this paper focuses on the US field sites in NYC and LA.

Data was collected through qualitative in-depth, semi-structured interviewing with sex workers, migrants, and trafficked persons lasting 60–90 min and ethnographic observations with community members of all genders. Key topics covered in interviews centered on experiences in early life and life before, during, and after migration (if applicable), work life, humanitarian encounters and system-involvement, surveillance and technology, health, relationships, and future goals. In addition, interviews were conducted with key informants from legal, health, and social service organizations and law enforcement institutions, with a focus on the specifics of their service provision, and how they situate their work within the broader anti-trafficking landscape. Sex workers and trafficked persons were compensated for their time with a one-time payment of \$50, while key informants were not. Interviews were conducted in English, Spanish, Chinese, or Korean with trained interpreters. The study procedures were approved by the Institutional Review Boards of Kingston University in London and the John Jay College of Criminal Justice at the City University of New York. Informed consent was obtained from all participants.

Sex workers, migrants, and trafficked persons ($n = 50$) and key informants ($n = 20$) were purposively sampled for interviews in NYC and LA. Participants included cisgender, transgender, and non-binary/gender-nonconforming people between the ages of 19–70 years old, born in the US, or in Latin America, the Caribbean, Africa, or Asia. Eligibility criteria included experiences with sex work, migration, trafficking, and/or encounters with "sexual humanitarian" institutions, such as law enforcement, court, service provision organizations, and anti-trafficking organizations. Recruitment took place through community-based organizations working with sex workers, migrants,

transgender communities, and survivors of trafficking, as well as through street-based snowball sampling and word of mouth referrals from interview participants.

A large portion of fieldwork in NYC was conducted in the Human Traffic Intervention Courts (HTICs) established in 2013 to divert “victim-defendants” from jail to social services (Gruber et al. 2016; Mogulescu 2011). In HTICs, people charged with prostitution-related misdemeanors are mandated to complete approximately 5–6 social service sessions in the form of, for example, trauma-based psychotherapy, group therapy, art therapy, life skills workshops, or yoga (Ray and Catherine 2014; Yale Global Health Justice Partnership 2018). Once completed, victim-defendants can pursue an “adjournment for contemplation of dismissal” (ACD) through the court, which is not an admission of guilt. If not rearrested within the following six months, the charge is dismissed and sealed.

In addition to observing the Human Trafficking Intervention Courts (HTICs) in NYC and the anti-trafficking task forces in LA, ethnographic fieldwork involved participating in sex worker, transgender, and migrant rights organizing spaces and attending community-based meetings, political forums, and social events. Specific activities included but were not limited to participating in the first and second NYC Slutwalk/La Marcha de Las Putas, the International Sex Worker Festival of Resistance in NYC, the Vanessa Campos Memorial for Trans Migrant Sex Workers in LA, the International Day to End Violence Against Sex Workers in both NYC and LA, and the International Whores Day rallies in both NYC and LA.

We also conducted participant observation in queer and trans bars, clubs, and cantinas in Queens and Brooklyn (NY) and Downtown LA, East Hollywood, El Monte (CA); observed major street-based sex work tracks/strolls and participated in mobile sexual health outreach in NYC and LA neighborhoods with high rates of sex work-related arrests, such as in Manhattan, Queens and the Bronx, Hollywood, South LA, and Long Beach. We also attended monthly Sex Worker Outreach Project (SWOP) meetings and transgender community gatherings at TransLatin@ Coalition and Bienestar in LA, and Colectivo Intercultural TRANSgrediendo in NYC and participated in a hearing of the NY City Council on the presence of Immigration and Customs Enforcement (ICE) officials in HTICs. Finally, we participated as stakeholders in the United Nations General Assembly Hearing to Combat Trafficking in NYC, and a national sex worker-led summit and strategy session in LA.

Interview transcripts were coded, sorted, and analyzed using a combination of thematic analysis guided by the theory of sexual humanitarianism and the constant comparative method for the development of grounded theory. Qualitative coding and data excerpting to select quotes demonstrating the themes related to policing, arrest, incarceration, social services, trafficking/anti-trafficking, system-involvement, violence, health, stigma, and community-based responses were identified and conducted in Dedoose.

To protect confidentiality, all sex worker interviewees have been provided a pseudonym. Furthermore, since many study participants were the only individual from their country of origin, they are described in the results by region rather than country of origin (e.g., Central American vs. Guatemalan). Key informants who elected to share their names or the names of their organizations are referred to by their real names, and those that did not are referred to by a general description (e.g., representative, member, etc.).

3. Results

To contextualize the landscape in which sex workers are responding to criminalization and humanitarian interventions via grassroots organizing and community-led health initiatives, we first outline the current social and legal climate in the US regarding sex work and migration gleaned from our ethnographic research. This is then followed by an overview of the negative consequences and health impacts of anti-trafficking laws and practices that include policing, arrest, mandated services, and incarceration (carried out with the intention of helping and saving). Next, we highlight the subsequent struggles sex worker communities have in accessing care due to stigma and other structural barriers such as lack of private insurance. The results section ends with examples of community-based efforts which have formed as a response to the harms of criminalization and the ineffectiveness of sexual humanitarianism interventions.

3.1. Current Social and Legal Landscape of Sex Work, Migration and Trafficking in the US

Prostitution is legislated in the US at the state level. In most jurisdictions, all forms of sex work and all parties involved are criminalized, with the exception of some small counties in Nevada. Since 2016, the situation for sex workers, migrants, and trafficking survivors has become increasingly perilous due to the Trump administration's implementation of policies and executive orders limiting rights for lesbian, gay, bisexual, and transgender communities (Diamond 2018), immigrants (Pierce and Selee 2017), sex workers and trafficking survivors (Jackman 2018), sexual assault survivors (Democracy Forward 2017), and mounting restrictions on sexual and reproductive health (Alonso-Zaldivar and Crary 2018). To put it plainly, a previously bad situation has gotten worse. Among sex workers and migrants, the overall climate is punctuated by fear: fear of working, fear of reporting crimes, fear of interacting with police and attending court, and fear of seeking medical help.² Within an environment of extreme "bordering" (Yuval-Davis et al. 2019), sex workers and migrants' access to information and communication is also constrained. Moreover, people viewed by authorities as potential victims of sex trafficking (e.g., all sex workers due to the problematic conflation of sex work and sex trafficking outlined above) are vulnerable to interventions that blur the boundaries between protection and punishment and state and non-state authority (Musto 2016; Gruber et al. 2016).

Non-state actors increasingly collaborate with law enforcement actors in the United States to address trafficking (Musto 2016). Victim advocates, social workers, and service providers may partner with law enforcement before, during, or following police raids to assist in the identification and protection of prospective victims (Musto 2016, p. 20). Established anti-trafficking organizations like the Polaris Project also support state-orchestrated anti-trafficking activities, for instance by compiling guides to assist law enforcement to "recognize the problem" (Polaris Project 2018, p. 8). The development of multi-agency anti-trafficking task forces or vice squads in NYC and LA further illuminate the constitutive overlap between state- and NGO-led sexual humanitarian efforts.

The fact that state and non-state actors partner around shared anti-trafficking goals is notable; it underscores the influence of the sexual humanitarian paradigm to address migrant sex work and trafficking, and further reveals how trafficking, framed in exoticized and ethnicized terms (Ticktin 2014, p. 282), provides state and non-state actors with common ideological ground to support humanitarian efforts.

Policymakers initiate the sexual humanitarian intervention cycle by implementing anti-trafficking/anti-prostitution policy as a form of moral governance; immigration and law enforcement then enforce those policies through profiling, policing, arrest, and detention. These efforts are framed as necessary to find victims, which sets into motion a vicious cycle (Mai 2018, p. xvi). Once subjects are system-involved, the state-led sexual humanitarian arm of the courts enters the frame, and presents itself as benevolent, and necessary for connecting victims with social services deemed crucial for the salvation of the "victim-offenders" (Musto 2016). NGO-led sexual humanitarians then step in and attempt to rescue and rehabilitate victims through the provision of mandated services and "regimes of care" (Ticktin 2014, p. 281) with the ultimate goal of getting them to exit sex work and/or to cooperate with the criminal justice system in identifying traffickers or other third parties.

An illustrative state-led sexual humanitarian intervention in NYC is the Human Trafficking Intervention Courts (HTICs). The first of its kind, HTICs reconfigure persons (in this case, mainly women) charged with prostitution not as petty offenders, but victims of domestic violence and trafficking (Gruber et al. 2016). Since 2013 the HTICs have evolved and the courts, together with a network of non-profit organizations, deliver a range of mandatory sessions that serve as preconditions for obtaining an adjournment for contemplation of dismissal (ACD). HTICs have been criticized by sex work rights advocates for being complicit with punitive and carceral anti-sex work law enforcement and for not addressing the socio-economic realities of the defendants, the majority

² Trump's weaponization of fear (Altman 2017) is linked to various legislative developments and immigration enforcement practices. These shifts include but are not limited to the passage of SESTA/FOSTA, the repeal of the DREAM Act for childhood arrivals, the separation of families at borders, and heightened surveillance by Immigration and Customs Enforcement (ICE) in courts and schools.

of whom are racialized US citizens and migrants (Ray and Caterine 2014). The emergence of the HTICs further point to the institutionalization of penal welfare (Gruber et al. 2016) and carceral protectionist (Musto 2016) sentiments and the emergence of specialized courts, collaborative anti-trafficking task forces, and purported “alternatives” to more traditional forms of punishment have not curtailed the policing of sex work and trafficking but reconfigured it by leveraging sexual humanitarian ideals.

In interviews with key informants representing organizations that provide legal, health, social, and immigration support to migrants and sex workers in NYC and LA, we learned that there have been increases in policing and raids over the past two years, a period of time that corresponds with anti-trafficking initiatives and the passage of anti-trafficking legislation intended to help individuals involved in the sex trade.

Attorney Leigh Latimer of Legal Aid Society, an organization that provides legal assistance to sex workers, migrants, and people with trafficking experiences, described a recent uptick in policing, arrests, and the disproportionate representation of certain groups in the Human Trafficking Intervention Courts (HTICs):

“Recently we saw a spate of arrests of migrant trans sex workers from Queens—and we’re not entirely sure why. But then we saw lots more migrant trans sex workers going through Queens Court ... Overall, there are more cisgender women going through the courts. But in terms of black trans vs. migrant trans being represented in courts, it depends on location typically, and has to do with policing. In Queens HTIC, we see a lot of migrant trans women. In Brooklyn HTIC, it’s more black trans women. We think it has to do with policing in those neighborhoods in one part, but also has to do with where different trans communities are hanging out ... There is definitely discriminatory policing happening against trans people—for much of the same reasons related to the idea that trans sex workers do this work voluntarily and are not vulnerable to the same exploitation cis women are.”
(Interviewed 20 December 2018)

Latimer highlights increases in racialized and gendered policing taking place in NYC—particularly against transgender migrants who are often illegible as “victims”—a finding that we have outlined elsewhere (Fehrenbacher et al., forthcoming A).

Another expert we interviewed, Dr. Freddy Molano, Vice President of Infectious Diseases and LGBTQ Programs at Community Healthcare Network (CHN) in New York City,³ confirmed an increase in raids in Jackson Heights, Queens in 2018. Yet according to Molano, the uptick in raids was linked to the passage of SESTA/FOSTA in April 2018. The Stop Enabling Sex Traffickers Act (SESTA) and Allow States and Victims to Fight Online Sex Trafficking Act (FOSTA), or SESTA/FOSTA for short, are federal laws that hold third-party networks and website hosts liable for any content that is deemed to knowingly assist, facilitate, or support sex trafficking. According to Molano, SESTA/FOSTA not only resulted in more policing by law enforcement officials but also led to heightened on and offline surveillance by state and non-state actors. Much like humanitarian-inspired laws and activities that precede it, sex workers and self-identified survivors of trafficking were not consulted in drafting or passing the law. While unfortunate, it is nonetheless unsurprising that SESTA/FOSTA has heightened sex workers’ vulnerability to policing, arrests, violence, unsafe work, and economic precarity (NSWP 2018; Survivors Against SESTA 2018).

What the HTICs and SESTA/FOSTA underscore are the ways in which sexual humanitarian efforts to assist people deemed “at risk” of trafficking authorize heightened surveillance, policing, and system-involvement of all sex workers, including people in trafficking situations. As our data further reveal, these trends contribute to various negative health impacts for sex workers, migrants, and trafficked persons, which we detail in the sections below.

³ CHN has been providing community health and HIV+ service provision to mostly undocumented Latina transgender sex workers for over 30 years.

3.2. Negative Health Impacts of Criminalization

Out of a total of 50 sex workers in NYC and LA, the vast majority of respondents reported violent, abusive, and coercive encounters with law enforcement during policing activities, anti-trafficking raids, in undercover stings, with correctional officers while incarcerated, or in immigration detention settings. Despite the rhetoric of victimhood that is incorporated into sexual humanitarian anti-trafficking policies and interventions, our participants described how the very actors tasked with protecting them were often the most likely to victimize them. These abuses included misgendering, humiliation, rape, forced condomless sex, coerced sexual favors in exchange for release, sleep deprivation, denial of access to bathrooms or showers, and being forced to sit in wet clothes (see Hoefinger et al., in submission). Whether participants became system-involved due to sex work or immigration-related offenses, many described how the threat of arrest or detention—based on their criminalized occupational and/or immigration status—rendered them vulnerable to state violence and misconduct.

Participants self-reported several negative physical or mental health outcomes perceived to be linked to immigration and criminal justice system involvement. Specific mental health issues cited were symptoms related to post-traumatic stress disorder (PTSD), panic attacks, acute stress disorder, anxiety, depression, and fear. Physical health issues that were self-reported included urinary tract infection, headaches, insomnia, and poor nutrition (Hoefinger et al., in submission; Fehrenbacher et al., forthcoming A; see also Balaguera 2018; Amnesty International 2016).

As outlined above, state-led sexual humanitarian efforts aimed at controlling trafficking and saving victims through increased policing, raids, and anti-trafficking stings have negatively impacted the health of participants. For many interviewees the arrest and booking process was particularly traumatizing and culminated in various negative physical and mental health outcomes. Skylar's (age 21, US-born African-American cisgender female) experience is exemplary of the ramifications of the merging of both state and NGO-led sexual humanitarian efforts to tackle trafficking through the process of "arrest to assist" (Musto 2016). Skylar explained the physical consequences and stigma she associated with her arrest and detention, which were the result of an undercover anti-trafficking sting when she was 17 years old. Though her age legally defined her as a victim of trafficking, she was nonetheless arrested, stigmatized, and treated inhumanely by the vice officers responsible for the sting. Despite her insistence that she was working independently and had not been trafficked (which she interpreted to mean being forced or exploited by someone else to work), the officers demeaned her intelligence, and she associated her detention with physical illness:

"[During the arrest] The cops were assholes to me. They were slamming me against cars. They said I was 'too stupid' to advertise myself online ... Now you know why people tell trauma stories of arrest. They treat you like a criminal—not a victim ... When I got arrested, I was in jail for 23 hours. I refused to go to the bathroom because they were so disgusting. And I got a UTI [urinary tract infection] after 23 hours, but I didn't know—I had no symptoms. So I got sick. 103 fever and my back was on fire. The woman working with me took me to the hospital because the UTI was spreading to lungs and kidneys ... Medication didn't help. I was in the hospital for five days. The case worker sent through the arrest records to the other case worker—because I was in foster care. And she was like 'Oh well. This is what you're doing [sex work] and this is why you're here.'"

Skylar was offered little sympathy as a trafficking victim, or in regard to her health condition by the officers who were tasked with "saving" her in the raid, which is an unfortunate but not uncommon example of a state-led sexual humanitarian intervention. Instead, the police belittled her and treated her roughly. That the case worker appeared to link her infection to her behavior rather than the unhygienic conditions of detention further reveals how stigma and prejudice against sex workers are inherent to these interventions and contribute to adverse health outcomes. In order to obtain her ACD ("adjournment for contemplation of dismissal" so that her case would be sealed if not rearrested within six months), Skylar was required to complete 10 sessions of mandated social

services with an anti-trafficking organization, which included participation in yoga classes. While going through the mandated services, she had to drop out of community college because of the difficulties in managing her three children and traveling long distances between three boroughs to live, study, go to court, and attend mandated sessions. Despite being designated a “trafficking victim” by the courts and according to anti-trafficking policy in the US, Skylar had an alternative perspective on her victimhood and the services that were meant to “assist”:

“I explained that some people are not trafficked—but they [anti-trafficking organization] didn’t hear me. I never felt like a trafficking victim. Sex work was the best option for me at the time. I feel like I was a victim of the courts ... [Anti-trafficking organization] didn’t give me room to talk about the reasons I did it [sex work]. \$5 a day and a yoga class is not going to fix that!”

Skylar’s narrative highlights the failures of the court-mandated services in addressing her social and economic precarity, and how “unheard” she felt regarding her own framing of her subjectivity and experiences—which has been well-documented in the literature (Doezema 2005; Hu 2019; Hamid 2019), and is typical of the silencing that takes place within sexual humanitarian anti-trafficking interventions (Musto 2016).

The experiences of arrest, detention and violence by sex workers who are trans migrant women of color expose the way sexual humanitarian law enforcement interventions target minorities that are stigmatized and criminalized on multiple, intersecting levels. Partly because of racist and transphobic prejudice, trans women, in general, and trans women of color, in particular, are assumed to be willing sex workers (Fehrenbacher et al., forthcoming A) and therefore targeted by repressive anti-prostitution sexual humanitarian interventions. Several transgender women participants reported experiences of violence upon arrest and cited the trauma associated with being misgendered and detained with cisgender men, all while being blamed and victimized by law enforcement often in the name of protection (Edney 2004).

Nayara (age 42, migrant Latin American transgender woman) explains:

“When the police arrested me, there was a lot of violence and discrimination in the station... They used my real name rather than my female name ... At the station, I was in the same cell with another trans woman and a man ... I was stressed, had headaches, I was not sleeping well from stress from my arrest, my court case, and from not working. It was very traumatic—all of it. It really affected me. It affected me mentally and psychologically. I have a psychologist to help with all this ... I’m always stressed about police—even though I have papers. It’s very stressful living here ... I worked a little again after that [arrest], because I had to. But I was scared. I only worked with clients who still had my number.”

Nayara highlights the lasting psychological impact of her system-involvement and the fear she had when having to continue sex work out of economic need. Britany (age 29, US-born African American transgender female) points out similar experiences of misgendering and being called “he-she” during her arrest and the subsequent physical and mental health outcomes of her undercover arrest. These included self-starvation while detained for six days because of the poor quality of the food, depression during incarceration, and the anxiety she had when returning to sex work out of necessity—despite that she had an adjournment for contemplation of dismissal (ACD) from the Human Trafficking Intervention Court, which required that she refrain from criminalized activities for six months so that her case could be dropped.

Clinique (age 52, US-born African-American transgender woman) described how her incarceration in a men’s jail in New Jersey psychologically impacted her, as well as similar experiences of “starving” and how she, too, had to return to sex work after serving her month-long sentence out of economic need despite feeling targeted by police:

“I had to go to a men’s jail. It was horrible. I was isolated with someone who committed attempted murder who stabbed someone in the neck with a saw. That mentally fucked me up. Their reasoning was keeping me out of general population. I had no violence from inmates in jail. I actually had a lot of sympathy. But I had several bad situations with the CO [correctional officer] and the nurse ... I was [also] starving in jail ... I couldn’t eat. I didn’t have an appetite. I didn’t have a sense of day or night. Other than looking out the little whole in the window. I witnessed two suicides. Two guys almost killed each other in a cell. I spoke to the guy who killed himself [sic] the day before. It was really traumatic... After that I felt targeted by the cops all the time ... Got out, I was on probation. I had to pay a healthy fine. From where? What was I supposed to do getting that money? ... Which left me to do survival sex work again.”

Clinique’s quote illustrates that under the auspices of sexual humanitarian “protection” (Edney 2004), she was placed in isolation with cisgender male inmates who had severe mental health issues. This, in addition to poor nutrition and negative experiences with employees at the jail, had left her traumatized.

JP (age 38, US-born Caribbean transgender woman) described the extreme state violence, misconduct, humiliation, and experiences of rape she endured within multiple instances of arrest and incarceration in New York:

“I’ve been arrested and assaulted many times by police. After arrests, guards inside Rikers raped and molested me. They let inmates rape me. People doing more than a year they let rape people. If they have to do more time in prison, they tried to get on us. [The] officer got me raped. ‘You want to get raped faggot?’ He got inmates to do it. I threw all my HIV paperwork to them to show them I was positive. That fucked me up. Still have PTSD from that ... I’m fearful to go back on the street [to work] because of police harassment. They say, ‘Suck on my dick or I’m gonna arrest you.’ Happened to me plenty of times. Some police laugh at trans people when they arrest you.”

JP’s multiple experiences of sexual violence and derision by police and guards, who even incited male inmates to rape her, clearly affected her psychological health to the point of developing lasting PTSD. Her disclosure of being HIV positive in an attempt to prevent being raped increased trauma related to the experience, pointing at the additional negative impact of stigma and discrimination experienced by those living with HIV. JP’s story reflects the specific way transgender people of color (particularly those who are HIV positive and sex workers) are targeted by abusers within carceral forms of sexual humanitarianism (Reisner et al. 2014) that ignore public health recommendations to reform the criminal justice system in order to reduce imprisonment, combat HIV and general ill-health, and improve access to non-discriminatory health services (Rubenstein et al. 2016). Indeed, both Clinique and JP’s experiences highlight the failing vicious circle of sexual humanitarian interventions aimed at ending sex work through its very criminalization: arrests made them both destitute, traumatized, and left them with no other option than making themselves arrestable again by re-engaging in survival sex work.

Interviews with migrant participants also illustrate how experiences of abuse in the context of law enforcement encounters exacerbate fears about immigration controls and detention (Keller et al. 2003; Silverman and Nethery 2015). For instance, several migrant Latina transgender women reported negative physical and mental health problems that they specifically associated with immigration enforcement and detention. Yolanda (age 35, migrant Latin America transgender woman) explained how she was put in a freezing cold room while in immigration detention in Texas, a treatment that can be seen as amounting to torture:

“We were tired and on the run, and ICE got us immediately. We were processed and then put in [immigration] detention. We were still wet from the river and they put us in a freezing cold holding area. I told them that I wasn’t a woman, so they put me in my own

cold room. The food and treatment were terrible in detention. The guards would laugh when I said I was cold ... I was deported. I came back in 15 days and went through it all over again ... An ICE officer asked if I was trans, and they said that they could offer me asylum. So they transferred me to prison instead of detention. I hadn't showered or changed my clothes in three days. I was finally able to shower in prison. It was the best day when I was transferred from detention to prison. In the detention center in McAllen (Santa Isabel), in the "Freezer" or "Refrigerator" as we would call it, woman would take off their clothes to wrap up their children. It was excruciating. When I got to prison, I was very severely dehydrated. I had mosquito bites all over my body, and I was finally able to get the care that I needed. They put me in my own cell in a clinic now with women. There, I was able to contact my mother. I was able to start fighting for hormones in prison."

Torture-like treatment, lack of medical care and derision in immigration detention, subsequent deportation, re-entry, and repeated detention left Yolanda severely dehydrated and covered in insect bites. The shockingly demeaning conditions of migration detention come particularly to the fore when Yolanda refers to the prison she was transferred to as essentially better than immigration detention, as she was finally recognized as transgender there and could start fighting for hormones and receive more appropriate care. According to recent research with transgender women in the US, 37% of the 321 respondents who had been incarcerated were denied essential hormones during incarceration (James et al. 2016), whilst other research highlights deleterious health consequences of the systematic misrecognition of transgender identities in both prisons and immigration detention (Hughto et al. 2018).

Valeria (age 25, migrant Latina American transgender woman) describes how she was denied hormones and mental health medication in immigration detention:

"In prison, I was getting hormones and Wellbutrin, but in detention, they confiscated my hormones and said the medications were too expensive so they wouldn't give them. Instead, they gave me medication for anxiety even though I had depression. They doubled my dosage, but it didn't do anything. They would give me sleeping pills just to make me pass out. There was no stable healthcare provided in detention. The doctor didn't always come. The correctional officer who was advocating for us couldn't get anything."

The experiences of Valeria confirm the ways in which she experienced ill-health in detention as compared to prison, where she was at least given hormones and medication. In immigration detention her mental health was put especially at risk by being given the wrong medication and in high quantity. Whilst breaches of rights and ill-treatment were also reported in prison, the extreme (and similar) experiences of ill-treatment our participants endured in immigration detention highlight specific anti-migrant, as well as anti-transgender violence (O'Day-Senior 2008).

Two migrant transwomen reported being cuffed for punishment or "protection" (Anderson 2010; Edney 2004). Yolanda (age 35, migrant Latin America transgender woman) further explains:

"I was constantly cuffed and placed in an area with mentally ill people. I had my own cell in a wing of the building that was all men, so people constantly harassed me, even asking to have me put into their cells so that they could rape me. They would cuff me in the shower "for my protection" and I would be all alone and unable to move. They treated us like dogs, and they didn't give us any drink, so we would have to drink from the toilet. Food was only provided under the door for eight days... The most traumatizing thing was that when they transported us on a plane, they would put us in handcuffs, so even drinking water was very difficult. Now, I am so traumatized that I can't go on planes. I was terrified that I would be stuck if anything happened on the plane."

The high risk of mental and physical ill-health during detention and deportation are further described by Yolanda, who was misgendered and put in a male wing, handcuffed in showers and

with mentally ill inmates who harassed her, denied basic needs and led to humiliating, unhygienic and risky practices such as drinking toilet water. Basic safety measures in-flight were also denied when she was transported in handcuffs, which left her traumatized and unable to ever travel by plane. These findings align with other research that has found that punishments and harmful measures such as isolation and segregation are often used on transgender detainees in the name of their protection from other inmates (National Center for Transgender Equality 2018, pp. 13–14; Anderson et al. 2016; Edney 2004).

M.C. Dreamy (age 42, migrant Latin American cisgender woman) also describes experiences of being inhumanely cuffed and left in the rain outside, while also being refused the ability to use the bathroom properly:

“Once the guard wouldn’t let me go to the bathroom, I was taking a shit, and I took too long, so she took me out and cuffed me and put me in the yard in the rain, and I told them they can’t do this.”

As with M.C. Dreamy’s account, similar denial of basic needs, denigration, and ill-treatments such as unjustified handcuffing were experienced in migration detention by cisgender as well as transgender women, highlighting the uniform and systematic nature of violence that often takes place in carceral settings.

Lucero (age 23, migrant Latin American transgender woman) describes witnessing a cisgender peer being denied medical attention in detention:

“[One person I knew] started to get blisters. They wouldn’t let her see a doctor. It took a long time [for her to get medical attention and she experienced] ... dizziness, vomiting. They didn’t take care of her. They didn’t believe she was sick. They said ‘No habla Español.’”

Again, Lucero reports the clear anti-migrant attitude of guards who would deride and deny urgent health care by claiming to not understand the detainees on the basis of language. Ill-treatment and denial of care in detention and by law enforcement were recounted to cause, as well as exacerbate, pre-existing health problems, as has been well-documented in the research (Keller et al. 2003; Silverman and Nethery 2015). It is of central importance to our argument to show how racialized, gendered, and sexualized migrants are particularly targeted and harmed by state and carceral forms of sexual humanitarianism. Yet, the lack of care and support was unfortunately not confined to the participants’ direct experiences with law enforcement. Many also struggled with insufficient care after or in-between detention and arrests.

3.3. *Struggles in Accessing Health Care*

Along with negative health outcomes linked with immigration or criminal justice system-involvement and sexual humanitarian anti-trafficking activities, several sex workers and trafficked persons in our sample self-reported other co-occurring mental and physical health issues and symptoms, including specific mental health disorders, substance use and addiction, eating disorders, diabetes, stomach ulcers, hormone therapy-related health issues, high cholesterol, HIV, Hepatitis C, breast cancer, heart attack, and calluses on feet (from working long hours on the street). Notably, many participants also expressed difficulties in accessing affordable, unbiased health care due to occupational or gender-related stigma, fear around immigration status, lack of private insurance, or general failing systems of state support.

Due to the stigma she experienced by her case worker while being treated for a UTI after her arrest (see above), Skylar (age 21, US-born African-American cisgender female) described feeling unsafe coming out as a sex worker when she needed sexual health testing, and then ultimately being denied those services when requested:

“When I was a sex worker, [a mainstream national sexual health organization] would not give me a full panel of STIs. I didn’t feel it was safe to be out [as a sex worker there] because I didn’t want to talk to a social worker. I asked for testing. But they refused me. I asked to be tested, and so they should just test me! ... it’s doing harm when they didn’t test me.”

Skylar felt as though she was harmed by the denial of services, but also felt compelled to hide her sex worker status out of a desire to avoid further system-involvement with a social worker. Research has shown how stigmatizing attitudes towards sex work by social and health workers deter patients from disclosing relevant information about their lives, or from seeking access to services altogether, which ultimately jeopardizes the efficacy of health support (Lazarus et al. 2012).

Anastasia (age 50, migrant Caribbean transgender woman) described how unsupported she felt as a sex worker, drug user, and US military veteran. When asked if she felt helped by social service providers she was mandated to interact with under the terms of the diversion courts she was sent to following prostitution and drug-related arrests, she explained:

“Back then, they didn’t know [what people really needed]. They [cops] caught me with drugs, but there were no rehabs. Acupuncture just made me sleepy. Talking to a psychiatrist didn’t help. I was like, ‘You’re not taking me off the streets. You’re not doing anything to really help me. So why the fuck am I talking to you? I’m only here to talk to you for a few hours.’ So no, they didn’t really help me. And the community service didn’t help me. The army helped me. It gave me stability and structure. But when you got out, they didn’t provide anything. I was homeless when I got out. No housing. Nothing. No mental health provider. No money. No help in any way.”

Anastasia’s quote exemplifies the failures of intersecting state systems in meeting her mental and physical needs (Sayer et al. 2014). Neither mandated services nor the Veteran’s Association (VA) provided her with the drug-use related or mental health care she needed, or other crucial determinants of health such as housing or financial assistance, despite her service to the US Military. The intersectional discrimination, stigma and harassment suffered for being a transgender sex worker with a history of mental illness and drug use aggravated both her health and her exclusion from care, services and support (Hughto et al. 2015).

Similarly, Sara (age 31, US-born American cisgender woman) explained her struggles with accessing affordable, sex worker/drug-user friendly services to meet her co-occurring needs for her self-reported bipolar disorder, severe depression and hepatitis C:

“I have hep C from injecting and sharing needles ... I also need to see a psychiatrist for my mental health stuff. But I’m trying to find a sex worker-friendly therapist. I used to go to PERSIST Health Project through RedUP. But it’s sort of defunct now [the project has officially ended; more on this below]. So it’s hard finding sex worker friendly services, in general. I’ve had a lot of stigma from general health providers. They always talk down to me and treat me badly because I’m a sex worker and a drug user.”

Sara associates her negative experience with services as stemming from the stigma providers attached to her work and drug use, which demonstrates how sex worker- and drug user-friendly support is critically necessary for accessing and receiving effective health care, yet often rare or difficult to find—a finding well-documented in the literature (Whitaker et al. 2011; Benoit et al. 2015b).

In addition to stigma related to sex work and drug use, gender identity and immigration status are also barriers to accessing quality, unbiased health care. Tiffany (age 26, migrant Caribbean transgender female) describes being stigmatized as having a mental disorder due to her gender identity while seeking general care:

“I lived in Texas for a little while, and my doctor was very stigmatizing. She told me, ‘You have gender identity disorder. You need counseling. You’re mental. You’re lying to yourself.’”

Tiffany’s experience of stigma related to her transgender identity in general health care services is a recurring problem for transgender individuals and affects their lack of access. The various barriers to good health faced by transgender women are confirmed by research on 271 transgender women in LA between 2015 and 2016 (Reback et al. 2018) and by a 2015 study on 235 African-American transgender female sex workers in San Francisco and Oakland (Nemoto et al. 2015). Both studies highlight large health disparities among transgender women, exacerbated by anti-sex work and racist attitudes for sex working, African-American participants (Nemoto et al. 2015).

Lack of documented status was also described as a powerful deterrent to accessing health care by our participants. Jung (age 54, migrant Asian cisgender woman), who framed her experience as “trafficking” and applied for a T-Visa (a specific visa granted to victims of trafficking), explained how her undocumented immigration status was a hurdle in receiving care for her physical health needs:

“I used to be very sick from an infection from a super-bacteria. I was really sick for six months. I’m getting better now but getting health care in the US is very hard and medical bills are my biggest issue right now. I was able to get treatment in New Jersey, which is different from NY in terms of insurance. I’m also undocumented. It feels like this is my big problem. While I’m waiting for my T-Visa, I’m very scared. My sibling is in California, but I feel like I can’t even take a plane there because I’m afraid of what would happen. I have a lot of fear. I’m worried about any moment I could get deported, get arrested, get in trouble. I am in constant fear of that.”

As Jung’s experiences more broadly suggest, being undocumented is detrimental to good health in a number of ways. First, it prevents someone from accessing employment and health insurance, leading to high debts and the incapacity to afford medical bills. Fear of deportation, itself, is a significant factor that negatively affects migrants’ mental health and stability (Hacker et al. 2011) and prevents them from accessing health services (Martinez et al. 2015).

The data collected in our study shows how people who experience the burdens of stigma, incarceration and deportability resulting from sexual humanitarian interventions have very limited, or even non-existent, access to basic health care. Our findings also confirm that the inability to assert one’s rights and obtain access to health care and support exacerbates the likelihood and severity of exploitation and negative health outcomes. They also show clearly that people who are intersectionally marginalized according to race, gender, sexuality, and migration status—specifically women, transgender individuals, people of color, migrants, and those in coercive situations—are impacted most severely by the negative effects of sexual humanitarian anti-prostitution and anti-migration policies, and corollary interventions on their health and rights.

3.4. “Standing in the Gap:” Community-Based Health Interventions and Support

In an effort to fill the gap in health care and support resulting from stigma emerging at the intersection of race, gender, sexuality, and migrant status, our research revealed some interesting examples of community-led, grassroots initiatives designed by marginalized migrants and sex workers of color and/or those who’ve been impacted by sexual humanitarian interventions and by the criminalization of sex work and migration. Through directly quoting respondents who were organizers and beneficiaries of these groups, we now turn to analyze the work of a number of sex-worker and transgender led initiatives, including Lysistrata, SWOP Behind Bars, RedUP and PERSIST Health Project, TRANSgrediendo, GLITS, Translatin@ Coalition, and Bienestar. These groups all provide resistance to sexual humanitarianism through a combination of support strategies, including direct financial assistance (e.g., Lysistrata), material and literacy support (e.g., SWOP Behind Bars), and education and legal advice (e.g., GLITS and TRANSgrediendo). Crucially, their

activities counter and respond to the shortcomings, abuses, and lack of care outlined above while providing a positive sense of community, solidarity, and belonging to extremely marginalized and stigmatized individuals and the groups they belong to.

Lysistrata describe themselves as a “mutual care collective and fund” that provides basic as-needed economic support for sex workers in crisis through crowdfunding. Their support will cover anything from bail money and post-incarceration support to groceries, phone bills, transportation, rent, childcare, or healthcare costs. Most contributors to the fund are sex workers, themselves. According one of the Lysistrata organizers and members (who is a cisgender African-American female), the group actively prioritizes support for “trans, queer, LGBTQ, youth, people of color, people who are homeless, and people who are engaging as survival sex work” (Interviewed 14 November 2018).

She goes on to explain how criminalization of sex work was one of the major factors leading to the development of the group and describes the range of support they offer through a harm reduction approach:

“We had a situation where we thought somebody had been incarcerated, forced and entrapped, so Lysistrata rallied around that to obtain funds for the person ... it really just came out of necessity because of criminalization... It was a couple of people in the sex industry who started it... People who had a little bit more money were putting money into the fund and people who need the money would receive it ... We don't have grants or anything like that ... It's about harm reduction ... we literally meet people where they're at ... Sometimes it's going to hospitals when people have been hospitalized. And sitting with them and making sure they have food and that nurses aren't treating them shitty and they're using their pronouns ... So it's understanding that ... these real-life scenarios exist and that they impact the ability for somebody to be well and whole [and] that we play the part of ... eliminating or alleviating what pressures could force people to do this type of work.”

She also expressed frustration over the immensity of community and individual needs and how to prioritize them. This is especially challenging since they, themselves, must provide basic support for one another in the face of structural barriers and oppressive anti-prostitution and sexual humanitarian anti-trafficking policies that have failed them:

“When do we begin to heal ourselves? We don't have time for that because we're constantly living in crisis ... [this] crisis is not just ... [from] the state of the government, it's housing and gentrification and displacement and disruption and police violence and police presence ... All of these things that impact the environment's health, impact people [too] ... I hope we [Lysistrata] don't exist anymore [in the future] ... Because if we don't exist anymore that means that people do not need our services ... It's unfortunate that it takes community to help community to get our life together, [and] that it's not the people who are making shitty-ass laws about us. It's not people who are impacting our ability to work or live full lives [who help us]. It's not those people who are responsible for the trauma that is helping [us] ... [Instead] it has to be people who are living in traumatic situations helping other people who live in traumatic situations to come out of it.”

In her first quote, she highlights the critical importance of the work Lysistrata provides to community members. As a reaction to sexual humanitarian interventions that make sex workers destitute and harm their health without providing any quality care, Lysistrata offers economic and practical assistance. As a response, they demonstrate their capacity for mutual support and community-building, which clearly contradicts sexual humanitarian victimhood narratives of helplessness. The second quote highlights the challenges in self-support for trauma-informed peer-to-peer initiatives—which will remain needed as long as structural marginalization exists. Since ameliorating harm requires sweeping legal reforms and broader structural, political, and social

change (Blanch et al. 2012), in the interim, groups like Lysistrata provide much-needed resources and services to cope with the harms of punitive laws and structural injustice related to sexual humanitarianism.

Other groups working to alleviate barriers, trauma, and health disparities related to sex work and incarceration are SWOP Behind Bars and PERSIST Health Project (the latter of which has now ended but was cited as helpful by participants). Using a harm reduction framework, SWOP Behind Bars is a national network dedicated to assisting those who face discrimination from the criminal justice system due to the stigma associated with the sex industry. They “draw attention to the effects of generational poverty on sexualized violence against marginalized and vulnerable populations, especially women, people of color, the LGBTQIA+ community, people who use drugs, people with disabilities, and people living with HIV” (SWOP Behind Bars 2019) by providing advocacy for maternity needs of incarcerated people, educational scholarships, and re-entry services to sex workers post-release.

According to a SWOP Behind Bars representative,

“SWOP Behind Bars continues to try to provide services and support for sex workers who are in prison and as they are released. We do this through newsletters, pen pals and Amazon wish lists. It’s not been easy to get sex work-positive information into prisons. Every time we get a new member, we send them a welcome letter telling them who we are and what we do and over the past few months even that welcome letter is being refused from many prisons. We are constantly having to adjust our ‘content’ so we can still reach people who are in prison ... This month we are trying a new concept ... and that is to send them material about being financially literate ... or to better understand money and credit ... We are hoping that this document will clear the mail rooms without any complications ... at least it gets in there with our name and address and community support line number.

We also try to assist our members who are released by sending them a smartphone and a gift card for clothes ... We try to help folks get connected to their identification documents and then refer them to local food banks, job centers and thrift stores to make their money go further and to help them fill gaps in services. In fact, I think I can honestly say that standing in the gap is what SWOP Behind Bars has always done. We are excited to see many more of these community-based food banks and job centers are becoming much more ‘sex work literate’ and many of them have started to provide a few health and mental health care services that make sense. We try to make alliances with these kinds of community-based organizations and help them learn about sex workers who have been in prison or jail ... Right now we have literally NO FUNDING to do these things independently ...” (from email correspondence on 22 May 2019)

This quote speaks to the creative and practical ways groups are overcoming hurdles in reaching community members who have been impacted by the synergy between criminalization and sexual humanitarianism, while helping other support organizations improve their knowledge of sex workers issues and building critical alliances that are necessary in the face of no funding (Rowe 2006). The work of SWOP Behind Bars responds directly to state-led sexual humanitarian carceral efforts by providing community building and moral support to sex workers in prison. They also respond to the failure of sexual humanitarian approaches to victim support by providing material assistance and community support to sex workers once released from prison.

PERSIST Health Project, which was part of the Red Umbrella Project (also known as RedUP—a now-dissolved NYC-based community-led group dedicated to amplifying the voices of sex workers through storytelling) focused their work on advocating for universal access to health services, including primary health care, HIV treatment, and sexual and reproductive health services to people involved in the sex trades. They provided direct support in the form of health referrals, health education, and peer support. Skylar (age 21, African American cis woman) explains the importance

of their support in making sense of her own experiences with sex work, arrest, court, and self-advocacy:

“Being at RedUP and PERSIST Health Project was the first time I was given the language to explain what I was experiencing. And that I’m the expert on my own experience. I can actually make my own decisions. I was a sex worker not a trafficked victim. It all made more sense to me. [During the court case] I couldn't tell my lawyers what was happening because I didn't have the language. [At RedUP] I was then able to discover advocacy for human rights was really needed. People can dictate what they need. I had agency in my life. I would be able to make the decisions I made. I made a choice. And stuck to it. Being connected to RedUP and PERSIST gave me the tools and language to learn that. They gave me the tools to be able to advocate for myself and others.”

Skylar highlights the crucial role of peer organizations in addressing and pushing back against the consequences of sexual humanitarian rhetoric of victimhood, which can be psychologically harmful (Fassin and Rechtman 2009) and constrain individual’s ability to speak out and defend one’s agency and life experience in their own terms.

Skylar goes on to explain the collective resourcefulness within the sex work community:

“Sex workers are very resourceful—we have a lot resources that are not readily available [in mainstream settings]. Sex workers are good at self-care ... We don’t want to deal with state sanctioned violence at hospitals. We have ways to get around not having insurance, or if we need medication. Sex workers are the best place to go! We’re a self-contained community!

If it [sex work] was legal, it would be better, and we could be a lot more useful. When decriminalized, we can also protect ourselves from fraudulent activities ... If you go to Community Healthcare Network, you can be out. That's only place I've ever told I was a sex worker. The ER [emergency room in hospitals] has to report if they think someone is trafficked. So we can't tell them there. We [RedUP] do best practice training for service providers. We also know sex worker-friendly therapists and doctors. We either create our own resources, or vet people out for sex workers.”

The manifold mutual help and resources Skylar speaks of indicate both the importance of peer solidarity amongst criminalized groups (Dewey et al. 2015) and the way sex workers can, and do form resilient and organized communities in the face of common experiences of criminalization, harm and exclusion—which starkly resist unidirectional sexual humanitarian framings of victimhood (Jackson 2019).

In NYC, Community Healthcare Network (cited above by Skylar) is an organization providing some of the mandatory sessions assigned by the HTICs. They collaborate with the Colectivo Intercultural TRANSgrediendo, a “trans-specific, trans-inclusive and trans-directed” group dedicated to supporting transLatinx community in NYC—many of whom have been impacted by both the criminalization of sex work and migration. In addition to promoting the overall health, safety, and culture of gender-diverse populations, TRANSgrediendo assists with health evaluations for undocumented sex workers trying to obtain immigration relief, and housing referrals. Nayara (age 42, migrant Latin American transgender woman) describes her positive experiences with their community-based approach:

“I love this community! ... I share everything with them. It pains me when they suffer ... It's like we are a family ... My experiences have been great... They are really focused on health, housing, and about learning about the laws, and providing workshops about my rights.”

The activities of the TRANSgrediendo Collective are in close synergy with those of the Lorena Borjas Foundation, a community fund that has been providing financial (e.g. paying bail out fees), housing, and health assistance to arrested Latinx migrant sex workers for nearly two decades. A newer small group named Gays and Lesbians Living in a Transgender Society (GLITS) is also specifically supporting migrant transgender sex workers seeking asylum in the US with the goals of focusing on the “health and rights crises faced by transgender sex workers holistically using harm reduction, human rights principles, economic and social justice, along with a commitment to empowerment and pride in finding solutions from our own community” (GLITS 2019). The group has helped to facilitate the entry and integration of trans sex workers from the Caribbean, Latin America, and Africa via connecting them with housing, holistic trans health care, and education, which has resulted in one of the members recently receiving a degree in nursing. These groups effectively respond to the convergence of several consequences of sexual humanitarian interventions, namely vulnerability to incarceration and its consequences for transgender sex workers of color in general, and deportability and barriers to education for migrant transgender sex worker, in particular.

Many sex workers also highlighted the ways in which the general sex work community was a strong and important source of help. Ashley (age 30, US-born African-American cisgender woman) explains how she’s felt supported by the informal network of sex workers in NYC that exist outside of any particular group or collective:

“I definitely have a strong support network among sex workers. We have built a network for ourselves. The network in NY is completely different from anything I ever experienced. Dallas was really segmented and sparse, which is how it is in other cities. But NY is special because there is opportunities to go to events and meet people and meet doms, whether you’re queer or trans ... The [sex worker] community has been built up, and with social media, the way we are able to reach communities online across the country—especially for those who can’t meet other sex workers—is really amazing. So I’ve met with people from other parts of the country or the world. So it’s nice to have that support system that’s grounding me.”

In LA, the trans-led organization TransLatin@ Coalition (TLC) provides services to transgender migrants recently released from detention or prison, many of whom are sex workers or have been trafficked. TLC is located within the Trans Wellness Center, a collaboration of six community-based organizations serving the trans community in LA and hub for community building and support. Another trans-led organization, Bienestar, provides social and healthcare support for transgender Latinxs, and regular self-help gatherings for trans Latinxs (mostly current and former sex workers) in El Monte, California. Several transgender sex workers we interviewed or met during fieldwork in LA were supported by these organizations after being victims of transphobic prejudice and violence and profiled as sex workers by law enforcement. When asked about her experience with both groups, a 39-year-old Central-American trans woman summarized it as follows:

“I experienced what [it] was like empowering trans sex workers to carve out our rightful place in a highly hostile society.”

The positive experiences of community-led initiatives of our research participants show clearly that autonomous, self-organized networks of support are able to successfully challenge sexual humanitarian and neo-abolitionist approaches to service provision that situate sex work itself as violence, a framing that both ignores and exacerbates the violence and health consequences of criminalization.

This insight is reflected in JP’s (age 38, US-born Caribbean transgender woman) response to our question about what should be done to improve the current situation, an insight that cogently encapsulates key findings from our larger study:

“We need safe places. We need more sex worker friendly spaces. We need funding for those. We need where they can find you jobs, school, sex working friendly spaces.

Sex workers should not be arrested, but instead referred to counseling, job training, work release, or service to the community ... We need sex work programs and harm reduction just for sex workers, like more drop-in centers for all women and girls who do sex work. Regular SEP [syringe exchange programs] are not welcoming enough ...

We need better LGBT liaisons ... We need protection laws. Do they [cops] think they can rape lesbian, bi, and trans women? Cops can't get away with that! Something must be done. All law enforcement needs laws to protect people both inside and outside the system, and when we're protesting so we can get people out of jail.

All programs need training and education on developmental disabilities, and chronic and severe mental illness that can lead to suicide. Train law enforcement in transgender [issues]. They have to understand these diagnoses and be educated and trained. If they can open more and more courthouses, jails and prisons, why can't they do more training and programs for when people get out?! ... We need advocates who support us, especially those of us who were harassed, targeted, or teased, or trafficked people. It's not their fault if they get raped! ...

I think sex work should be allowed—either legalized or decriminalized. Sometimes when you do sex work, you do what you can to survive and eat and feed your kids or get your sex change. Transmen, transwomen, we do it for different reasons... Treat us like... the humans we are! We need more transgender support groups and harm reduction programs, more more more trans support groups!”

In addition to distilling the demands conveyed by most research participants in our study—some of whom also highlighted the need to get help in accessing housing and alternative livelihoods—JP's reflection emphasizes that the key issue needed to improve the current situation is that sex work should not be criminalized.

4. Discussion

The reflections of participants involved in community-based projects, loose networks, and collectives in NYC and LA show how they “stand in the gap” and act as critical buffers against the onslaught of repressive legislation, providing support for coping with deleterious conditions facing sex workers. These efforts demonstrate survival-oriented reactions against mainstream sexual humanitarian organizations and interventions, which limit rather than promote the agency of sex workers and trafficked persons. Arguably, their efficacy derives from centering the lived experiences of migrant, trans, and sex workers of color, including experiences of violence and harm by state and sexual humanitarian actors.

4.1. Theoretical Contributions

We have framed policing, arrests, court involvement, court-mandated services, incarceration, and immigration detention as specific forms of sexual humanitarian interventions that are simultaneously aimed at “rescuing” victims (Agustin 2007) while abolishing both trafficking and sex work (Weitzer 2010; Ditmore 2008; Doezema 2005). At present, in the US and globally, sexual humanitarian approaches legitimize repressive policies that exacerbate rather than reduce sex workers' and migrants' vulnerability to exploitation and their exclusion from healthcare services (Mai 2018). Our interviews illuminate that the very people sexual humanitarian actors deem incapable of “saving” themselves from exploitative situations are instead actively involved in self-

organizing efforts to create more effective solutions to support their communities and address gaps in healthcare provision.

Our analysis has focused primarily on the criminalization of migrants—documented and undocumented—and US-born women of color—both cis and trans. These groups are particularly affected by the convergence of two factors—(1) the necessity to sell sex because of structural exclusion from jobs outside of the sex industry, and (2) exposure to joint carceral and sexual humanitarian law enforcement activities. The latter includes police activities designed to combat sex trafficking in collaboration with anti-trafficking NGOs. As interviews with research participants reveal, such activities can heighten vulnerability to abuse and negatively impact sex workers' physical and mental health by coercing them into services via the threat of a criminal record and the simultaneous denial of their personal agency.

Our findings advance the study of sexual humanitarian governance by analyzing jointly the negative impact of the related policymaking policies and interventions on the lives of sex workers, and on the community-led responses that counter them. Our data reveals the strategic role of racialization and sex-gendered discrimination in the enforcement of sexual humanitarian policies and interventions resulting in the harming of social groups that are already most heavily and intersectionally marginalized according to their social class, race, gender, sexuality, migration status, and for being sex workers. At the same time, our research findings contribute to the study of humanitarianism by showing how community-led initiatives can challenge and address its negative impacts, as well as how sexual humanitarian governance can be successfully countered, and its effects reversed, if more resources were made available to communities in a decriminalized context, as funding is fundamental for the sustainability and efficacy of peer support initiatives (Cornish and Campbell 2009).

4.2. Methodological Contributions

This article sheds light on the resiliency of peer-to-peer support networks organized by communities who are targeted by the convergence of neo-abolitionism and sexual humanitarianism. By focusing on the voices of those most affected by these policies and interventions through in-depth interviewing and a long period of ethnographic observation inside community, work, and political spaces, we have documented the harms that result from carceral oriented sexual humanitarian interventions, and the practical, community-based efforts that have developed as a reaction and survival-oriented response.

This in-depth, qualitative, multi-year, multi-site research specifically draws attention to the ways in which sex workers develop their own grassroots initiatives to access much-needed services and support in the face of persistent and enduring marginalization across time and space. We purposely used immersive ethnographic, qualitative methods, and asked open, non-leading questions, as we were aiming to center our findings on the very voices and experiences of our respondents—a method that is in opposition to the silencing and lack of meaningful consultation that is typical of sexual humanitarian-oriented quantitative research on sex work (e.g., Farley 2006). We found that the process of building trusting relationships with people in their community and organizing spaces was key to “successful” fieldwork and theory-building, particularly when working with populations who generally lack trust in institutions and academic research (Hoefinger 2013, p. 52). We argue that our immersion into the life worlds of participants aided us in providing complex, multi-layered portrayals of participants' lived experiences with work, sexual humanitarianism, and health, which ultimately led to the creation of more sophisticated and egalitarian research (Hoefinger 2013).

4.3. Policy Recommendations

The day-to-day experiences of our research participants show clearly that the criminalization of sex work and migration exacerbates the marginalization, vulnerability and hence exploitability of sex workers and survivors of trafficking alike, despite sex work and trafficking being distinct phenomenon (Albright and D'Adamo 2017). Our research findings indicate a pressing need to fully

decriminalize sex work (Howard 2018) and reform institutional practices in the US to reduce the overall negative impact of policing and system-involvement on the health, lives, and rights of both migrant and non-migrant sex workers.

The findings of the SEXHUM project strongly suggest that police involvement and criminal sanctions against sex workers (even when condoned in the name of sexual humanitarianism) lead to the perpetuation of violence, discrimination, harm, and lack of access to justice and quality health care for all sex workers, in particular trans persons, migrants, and people of color. The testimonies of our respondents indicate that, when sex work is criminalized, it is virtually impossible for sex workers or people in trafficking situations to rely on the criminal justice system for access to justice or protection, resulting in sex workers having to resort to self-help and self-organization in order to increase their chances of survival. On the other hand, in contexts where sex work is (albeit partially) decriminalized, such as in the state of New South Wales in Australia and in New Zealand (where public funding has been made available for sex worker-led organizations), research has shown that relations between sex workers, people who are trafficked, and the police, as well as access to justice and health care, have dramatically improved (Howard 2018; see also Cunningham and Shah 2017; Harcourt et al. 2010).

Peer-to-peer interventions in the US provide a critical resource for sex workers in creating a sense of solidarity and providing fundamental services that counter the systemic violence that leads to negative health outcomes. Overall, our research findings highlight that in response to the harms associated with sexual humanitarian efforts and resulting system-involvement, sex workers, migrants and people with trafficking experiences are creatively designing and implementing their own grassroots solutions to support their communities and ultimately “saving themselves” in their own terms (Hoefinger 2013; Hoefinger and Srun 2017). In this respect, the experiences of sex workers involved in community-based responses show the paradoxical situation they face as they successfully address the harms caused by well-funded and politically endorsed sexual humanitarian programs with no other financial support other than their own resources.

Our findings thus make the case for why broader public health support, research, and, crucially, funding for community-led health initiatives are needed to address barriers to health care resulting from stigma and criminalization. We propose channeling funds to community-led projects and initiatives aimed at supporting sex workers and victims of trafficking, rather than to mainstream sexual humanitarian, anti-migrant and anti-sex work policies and interventions that still rely heavily on punitive and carceral approaches. Ultimately, our research highlights that the most evident, necessary step to challenge the harms of sexual humanitarianism is the full decriminalization of sex work.

4.4. Directions for Future Research

In the US, as in all settings where repressive anti-sex work policies mean that sex workers are targeted by law enforcement, sex workers live and work outside the protections offered by labor laws and the justice system. As such, they are disproportionately affected by harassment from the police and other state authorities (NSWP 2014a, 2014b). While sex workers of all genders endure harms related to criminalization, as the Red Umbrella Fund (2014) notes, transgender and male sex workers may experience violence and harassment differently compared to female sex workers.

We therefore argue that the development and implementation of “innovative, accessible and non-judgmental health care” (Lazarus et al. 2012, p. 1) should be based on the direct involvement of sex workers of all genders. We underline the critical importance of community responses in countering the negative impacts of sexual humanitarian interventions, a finding that further suggests that community-based efforts are more effective in addressing the needs and priorities of the people directly concerned, which is an area where more research is needed. Our work indicates the existence of a gap in research to be filled through more studies on the efficacy of emerging sex worker, transgender, POC, and migrant peer-to-peer, grassroots initiatives in meeting community needs.

Finally, to counter the lack of consultation with the subjects of interventions typical of sexual humanitarianism, this research points to the critical need for more quantitative and qualitative

participatory research informed by, and directly involving, members of marginalized communities, such as sex workers who are migrants, transgender, and people of color (Kim and Jeffreys 2013). While some studies have described the crucial value of researchers working with community members to address issues like trafficking (Picarelli 2015), more research is needed on how to remove institutional and concomitant barriers in these types of collaborative studies, so that community expertise is centered and sex worker voices are heard, valued and taken seriously in policymaking.

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