THE UNIVERSITY *of* EDINBURGH

THE UNIVERSITY of EDINBURGH

Migrant women sex workers: a qualitative thematic analysis of their healthcare access experiences in a Thai context

Paichit Amsri

Thesis submitted in fulfilment of the requirements of the degree of Master of Philosophy

The University of Edinburgh

2025

THE UNIVERSITY
of EDINBURGH

Declaration

I hereby certify that the content of this thesis is solely my own original work. No portion of this work has been submitted previously, in whole or in part, for the award of any other academic degree or professional qualification.

Paichit Amsri

2025

Acknowledgements

This academic journey would not have been possible without the solid support and guidance of my supervisors. I am profoundly grateful to Professor Elaine Haycock-Stuart, who has accompanied me with patience and persistence during this long and, at times, interrupted route. Elaine, your encouragement during challenging periods, especially through study delays and shifting timelines, meant more than I can express. Your efforts to help me think conceptually and analytically, beyond an operational mindset, were invaluable.

My honest thanks also go to Dr. Rebecca Hewer, Dr. Rosie Stenhouse, Dr. Susanne Kean, and Dr. Fiona Cuthill for their expert supervision, thoughtful insights, and ongoing encouragement. Throughout the complexities of this research, including the disruption caused by the COVID-19 pandemic, your collective support kept me focused and motivated. I am especially thankful for the academic and personal growth I gained under your mentorship.

I am immensely indebted to the women who participated in this study. Your willingness to share such personal and sensitive experiences during a particularly difficult time amid a global pandemic and national lockdown is truly admirable. Thank you for your openness, honesty, and trust. I have learned a great deal from you, and I remain committed to advocating for your rights and ensuring equitable access to healthcare services.

I would also like to express my sincere appreciation to the staff at EMPOWER Foundation Thailand for their generous support and collaboration during my fieldwork. Their facilitation and trust were essential in enabling access to participants and navigating the complex realities of conducting research during the pandemic. Without their involvement, this thesis may not have been possible.

To my fellow doctoral students, thank you for your solidarity, shared experiences, and academic support over the years. Your presence made this journey less isolating and more meaningful.

I would also like to express heartfelt appreciation to my family and friends. Your love, patience, and understanding created the supportive environment I needed to persevere through the most demanding phases of this work.

Finally, I would like to thank my proofreader, whose careful attention and assistance in the final stages of writing were greatly appreciate.

Abstract

This thesis examines migrant women sex workers' (MWSWs) experiences of healthcare access and provision in Thailand. Grounded in a constructivist paradigm and guided by an intersectionality lens, the study applies thematic analysis to explore how MWSWs experience and navigate formal healthcare systems.

Despite Thailand's widely praised achievement in developing a system of universal healthcare, qualitative semi-structured interviews with MWSWs and the Thai NGO EMPOWER Foundation (n=39) suggest that MWSWs' lives are not lived under the umbrella of universal provision. Rather, their healthcare navigates precarious and contested negotiations.

Intersectionality theory is used to identify how overlapping systems of disadvantage, including migration status, gender, socio-economic position, documentation, and sex work stigma, interact to shape the MWSW's healthcare access and exclusion.

Findings identify four interrelated forms of exclusion:

- *Communicative and Cultural Exclusion,*
- *Symbolic Misrecognition,*
- *Systemic Inaccessibility, and*
- *Intersectional Hierarchies*.

Collectively, these forms of exclusion illuminate how policies, institutions, and everyday practices interact to position MWSWs as marginal, illegitimate, or invisible patients.

At the same time, MWSW participants fought against their discouragements and exclusions through bounded strategies using: selective disclosure, peer solidarity, and NGO intermediation. Although such practices served to mitigate immediate harm, the women were also restricted by the structures that they sought to manage their situations. To capture this paradox, the thesis develops the concept of the *exclusion–resistance feedback loop*, which demonstrates how exclusion and resistance are not sequential but co-occurring processes that reinforce one another over time.

The study makes three key contributions. Empirically, it offers an intersectional analysis of MWSWs' healthcare experiences in Thailand in a systematic manner that supplements the existing literature, which is predominantly centred on HIV/STD. Theoretically, it contributes to the practical use of intersectionality in health research and introduces my development of exclusion–resistance feedback loop as a model for understanding how exclusion and agency are co-constituted.

Ultimately, this thesis argues that the universalist healthcare system in Thailand is diminished by women having to backdoor stratified access to services. Healthcare rights are theoretically recognised but unattainable in practice for people on the legal, labour, and social margins. Addressing this requires systemic transformation that dismantles communicative, symbolic, systemic, and hierarchical exclusions whilst embedding the capacities of peer and NGO networks into formal healthcare systems.

Words count: 60,046

Lay Summary

In this thesis, I set out to explore how migrant women sex workers (MWSWs) in Thailand experience healthcare provision and how they perceive and navigate access to services. My central research question asked: *How do MWSWs experience healthcare in Thailand, and what are their perceptions of accessing it?*

In response to this, I utilised a constructivist qualitative perspective and drew insights from intersectionality theory. Data were collected through semi-structured interviews with MWSWs and members of EMPOWER, a Thai non-governmental organisation supporting sex workers. Thematic analysis, operated through an intersectional coding strategy, enabled me to trace how gender, migration status, documentation, socio-economic precarity, and stigma surrounding sex work intersect to shape exclusion and resistance.

My findings demonstrate that healthcare exclusion is not the result of discrete identifiable barriers but is the compounded interaction of multiple disadvantages. I categorised these into four domains of exclusion: *communicative and cultural exclusion, symbolic misrecognition, systemic inaccessibility,* and *intersectional hierarchies*. The domains indicate how policies, institutions, and everyday behaviours intersect and interact to produce forms of marginalisation that are more than the sum of their parts, shaping the lived realities of MWSWs in deeply compounded ways.

Meanwhile, I recognised that women use forms of bounded resistance, such as selective disclosure of sensitive information, peer solidarity, and NGO mediation. Although these approaches provide immediate protections, they do not transform structural inequalities. Instead, they sustained what I conceptualise as the *exclusion–resistance feedback loop*, a cycle in which exclusion produces resistance that, paradoxically, further reinforces exclusion.

This thesis contributes empirically by providing an intersectional account of MWSWs' healthcare experiences in Thailand; theoretically by advancing the practical application of intersectionality and introducing the exclusion–resistance feedback

loop; and practically by recommending reforms that separate healthcare from documentation, recognise sex work as legitimate labour, institutionalise interpreters and cultural mediators, and integrate NGOs into formal provision.

In the end, my analysis indicates that Thailand's universalist health system reproduces stratified access in which rights exist in principle but are unavailable in practice. Disruption of this cycle demands system-wide transformation that removes exclusions on communicative, symbolic, systemic, and hierarchical levels as well as policies that extend the capacities of peer and NGO networks in healthcare delivery.

Foreword: My motivation for this research

In studying access to healthcare by migrant women sex workers (MWSWs) and seeking service providers' views about challenges and opportunities in access to healthcare provision, I am both an insider and an outsider as a researcher. I need to acknowledge and address here how that may influence how I relate to participants, how data is collected, and how findings are interpreted.

I am a single Thai mother from Roi Et, north of Isaan, which is one of the poorest Thai provinces. I grew up in a peasant farming community and, as a child, lived the struggle of rural life, working barefoot in the rice field before school. I knew hunger and the powerlessness that many of the MWSWs describe. I learned the place and obligations of girls. Being successful at school opened options to me to graduate as a registered nurse and midwife within the powerful Bun Khun cultural expectation that I would find work to support my family.

I, too, did a 700 km migration, in my case, from my village to Pattaya to work as a senior nurse. After my interview, the HR person noted on my report that I am "*a brown-skin nurse from the Isaan area*". That is undermining, Thai-style. Brown skin in a Thai context, where pale skin is highly regarded, and reference to Isaan, widely acknowledged as shorthand for low status, were unlikely to enhance my standing with my new work colleagues.

Pattaya is a sex entertainment industry and sex tourism city with an ethnic diversity of workers who became my neighbours and friends, Thai and migrant sex workers, among others. Despite our different daily lives and professions, we all shared a common purpose of working hard and sending money back home. This was, in some ways, a window into their world, and I began to see specific problems in their lives, especially with regard to healthcare. Each day, my empathy and compassion for the MWSWs increased further.

Despite the shared community – streets, shops, and parks - and friendships with MWSWs, I also became aware that there were also undocumented migrants who

operated in a world apart from me. They lived on the margins for so much of their lives, and I came to observe that they experienced specific obstacles related to accessing healthcare, such as language barriers, discrimination, and fear of arrest, abuse, or deportation. I never got to talk to them at that time about their worries about ill health and sickness, and how they managed their health in a system designed so often to exclude them. In time, as a postgraduate researcher, I considered this an opportunity to finally meet MWSWs and learn and listen to their first-hand experiences about how they experienced healthcare services in Thailand.

My inspiration for this study stems from my professional and personal interests. Migrant women sex workers (MWSWs), their opinions, and lived experiences are frequently discounted in healthcare research or rendered unstructured and voiceless. I believe they have vital insights to share, not only for themselves as human beings, but also as women, and for the benefit of public health. This research is my way of amplifying the voices of MWSWs and ensuring they are included in the conversation when discussing adequate healthcare provision.

My study aims to better appreciate MWSWs' perspectives and potentially develop new practices for providing inclusive and compassionate care adapted to their needs.

Contents

Chapter 1: Introduction *1*

1.1 Background of the Study **1**

1.2 Rationale for the Study **2**

1.3 Research Aim and Questions **3**

1.4 Thesis Structure **4**

Chapter 2: Background of Thailand's Healthcare Landscape *5*

2.1 Introduction **5**

2.2 Thailand country profile **6**

2.2.1 Political and economic landscape 7

2.2.2 Gender norms and inequality 8

2.3 Healthcare policy in Thailand: conditional universality **10**

2.3.1 Healthcare system for Thai citizens 10

2.3.2 Healthcare system for migrants in Thailand 11

2.3.3 Challenges and opportunities in Thailand's healthcare system 12

2.3.4 Challenges of healthcare services among migrants 13

2.4 Migration and documentation: from labour flows to healthcare exclusion **14**

2.4.1 Migrant women's pathways to Thailand 15

2.5 Sex work and criminalisation: between economic survival and structural stigma **17**

2.5.1 Statistical invisibility: migrants and sex workers as uncounted populations 17

2.5.2 Law and regulation 19

2.5.3 Health and Human Rights 20

2.6 Research gap: the hidden experiences of migrant sex workers **20**

2.6.1 Healthcare access for sex workers 20

2.6.2 Challenges in accessing healthcare 21

2.7 Chapter summary **21**

Chapter 3: Literature Review *24*

3.1 Introduction **24**

3.2 A review of migrant women sex workers' experiences and perceptions of access to healthcare **26**

3.2.1 Literature search methods 26

3.2.2 Healthcare access among migrant women sex workers: a thematic review 33

3.3 Towards an intersectional healthcare framework **56**

3.3.1 Rethinking intersectionality in sex work research 57

3.4 Chapter summary **59**

Chapter 4: Methodology and Methods *61*

4.1 Introduction **61**

4.2 Research aims and questions. **61**

4.3 Epistemological considerations 62
4.3.1 Reflexivity on epistemological stance 63
4.3.2 My insider and outsider positions in this study 65

4.4 Research design 68

4.5. Data collection process 69
4.5.1 Study samples and setting 70
4.5.2 Access and recruitment 70
4.5.3 Research participants 75
4.5.4 The language used in the interviews 78

4.6 Methods of data collection. 79
4.6.1 Semi-structured Interview 79
4.6.2 Interview process 81

4.7 Data analysis process 85
4.7.1 Translation and interpretation 85
4.7.2 Thematic analysis as an analytical framework 87
4.7.3 Re-analysis process using thematic and intersectionality approaches. 95

4.8 Ethical and methodological considerations 102
4.8.1 Informed Consent 103
4.8.2 Confidentiality and anonymity 104
4.8.3 Do no harm 105

4.9 Trustworthiness of this study 106

4.10 Emotional work in sensitive topics 108

4.11 Limitations of this research 112

Chapter 5: We Were There, But Not Seen: Navigating Exclusion and Resistance in Healthcare 111

5.1 Introduction 111

5.2 Who are my participants? 111

5.3 Theme 1: Speaking through silence: structural exclusion and healthcare navigation 123
5.3.1 Exclusion through communication disempowerment 123
5.3.2 Symbolic misrecognition: being present but not seen 129
5.3.3 Systemic inaccessibility: institutional expectations vs. everyday realities 131

5.4 Theme 2: Survival and resistance: navigating through stigmatisation and discrimination 136
5.4.1 Hierarchies of exclusion in healthcare spaces 136
5.4.2 Stigma as structure—how healthcare marks and marginalises. 140
5.4.3 Layered exclusion: gender, migration, and sex work in clinical encounters 144

5.5 Chapter summary 150

Chapter 6: Negotiating Visibility: The Conditional and Contested Nature of Healthcare Access for MWSWs 153

6.1 Introduction 153

6.2 Excluded in plain sight: structural, symbolic, and social barriers to healthcare 157
6.2.1 Structural fear and access shaped by the interaction of formal policy and informal risk perception 157
6.2.2 Stigma, silence, and social risk: healthcare avoidance as survival 162

6.3: Informal care, peer networks, and dignity in the gaps **167**
6.3.1 Dignity as a surprise: when care feels exceptional 168
6.3.2 Peer navigation and collective care 172
6.4 Chapter summary **181**
Chapter 7: Discussion, Conclusion, and Recommendations ***184***
7.1 Introduction ***184***
7.1.1 Positioning findings within the literature 185
7.1.2 Methodological reflections 188
7.2 Discussion of key findings **190**
7.3 Theoretical contribution **196**
7.4 Empirical contribution **197**
7.5 Revisiting the research question and objectives **198**
7.6 Conclusion **199**
7.7 Recommendations **201**
References ***211***
APPENDICES ***232***

List of Tables

Table 3.1: Inclusion Criteria…….26
Table 3.2: Exclusion Criteria…….26
Table 3.3: PICOs search strategy……27
Table 3.4: Search terms ……...28
Table 4.1: Socio-demographic characteristics of MWSWs……71
Table 4.2: Socio-demographic characteristics of Service Providers (SP)……72
Table 4.3: Emerging Codes…….....87
Table 4.4: The initial analysis themes……88
Table 4.5: The final TA themes……92
Table 4.6: Final thematic and intersectionality analysis themes……99
Table 5.1: Service provider participant group……117
Table 5.2: Service provider/migrant sex worker group……118
Table 5.3: Migrant sex worker group…….....119
Table 5.4: Participant data contributing to the themes……121
Table 6.1: Participant data contributing to the themes……155
Table 7.1: From thematic findings to conceptual framework……191
Table 7.2: Exclusion domains, data examples, and corresponding resistance strategies……198

List of Figures and Diagrams

Figure 3.1 PRISMA flow diagram ……..31
Flow diagram 4.1: Reviewing and refining themes…….90
Figure 7.1: Exclusion-Resistance Feedback Loop……199

List of Appendices

Appendix A: Inclusion articles: Healthcare Access Among Migrant Women Sex Workers…….233

Appendix B: Ethical Approval……..……..253

Appendix C: Participant Consent Form……254

Appendix D: Participant Consent Form Thai……..256

Appendix E: Participant Information Sheet…….257

Appendix F: Participant Information Sheet Thai…….265

Appendix G: Reflective Journal ……267

Appendix H: An interview guide, service providers, sex workers…….269

Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ASEAN	Association of Southeast Asian Nations
CASP	Critical Appraisal Skills Programme
CBOs	Community-based organisations
CESCR	United Nations Committee on Economic, Social and Cultural Rights
CLMV	Cambodia, the Lao People's Democratic Republic, Myanmar, and Viet Nam
COVID-19	Coronavirus Disease
CSMBS	Civil Servant Medical Benefits Scheme
EMPOWER	Education Means Protection of Women Engaged in Recreation
FEM	Female Entertainment Workers
FMSWs	Female migrant sex workers
GDP	Gross Domestic Product
GP	General Practitioner
HIV	Human Immunodeficiency Virus
IOM	International Organization for Migration
MHIS	Migrant Health Insurance Scheme
MSWs	Migrant sex workers
MWSWs	Migrant women sex workers
NZPC	New Zealand Prostitutes' Collective
NGO	Non-Governmental Organisation
NV	Nationality Verification
OECD	Organisation for Economic Cooperation and Development
PEP	Post-Exposure Prophylaxis
PrEP	Pre-exposure prophylaxis
PRISMA	Systematic Reviews and Meta-Analyses
SHI	Social Health Insurance
SSS	Social Security Scheme

STD	Sexually Transmitted Disease
STIs	Sexually Transmitted Infections
SWEAT	Sex Workers Education and Advocacy Taskforce
SWINGS	Service Workers in Group Foundation
UCS	Universal Coverage Scheme
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

Chapter 1: Introduction

I position this study against the backdrop of Thailand's complex and contradictory healthcare terrain, in which internationally acclaimed successes of universal health coverage contrasted with manifest inequality in access to care for marginalised populations. Drawing upon the unique experiences of migrant women sex workers (MWSWs), I show how their healthcare experiences are influenced by intersecting factors of their irregular migration status, criminalised labour, gendered inequalities and socio-cultural norms. Contextualising these dynamics within the collective and individual vulnerabilities evident throughout the COVID-19 pandemic, to consider demands for healthcare inclusion that better recognise people at the edges of legality and illegality in Thailand, not only as a public health imperative but also a matter of individual humanity.

1.1 Background of the Study

For years, Thailand has been recognised for its ambivalent views toward sex work (Derkinderen, 2017; EMPOWER, 2012; Fisher & Olsen, 2019; Hugo, 2017; Hung, 2023a) and migration (Human Rights Watch, 2010; International Organisation for Migration [IOM] Thailand, 2024). On the one hand, it is a country widely recognised for achieving universal health coverage (UHC) and frequently praised as a model to be followed by low- and middle-income countries (Nundy & Bhatt, 2022; Rigg et al., 2014; Suphanchaimat et al., 2019b). On the other hand, healthcare access in practice remains deeply stratified, particularly for those at the intersection of illegality, gender inequality, and socio-economic precarity (Jamyam et al., 2020; Nundy & Bhatt, 2022; Tangcharoensathien et al., 2022). Migrant women sex workers (MWSWs) occupy precisely this space (Derkinderen, 2017; EMPOWER, 2012). They are both vital contributors to Thailand's informal economy and among the most marginalised in terms of health rights and protections (EMPOWER, 2012; Fisher & Olsen, 2019; Villar, 2019).

The dynamics of migration in Southeast Asia further complicate this picture (IOM Thailand, 2023, 2024). Thailand attracts large numbers of migrants from neighbouring Myanmar, Laos, and Cambodia, many of whom are women seeking to support their

families through work in the service and entertainment industries (Fisher & Olsen, 2019; IOM Thailand, 2019, 2021). In their home countries, for many, sex work is perceived as one of the few livelihood strategies that they can take up to escape poverty and the low educational attainment that fosters gendered labour opportunities (Derkinderen, 2017; EMPOWER, 2012, 2016; Fisher & Olsen, 2019; Villar, 2019). However, the criminalisation of undocumented migration and sex work simultaneously imposes this climate of surveillance, stigma, and opposition (Fisher & Olsen, 2019; Hung, 2023b). Thus, healthcare is not seen as a right but instead as a questionable and conditional negotiation (Barmania, 2013; Fisher & Olsen, 2019; Villar, 2019).

These dynamics are also shaped by cultural norms. Buddhism's conceptions of *Karma* and the social obligation allied with *Bun Khun* (reciprocity and indebtedness) play a major role in the account of women's positions in Thai society itself and among migrants (Ariyabuddhiphongs & Li, 2016; Falk, 2010; Kidpromma, 2022; Mills, 1999). Such a mindset not only perpetuates gender power asymmetries that stigmatise women's bodies, but it also limits their access to health (Arora, 2017; Avila, 2008).

1.2 Rationale for the Study

Analysing the literature, I found interesting gaps in knowledge. Foremost, the literature on healthcare and sex work in Thailand was limited mainly to HIV/STD subjects (Ayuttacorn et al., 2019, 2021; Hongjaisee et al., 2020, 2024; Jirattikorn et al., 2022; O'Connor et al., 2022; Surit et al., 2018). There was an insignificant emphasis on the sex workers' access to general healthcare, such as primary care, chronic disease management, or reproductive health. Then, study on migrant health regularly regards migrants and sex workers as unconnected populations (EMPOWER, 2012, 2016; Fisher & Olsen, 2019; Villar, 2019), overlooking those who represent both identities. This imbalanced methodology masks the combined realities of MWSWs, who navigate healthcare underneath intersecting vulnerabilities (Derkinderen, 2017; Jamyam et al., 2020).

Third, although intersectionality has been more frequently mentioned in public health studies, it is less often utilised as an analytical framework and is adopted for descriptive purposes instead (Calang & Sunanta, 2025; Cheung, 2023a, 2023b;

Chuemchit et al., 2024; Thwe, 2022). My research bridges this gap by connecting intersectionality to both exclusion and resistance. By doing so, I show how healthcare access is shaped not only by structural and systemic barriers but also by women's bounded agency — their capacity to act within constraints, to resist, adapt, and endure.

Finally, the timing of my research coincided with the COVID-19 pandemic, and this brought an added urgency and complexity to it. Migrant sex workers and other informal migrant workers were excluded from COVID-19 health schemes and among the last to get vaccinated (Jamyam et al., 2020). Fieldwork during that period reveals the creation of vulnerabilities faced by these individuals as well as the resistance provided by their strategies, thus justifying a historicisation of health experiences.

1.3 Research Aim and Questions

My study aims to explore the experiences of migrant women sex workers (MWSWs) in accessing healthcare services in Thailand, centering on the barriers they encounter as well as the strategies they use to manage and navigate these barriers. Precisely, my study seeks to:

1. Understand the experiences of MWSWs in accessing healthcare services within the Thai context.
2. Identify and understand the barriers that affect access to healthcare from the perspective of MWSWs.
3. To understand the roles of local Thai NGOs for MWSWs to access healthcare.

The central research question is:
How do migrant women sex workers experience healthcare provision in Thailand, and what are their perceptions about accessing healthcare?

1.4 Thesis Structure

This thesis is organised into seven chapters. In Chapter 2, I provide the background and rationale for the study, situating it within Thailand's demographic, cultural, and healthcare contexts. Chapter 3 reviews the existing literature on migration, sex work, and healthcare access, highlighting the limitations of current research and the analytical value of intersectionality. Chapter 4 outlines the methodological framework, explaining my use of a qualitative, constructivist approach and how I operationalised intersectionality within thematic analysis. Chapters 5 and 6 present the empirical findings: Chapter 5 focuses on domains of exclusion, while Chapter 6 examines bounded strategies of resistance and informal networks of care. Chapter 7 then draws these findings together, situating them within the wider literature and presenting the study's theoretical, methodological, and practical contributions. Finally, I conclude by reflecting on the broader implications of this research for healthcare policy, practice, and future scholarship.

Chapter 2: Background of Thailand's Healthcare Landscape

2.1 Introduction

This chapter sets the basis for my study of migrant women sex workers' (MWSWs) access to healthcare in Thailand by locating their experiences within wider demographic, traditional, legal, and policy surroundings. In Section 2.2, I present the country's demographic and economic prospects and subsequently examine how cultural traditions, including Bun Khun and Buddhist views on Karma, shape gender norms and women's roles in society. These traditions not only impose principles for women, but they also regulate viewpoints around sex work and women's health, rooting stigma into everyday life.

In Section 2.3, I turn to Thailand's healthcare system, showing how access is stratified by citizenship and migration status. While celebrated internationally for its universalist aspirations, in practice the system delivers highly uneven access: Thai citizens, documented migrants, and undocumented migrants are subject to very different entitlements and exclusions. Then, section 2.4 analyses the regional migration flows, emphasising the gendered migration and women's engagement in sex work as a form of employment. Here, migration is not just a mere movement of labour, but it organises vulnerability and modulates the way healthcare is approached or shunned.

Section 2.5 illustrates Thailand's contradictory relationship with the sex industry. Despite the fact that sex tourism has been a household contributor to the Thai national economy both historically and now, sex work is still criminalised – meaning the workers have no protection under law nor rights as workers. This paradox results in sex workers who are hyper-visible as economic agents and invisible within forms of protection such as healthcare. Lastly, Section 2.6 studies the formal and also informal barriers to healthcare that migrant sex workers face through a combination of documentation requirements or bureaucratic unavailability, economic hurdles, stigma, and discrimination. By situating these barriers within the broader Thai context of policy and social provisions, I display how health services for MWSWs are not exclusively

around service delivery. In this place, there are sites where cultural practices transect with rightful structures and influence to experiencing systems of exclusion.

2.2 Thailand country profile

Thailand is an upper-middle-income country located in Southeast Asia, and its influence is felt significantly at the Association of Southeast Asian Nations (ASEAN) (a regional intergovernmental organisation) level, where Thailand was one of the founding members in 1967 (Suphanchaimat et al., 2017). The National Statistical Office (2024) reports that Thailand's total population was approximately 71 million in 2023, including an estimated 1.8 million irregular migrants, or approximately 2.5%. Approximately 500,000 hill tribe people live in the country without formal Thai citizenship (Kosiyaporn et al., 2020; Kunpeuk et al., 2022). The population is a male-dominant region (51.1%, female 48.5%) (National Statistical Office, 2024).

Thailand is also moderately ethnically heterogeneous; Thais from different regional origins, ethnic Chinese, Malay, and many hill tribes constitute the majority of the population, with 95% being subgroups of Thai (National Statistical Office, 2020). The official religion of the country is Theravada Buddhism, which has a pervasive impact on Thai culture and social behaviours (Keyes, 1984). National Health Security Office (2020) reported that 93.5% of the public were Buddhist. Of the rest, 5.4 per cent are Muslim, 1.1 per cent Christian, and 0.1 per cent other faith or no religion at all. The official language in Thailand is Thai (National Statistical Office, Ministry of Digital Economy and Society, 2020). According to the Government Public Relations Department (2022), Thai is (officially) the most spoken language in government, healthcare, and everyday communication throughout the country. Over half of Thailand’s population now lives in urban areas, reflecting a substantial shift in the urban-rural balance during the rapid population growth over the past half-century. Thailand’s ageing population is growing faster than its neighbouring countries (World Bank, 2022a, 2022b).

2.2.1 Political and economic landscape

Thailand, a constitutional monarchy, has seen much political instability. The Government is led by a Prime Minister, who is elected in the lower house of the Parliament (general assembly). It has had a series of coups and extended periods of army rule since 1945. The upper house is appointed by the military (Chaloemtiarana, 2007).

Thailand's membership of the ASEAN has served as a vehicle for economic and industrial modernisation enabling it to be recognised as a modernised and prosperous state (Suphanchaimat et al., 2017). Membership of ASEAN has been a vehicle for Thailand's ambition to be recognised as a modernised and prosperous state. The drive to create a national system of healthcare in 2001-2002 was in part driven by a desire for respect in international health forums and in part by pressure to address the failings of a system that excluded from health insurance nearly a third of the population, mainly the poorest households in the rural areas (Nundy & Bhatt, 2022).

Thailand's economy has expanded rapidly since the 1970s, mainly driven by exports, foreign direct investment, and tourism. It was classified as upper-middle-income in 2010 (Rigg et al., 2014). Thailand's economy is diverse, with main sectors including services (notably tourism, including sex tourism), manufacturing, agriculture, and fishing (National Statistical Office and the Ministry of Digital Economy and Society, 2020). Thailand's GDP reached USD 506 billion in 2021, making it the second-largest economy in ASEAN, after Indonesia.

Economic growth has been uneven between the urban centres and the rural, rice-growing hinterland, which still accounts for nearly half the population, though down from almost 80% in 1960. Thailand has the highest level of income inequality in Southeast Asia. In 2019, per capita monthly income in rural households was about 68% of what urban households had. The North-South divide is also more pronounced, with rural households in the north and northeast reaching only half of what rural households in the south have. Structural barriers, for example, the gender pay gap and the restricted formation of professions in rural areas, limited employment opportunities, and the unstable nature of destitute communities' lives. The standard of healthcare delivery, especially in rural areas, is uneven (World Bank, 2022b). In the

legitimate work market, a high-paying job is typically kept out of a woman's reach through whatever combination of discrimination and career obstacles it turns out one has. High rates of unemployment, especially among women and youth, are a pull for some people to join the sex work and entertainment industry (Hung, 2023b).

The Thai economy, including its tourism sector, was severely impacted by the global COVID-19 pandemic. Thailand's Economic Dilemmas in Post-Pandemic Asia by Richardson and Pettigrew (2022) provides a withering look at Thailand's structural economic vulnerabilities, including how it rests upon an export-led model of growth based on overseas tourism and foreign direct investment that has long rendered the kingdom susceptible to external devastations, most noticeably the COVID-19 pandemic. For example, Yasami et al. (2023) focused on the effect of the COVID-19 pandemic because of its psychological and economic consequences on 270 sex workers in Phuket, Thailand. The exploration suggested that the downfall of Thailand's tourism commerce, which is a considerably profitable driver for the sex trade, led to an expansion in deprivation, mental stress, and suicidal thoughts among this group.

Hung (2023b) underscores the flaw between prostitution's legal ban in Thailand and its magnitude in the national wealth, supplementing the tourism and service businesses. Despite this, sex workers are vulnerable to the law and without lawful recognition, and are at risk of abuse, exploitation, and financial uncertainty, which were exacerbated during the COVID-19 pandemic.

2.2.2 Gender norms and inequality

Thai culture is grounded in traditional values and social standards that directly impact gender roles and stereotypes (Falk, 2010; Lemberger, 2023). Traditional gender norms and the rooted cultural beliefs are critical in determining the roles and status of women in Thailand and the neighbouring Southeast Asian countries (Lemberger & Waters, 2022). Traditional values of Karma (the moral effects of actions) and Bun Khun (the sense of responsibility, reciprocity, and appreciation within families) (Kidpromma, 2022; Mills, 1999) play a significant role in reinforcing patriarchal structures. Hung (2023a) notes that such traditions also position women as equal caregivers and primary sources of income, hindering their ability to exercise their rights, including basic human rights, for instance, access to healthcare.

Buddhism also holds views and beliefs on women and their sexual interests (Kidpromma, 2022; Lemberger, 2023). These religiously informed norms are embedded within broader socio-cultural contexts and vary across regions, influencing how women navigate and mediate social and institutional structures. These marginalisations are compounded by others, including ethnicity, legal status, and economic precariousness, which my study explores through the experiences of migrant women sex workers.

Although women represent 48.5% of the Thai population (National Statistical Office, 2024), conventional Thai gender roles position women in an inferior status to men, assume that women fulfil household duties, and confine them through adherence to social customs (Ramwong, 2019; Tantiwiramanond & Pandey, 1987). The pride and dignity of a woman's family rest on her shoulders. For instance, Keyes (1984) and Tantiwiramanond and Pandey (1989) stressed that women are considered a sign and guardian of cultural tradition, norms, morals, and values. Although these myriad tasks, cultural and religious beliefs (especially those advancing from Theravada Buddhism) are prone to marginalising women by reinforcing their subordinate status in society and hindering their prospects. Being seen as a commodity, women get commodified in the sex industry (Hung, 2023b).

Karma and Bun Khun further embed gendered roles (Mills, 1999). Karma teaches that what you do in this life will directly affect your future in your next life. Performing yourself properly goes hand in hand with societal respect (Falk, 2010). Bun Khun is a deep emotional and spiritual commitment view that also affects women. It stresses gratitude and faithfulness, primarily pointed towards parents or elders, thus filling deeper traditional family values (Ariyabuddhiphongs & Li, 2016).

Kidpromma’s (2022) analysis links and investigates the moral oppositions of Thai Buddhism by proving how some women sex workers eagerly negotiate their religious identities in spite of social and doctrinal stigma. Conventional analyses of Karma render sex work as a work that produces harmful Karma. However, research demonstrates that to some sex workers, sex work is seen as the result of past Karma rather than an event that will lead to future punishment. This vital distinction enables

them to disentangle themselves from moral condemnation and treat their work as one of circumstance rather than a moral failing. By performing merit-making rituals - temple donations, almsgiving, chanting - they believe they can counteract any possible evil Karma and reaffirm their identities as devout Buddhists. In doing so, they eschew the idea that their work positions them outside of spiritual legitimacy, showing that Buddhist modernism does not fix them to doctrinal fatalism but instead opens the opportunity for flexible moral agency (Kidpromma, 2022).

Gender roles are constantly negotiated and renegotiated. There are tensions between these traditional social concepts rooted in a traditional rural society and participation in Thailand's contemporary dynamic urban economy (Falk, 2010). Although this way of life may appear unfamiliar from a Western perspective, such perceptions risk overlooking the cultural and structural factors that shape women's status in Thai society, particularly among migrant women engaged in sex work (Kidpromma, 2022).

The disparity of gender is not only about economics but also about health: it positions migrant women sex workers as predominantly vulnerable in their interactions with healthcare, setting up expectations regarding gender, morality, and respectability that come to complicate their vulnerability further. By connecting gender norms to healthcare access, this may help reveal how structural inequalities extend beyond the workplace into the health system, directly informing the exclusions explored in this thesis. Women who go into the sex industry often feel trapped there, not because they lack drive or capacity, but because the work they do is stigmatised by wider conservative Thai society. They are disqualified from traditional labour groups (Arora, 2017; Ayuttacorn et al., 2019).

2.3 Healthcare policy in Thailand: conditional universality

2.3.1 Healthcare system for Thai citizens

Thailand has an internationally recognised success story in its Universal Health Coverage (UHC) (Sumriddetchkajorn et al., 2019; Tangcharoensathien et al., 2015). The Universal Coverage Scheme (UCS), implemented in 2002, now covers around 75% of the population with services free at the point of care, funded through general taxation. Together with two other public schemes, the Civil Servant Medical Benefits

Scheme (CSMBS) and Social Health Insurance (SHI), UCS has dramatically expanded access to healthcare, especially for rural and economically vulnerable populations, while curtailing out-of-pocket (OOP) expenditures (Nundy & Bhatt, 2022; Tangcharoensathien et al., 2018).

There are challenges, however, despite the widely recognised achievements. There are still barriers to accessing healthcare for some marginalised groups, including undocumented migrants. The ageing population and the healthcare quality gap between urban and rural areas have led to increasing costs that may undermine the sustainability of UHC (Nundy & Bhatt, 2022; Tangcharoensathien et al., 2018).

2.3.2 Healthcare system for migrants in Thailand

Given its position as a sizable endpoint for migrant populations in the region, Thailand, as stated by the WHO (2023), faces challenges in health service provision and the general health of migrants (Tawaytibhongs, 2022). Up to a third of documented migrants employed in the informal economy, such as domestic or temporary farm work, are not eligible for the UCS program (Tangcharoensathien et al., 2022). Sex work, being prohibited, is not plainly cited in official descriptions, but can be presumed to fall within the informal economy.

Two separate insurance schemes have been created for migrants: the Social Security Scheme (SSS) and the Migrant Health Insurance Scheme (MHIS). They are differently funded but are intended to bring migrants under the umbrella of Thailand's healthcare systems. The SSS scheme covers 'documented' migrants – those who have work permits. This is a mandatory scheme financed by payroll taxes, to which employers and employees contribute equal parts, with the government contributing a smaller share. Thai nationals and migrants who contribute to the SSS have equal rights to social security benefits, including health services for themselves and their dependents (Suphanchaimat et al., 2019b).

A separate MHIS was established in 1999, specifically aimed at migrants from Myanmar, Cambodia, and the Lao People's Democratic Republic, Thailand's neighbours to the north and west (Tangcharoensathien et al., 2018). The MHIS provides access to healthcare benefits to both documented and undocumented

migrants to minimise the financial hardship on migrants and their families (Suphanchaimat et al., 2017). Migrant workers who travel to Thailand through bilateral contracts, border pass employment, or nationality verification are eligible to register with the MHIS. The dependents of such migrants registered through nationality verification can also be covered (Mekong Migration Network, 2011; Suphanchaimat et al., 2019a).

Previously, undocumented migrants facing catastrophic treatment costs might get help with payments supported by hospital profits, but only at the discretion of the administrative and clinical staff in that healthcare facility (Tangcharoensathien et al., 2017). All MHIS users pay a fee of BHT30 (£0.66) per visit. The benefits package includes general medical and rehabilitation services, high-cost medical treatment, and emergency care. They may have to pay extra hospital fees for particular treatments, such as chronic illness that requires treatment for more than 180 days, cosmetic treatment without medical indications, diagnosis and treatment that is beyond medical indications, a treatment that is being researched and tested, or organ transplantation (Suphanchaimat et al., 2017).

Reviewers note that MHIS provides less comprehensive coverage than Thailand's UCS and SSS schemes, which offer more extensive advantages for Thai nationals and legally employed workers. Migrants with no insurance can access both public and private health amenities, although at their own cost (Suphanchaimat et al., 2017).

2.3.3 Challenges and opportunities in Thailand’s healthcare system

The WHO Thailand (2023) reported considerable gaps in access to and the condition of public and private health services for users in Thailand. A selection of Thai public healthcare facilities, including provincial, district, and subdistrict hospitals, is available. Public hospitals account for 75% of total hospitals and 79% of the country's total beds (Tangcharoensathien et al., 2015). Then again, Thailand's private healthcare division is vigorous and well-established, extending from community-level clinics and small local pharmacies to high-grade hospitals and medical teams, which appeal to well-off Thai residents and persons from around the world, particularly those from the Middle East and Europe (Nundy & Bhatt, 2022).

There are over 1,000 public hospitals offering care with general reliable quality, but lengthy wait times and comparatively limited equipment. They are the main healthcare option for most Thai people, covered through the UHC scheme. (Tangcharoensathien et al., 2017). Private facilities deliver high-quality treatment and care with the latest equipment and short waiting lists (Nundy & Bhatt, 2022). Those who can afford it are more likely to seek care from private healthcare sector. Disparities in the quality and availability of healthcare services disproportionately disadvantage the rural population (World Bank, 2022b).

Medical tourism was worth $3 billion in 2015. Harris and Maia (2022) found that employees at privately owned medical institutions can earn significantly more—sometimes ten times more—than staff in Thailand's public medical facilities. This salary disparity attracts qualified healthcare professionals to private hospitals and pulls them away from government-owned hospitals.

2.3.4 Challenges of healthcare services among migrants

A majority of migrants are uninformed that they are entitled to the MHIS program (IOM Thailand, 2024). For example, Suphanchaimat et al. (2019b) estimated that close to 2 million undocumented migrants from Cambodia, Laos, and Myanmar (CLM countries) were residing in Thailand at the end of 2018, accounting for about two-thirds of the total 3 million migrants. Although the government had implemented policies and programmes to regulate migration access to healthcare, such as the One Stop Service (OSS) and Health Insurance Card Scheme (HICS), many individual migrants were yet to be registered or insured due to bureaucratic inefficiencies, unclear policies, and enforcement challenges.

Efforts of organisations like the International Organisation for Migration (IOM), in partnership with the Ministry of Public Health, have increased awareness of the system among migrant communities and have gradually increased take-up (IOM Thailand, 2023, 2024). Altogether, UHC, SSS, and MHIS appear inclusive; yet in practice, they shield access to care around issues of nationality, lawfulness, and recognised work. This suggests that migrant sex workers may be structurally disconnected from substantive access and illustrates the reality of stratified "universal" health coverage in Thailand.

2.4 Migration and documentation: from labour flows to healthcare exclusion

Thailand is a destination and transit country among neighbouring countries with long-standing migration patterns (Harkins, 2019). People migrate to Thailand for many reasons. They could be attracted by higher earnings, escaping armed conflict, or simply seeking a better life (Lemberger & Waters, 2022). Most migrants to Thailand are from neighbouring countries, including Myanmar, Cambodia, and Laos (IOM Thailand, 2021; Smith et al., 2019).

Map of Thailand:
http://drishtiias.com/images/uploads/1682076643_Thailand_Drishti_IAS_English.png

Thailand's immigrant population can be divided into four major groups: documented and undocumented economic migrants, refugees, and asylum seekers. The millions of tourists, business visitors, and expatriate residents are not included in the data. Economic migrants are frequently employed in low-paying, labour-intensive jobs in construction, farming, and the domestic service industry (IOM Thailand, 2019; Tipayalai, 2020), and many are engaged in sex work and the Thai entertainment industry (Fisher & Olsen, 2019; Harkins, 2019; UNODC, 2017). Migrants accounted for more than 6 per cent of the national Gross Domestic Product (GDP) (IOM Thailand, 2019). While migrant workers are essential to the economy of Thailand, they are likely to live in challenging conditions and have limited access to social services, including healthcare. Recognising the demographics and drivers of migration to Thailand is

essential to addressing the specific needs of migrant worker groups, including healthcare access (Punpuing, 2010).

According to the IOM Thailand reports (2024), the country has approximately 5.3 million non-Thai citizens, excluding business visitors and tourists. Migrants in irregular situations have also increased, with over 1.8 million migrants alone in irregular situations compared to 811,437 in 2019 (IOM Thailand, 2024). There are various reasons for irregular immigration status, such as entering the country without adequate travel documents, overstaying the expiry date of their visa, or being born in Thailand without an official birth certificate registration (IOM Thailand, 2024). Many of them are found to stay in an uncertain status (WHO Thailand, 2023).

Over three (3.2) million foreign migrant labourers hold work permits from the Department of Employment. This workforce is 96 per cent from Cambodia, the Lao People's Democratic Republic, Myanmar, and Viet Nam. The remaining 4% of migrants are trained or qualified workers from further afield, naturally covered by international health and social protection plans that serve to their needs (Smith et al., 2019).

From 1992 to 2012, the Thai government approved more than 20 domestic and local categories of work among migrant workers, allowing specific groups of undocumented workers to stay in the country under specified conditions. Since 2009, undocumented migrants must undergo a nationality verification (NV) process to secure a temporary passport/certificate of identity and a work permit (IOM Thailand, 2019). However, registration and verification present a considerable challenge and are unattainable for many, especially those working in informal sectors.

2.4.1 Migrant women’s pathways to Thailand

The proportion of women migrants in the population has increased over time (WHO Thailand, 2020). This trend is often linked to the feminisation of migration, driven by gendered labour demands in sectors such as domestic work, caregiving, and the entertainment industry, as well as women’s increasing economic responsibilities within households (Hung, 2023). The IOM Thailand (2024) highlighted Thailand's relatively

robust and expanding economy, as well as its extensive borders. There are roughly 3,005,376 registered migrant workers, with 1,291,722 or around 43 per cent being women. This signifies a substantial presence of women in the country's migrant workforce.

Socioeconomic factors, such as poverty, lack of education, and limited employment opportunities in their home countries, draw a significant number of migrant women to Thailand to seek employment in sex work (Fisher & Olsen, 2019; Meyer et al., 2015; Villar, 2019). Hung (2023) suggests that a lack of education restricts women's access to the formal labour market. Hence, the Thai sex work and entertainment industry becomes a viable opportunity for those who move to Thailand. In rural and resource-constrained households in their home nations, parents are often unable to provide education for their children, impaired by societal norms that assign significant value to boys' education over girls'. Many of these women seek to avoid official migration options and engage with underground organisations and operations in the informal economy (Decker et al., 2011; UNAIDS, 2020; Villar, 2019).

The majority of migrants share the same customs and cultures as Thailand (Avila, 2008; Mills, 1999). These Thai and migrant women in the sex industry also recognise traditional cultural pressures of Karma and Bun Khun (Lemberger, 2023; Mensendiek, 1997). Mensendiek (1997) found that migrant sex workers usually are the only members of their families to bring in an income, and in many cases send those earnings out as very large remittances to people living at home.

These migration flows are not just commercial, but also political: they reveal who can get healthcare as a right and who needs to navigate it uncertainly. For migrant sex workers, the intersection of undocumented status and criminalised work creates healthcare access that is uncertain, weak, and often unfeasible (Fisher & Olsen, 2019).

2.5 Sex work and criminalisation: between economic survival and structural stigma

Thailand's sex work and entertainment is an illicit industry which takes place in front of everyone's eyes (Davis, 2017; Petpailin, 2024; UNAIDS, 2012). It impacts people and entire communities (Chandran, 2018). The sex work and entertainment industry, as well as informal labour practices in Thailand, expanded and transformed during the Vietnam War period, when it attracted US and other military personnel for all manner of leisure activities (Hung, 2023a).

Sex work is an important aspect of Thailand's entertainment industry, though one that does not find an official place in the statistics. Sex work makes up a large part of the hospitality, entertainment, and service sectors of Thailand and is attractive for its local and international tourist markets (Apidechkul et al., 2018; Chandran, 2018, 2019). On the other hand, Hung (2023b) suggests that the fact that money is being pumped into Thailand by foreign tourists to commit these acts of sex tourism strengthens and sustains demand for the industry, as well as dissuading the Thai government from imposing policies that would prohibit or eradicate the sex industry altogether.

Weak and inconsistent law enforcement together with corrupt law enforcement agencies make it possible for exploitation among sex workers to continue, along with illegal sex work (Hung, 2023b). Though sex work and sex entertainment are pervasive in Thailand's tourist hotspots, the illegal status of sex work has created a contradictory socio-legal and cultural landscape for people working in the industry (Fisher & Olsen, 2019; UNAIDS, 2023a, 2023b).

2.5.1 Statistical invisibility: migrants and sex workers as uncounted populations

According to a report by EMPOWER Thailand (2016), the Thai government estimates that some 300,000 people - women and men – work in the sex entertainment industry. But calculating numbers is difficult, as sex work is illegal. An International Union of Sex Workers report in 2024 estimated 250,000 (Petpailin, 2024), placing Thailand 8th worldwide. Thailand's sex and entertainment business also gives jobs, not just for sex

workers but also for bar workers, hotel staff, and other service division workers (Petpailin, 2024; Thailand Life, 2023). Types of sex work include street work, brothels, massage parlours, bars, and high-end escort services (UNAIDS, 2012).

There is no predominant demographic among workers in the Thai sex work and sex entertainment industry (Chandran, 2018; Davis, 2017). Most Thai nationals in the sector have migrated from the most impoverished rural areas, notably the northern province of Isan, to urban areas (Thailand Life, 2023; Wittman, 2011). With economic pressure in the rural economy, limited access to education, and high unemployment, especially for women, sex work is often accepted as an option to support themselves and their families (Hung, 2023a).

A significant number of migrant sex workers originate from bordering nations, for example, Myanmar, Cambodia, and Laos (Fisher & Olsen, 2019; UNAIDS, 2012). The Joint United Nations Programme on HIV/AIDS (UNAIDS, 2012) estimates that there are around 145,000 migrant sex workers in Thailand. However, this statistic is broadly observed as an underestimate, given the informal and criminalised nature of the sex industry, which makes precise records challenging. Another data (IOM Thailand, 2024) suggests the definite number may be closer to 250,000. This variation highlights both the lack of official records and the challenges of assessing the scale of an industry that operates primarily outside formal government oversight (IOM Thailand, 2024).

The gaps in population numbers are not neutral data discrepancies but signs of structural invisibility, a situation where migrants and sex workers are left out of official tracking. In the case of migrant sex workers, such a double invisibility is analogous to their contact with health services: they exist in material terms. Still, they are recognised as either illegitimate patients or invisible ones. Behind the flashing lights and noise of sex entertainment's contribution to Thailand's economy stands the reality for individuals involved, especially migrant sex workers, who do not receive legal protections, suffer from societal stigma, and encounter formal and informal barriers to accessing healthcare.

2.5.2 Law and regulation

Legal Framework

Three separate laws criminalise sex work in Thailand: The Prevention and Suppression of Prostitution Act, the Penal Code Amendment Act, and the Anti-Trafficking in Persons Act (Godwin, 2012; Hung, 2023b; UNAIDS, 2012).

- In 1996, the Prevention and Suppression of Prostitution Act: B.E. 2539 (1996) outlawed prostitution and penalised anyone who manages or profits from prostitution, especially if the case involved forced or trafficked individuals, particularly minor girls. It prioritises the rehabilitation and reintegration of sex workers, and treats minors in prostitution as victims requiring protection. Public solicitation is a crime punishable by fines. UNAIDS (2012) reported that an estimated 30,000 sex workers are charged yearly under the Prevention and Suppression of Prostitution Act in Thailand.
- Penal Code Amendment Act (No. 14), B.E. 2540 (1997) provides harsh penalties for anyone over 16 years old who profits from sex workers, including prison and fines, but does not apply to those financially dependent on sex workers who are legally bound to support them.
- The Anti-Trafficking in Persons Act: B.E. 2551 (2008) makes all forms of human trafficking, sex trafficking included, a criminal offence, with measures to prevent and suppress the crime as well as protection for victims with severe penalties for offenders and their accomplices.

In 1966, the Entertainment Places Act was introduced, regulating bars and massage parlours that catered to US and other military personnel during the Vietnam War, laying the foundations for the structure of modern Thai sex entertainment and the tourism-based economic prosperity within the country (Hung, 2023b; Lemberger & Waters, 2022; Sings & Hart, 2007).

The Thai government has wrestled for decades to balance its economic reliance on the sex industry with the need both to do the right thing by those working in it and to ensure that they are protected socially (UNAIDS, 2023b). The criminalisation of sex work and lack of regulation on labour conditions make sex workers more vulnerable

to police harassment, deny them access to legal and social protections, and add to the decent work deficit in this sector (Villar, 2019; UNAIDS, 2020). Local government agencies sometimes accept or openly tolerate it (Open Society Foundations, 2006). Contradiction in law enforcement is complicated by the fact that sex workers are easily targeted for exploitation and violence since they can hardly believe that laws designed to protect them will be implemented (Hung, 2023b; Villar, 2019).

2.5.3 Health and Human Rights

Like sex workers all over the world, sex worker groups in Thailand share similar perspectives about health and human rights issues (EMPOWER, 2012; Jamyam et al., 2020). However, the criminalisation in Thailand further increases workers' risk of HIV infection and other health vulnerabilities as it pushes sex work underground and limits access to needed healthcare services (WHO Thailand, 2015). UNAIDS (2023b) recently speculated that decriminalisation would drastically improve health outcomes by allowing access to healthcare and decreasing stigma. The outlawing of sex work indicates that healthcare is not naturally a service to be accessed but a location of risk, where disclosure may call legal penalty, police notice, or additional stigma. For migrant sex workers, the outlawing of sex work and the legal limitations around migration convert healthcare from a basic right into a possibly uncertain negotiation.

2.6 Research gap: the hidden experiences of migrant sex workers

2.6.1 Healthcare access for sex workers

Access to healthcare services for sex workers in Thailand is affected by a range of social, legal, and economic factors as discuss above (Barmania, 2013). Across Thailand, sex workers have theoretical access to a variety of healthcare services that include HIV testing, counselling, and contraception (Davis et al., 2019). These services are carried across government works, non-governmental organisations (NGOs), and community-based groups (Decker, 2017; Singh & Hart, 2007). Though, the quality and accessibility of healthcare services can vary from one province or region to another (Smith & Hankins, 2019; WHO Thailand, 2020).

Some NGOs and community-based initiatives provide healthcare and support services to sex workers (Global Network of Sex Work Projects, 2021). The Empower

Foundation and SWING Thailand have countrywide networks that provide health, educational, and counselling services to sex workers. They provide full medical care for sex workers, education about sex worker rights, and fight against stigma/discrimination (Davis et al., 2019). Such services are essential for key populations of sex workers, transgender people, and men who have sex with men (Davis et al., 2019). These generally revolve around sexual and reproductive health, HIV/AIDS, and primary care access. However, the coverage of these services is not comprehensive, with many sex workers and migrant women sex workers continuing to have unmet healthcare needs (Decker et al., 2011).

2.6.2 Challenges in accessing healthcare

I will detail in my literature review (chapter 3) and in the findings (chapters 5 and 6) of my research, how sex work has different dimensions and is informed by cultural, legal, language, and gender factors. One key reality is that even where sex worker-accessible healthcare is theoretically on offer, many find it practically and psychologically challenging to engage with such services (UNAIDS, 2023b). There is a kaleidoscope of reasons for this sense of exclusion. Healthcare staffs' attitudes trigger stigma and discrimination that, in turn, dissuade sex workers from utilising medical care (Naranong, 2019). The legal ambiguity concerning sex work hampers access to healthcare out of fear of being discovered and penalised, or mistreated (Smith & Hankins, 2019). Bureaucracy and interactions with healthcare staff also pose language problems for those who do not speak Thai (Naranong, 2019; Villar, 2019).

2.7 Chapter summary

In this chapter, I presented an overview of the economic, cultural, healthcare, migration, and sex work elements that give context to the healthcare subjects affecting migrant women sex workers in Thailand. Understanding these dimensions is essential to building a picture both of their healthcare needs and the formal and informal barriers that inhibit their access to appropriate and effective healthcare.

Thailand's history, economy, and politics have produced a healthcare system fundamentally designed for the majority of the mainstream Thai population. However,

marginalised vulnerable populations such as women in sex work, especially migrant women sex workers, are effectively excluded or exclude themselves.

The roles and status of women are influenced by traditional gender norms and cultural beliefs in Thailand and neighbouring countries, including Karma and Bun Khun. The paradox of working in an unlawful industry in order to sustain greater personal moral and social obligations is difficult to convey. It undoubtedly underpins some of the internalised feelings of stigma and isolation explained by migrant women sex workers and their ambivalence about engaging with a healthcare service that is unsure about engaging with them. That is unsatisfactory for either individual or public health.

We can learn how to better protect the health and safety of migrant women sex workers by understanding the deeper systems in which they are embedded. Intersecting status factors of migration status, gender, stigma, and legal exclusion deeply influence access to healthcare for migrant women sex workers in Thailand. Thailand makes laudable claims about its Universal Health Coverage (UHC) system. However, the reality is far different for immigrant sex workers, especially those undocumented or trafficked, who are, at best, at risk of inequitable access to healthcare (Nundy & Bhatt, 2022; Tangcharoensathien et al., 2018). The dual criminalisation of sex work and undocumented migration forces these women into informal, underground sex networks where they are subject to exploitation and health vulnerabilities like sexually transmitted infections (STIs) and violence against them, but often cannot or will not seek care for fear of legal consequences, deportation or social stigma (Hung, 2023b; WHO Thailand, 2020). Although the Migrant Health Insurance Scheme (MHIS) is designed to address this access gap among informal workers, there are gaps in coverage. Many either do not know about or cannot access the benefits because of systemic issues like language barriers and lower outreach (Kantayaporn et al., 2014, 2020; Suphanchaimat et al., 2017).

Thailand's healthcare policies, however, fall short of a full alignment with that country's commitments under international conventions on trafficking and human rights to protect the health and dignity of vulnerable populations, including migrant sex workers (WHO Thailand, 2020). Public opinion in Thailand is that its sex work—a gray-area domain of employment—is an embarrassment to the country abroad, as well as for

Thais themselves who live with—sometimes next door to—the industry of sex work, but the path forward to reform remains complex and entwined in controversy linking social and cultural wisdoms, on one hand, with political considerations (Hung 2023b; Wadekar 2022).

The background context, explored in Chapter 2, underpins the focus of my literature review in Chapter 3, where I examine current research on migration, sex work, and healthcare access. By positioning my study into this broader scholarship, I recognise the gaps—mainly around the lived experiences of migrant women sex workers in Thailand—that my thesis seeks to address.

Chapter 3: Literature Review

3.1 Introduction

In the background chapter, I outlined Thailand's socio-political, economic, cultural, and health contexts as they relate to migrant women sex workers (MWSWs). The radical reform of the healthcare system in 2002 under the umbrella of Universal Health Coverage (UHC) was designed to assist the mainstream Thai population in accessing healthcare (Sumriddetchkajorn et al., 2019). Further schemes and refinements extended healthcare access in stages to cover migrants and participants in the informal economy (Jirattikorn et al., 2022; Kunpeuk et al., 2022).

However, the healthcare needs of short-term or undocumented migrants, including those engaged in sex work, are under-represented in public policy, which tends to consider them, usually negatively, as a homogeneous group (Jirattikorn et al., 2022). As individuals, however, the intersections of traditional gender norms and cultural beliefs, such as *Karma* and *Bun Khun*, reveal a more complex picture (Kidpromma, 2022; Mills, 1999). Many grapple with the contradictions of working in an illegal and disreputable industry in order to meet their own perceived moral and social obligations (Falk, 2010; Janyam et al., 2020).

The right to healthcare is set out in several international legal frameworks, including the Universal Declaration of Human Rights (UDHR, 1948), Article 25, and the International Covenant on Economic, Social and Cultural Rights (CESCR, 2000), Article 12. Healthcare is recognised as a universal right, regardless of legal or migratory status, and countries are obliged to guarantee everyone equal access to healthcare services. In addition, the World Health Organisation (WHO) (2023) considers universal health coverage (UHC) to be one of the significant cornerstones of health equity, promoting migrant-sensitive policies to overcome legal and administrative barriers to essential health services .

In South East Asia, the 2017 ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers reinforces these commitments in Article 17, stipulating that adequate medical and healthcare services should be accessible to all migrant workers (ASEAN, 2017).

However, in practice, this entitlement depends for implementation on the national laws and policies of the receiving states (ASEAN, 2017), which may still limit provision to formal residents. Thailand's national healthcare policies for migrants have been influenced by national security interests, economic needs, and bureaucratic complexity, leading to limited healthcare access for informal workers, including sex workers and sex entertainment workers (Arora, 2017; Decker, 2011; Stenquist, 2023; Suphachaimat et al., 2017). Despite recognising the importance of protecting migrants from discrimination and exploitation, the ASEAN Consensus does not mention the particular experience and vulnerabilities of sex workers who face legal, financial, practical, and social barriers to healthcare access. Even when services are available, the fear of privacy invasion, fear of detention, and vulnerabilities in their workplace may keep them from engaging with medical care (Ayuttacorn et al., 2019, 2021).

In Thailand, research has consistently found that migrant sex workers (MSWs) experience disproportionately high rates of infectious diseases, prompting fears of broader public health implications (Godwin, 2012; O'Connor et al., 2022; Villar, 2019).

Broader sex work research indicates that in reality, healthcare access among migrant sex workers is particularly heavily restricted owing to intersecting barriers, including legal restrictions, stigma, cultural and linguistic issues, and economic difficulties, increasing the risk of poor health outcomes, diagnosis delays, and a greater risk of infectious disease transmission (Barmania, 2013; Hongjaisee et al., 2020).

Recognising the gap between legal entitlements and meaningful access to healthcare services, my review of the literature searches for the complex structural, legal, and social determinants that shape the healthcare experiences of migrant women sex workers (MWSWs) in Thailand, and comparable settings worldwide. This framing moves the focus away from individual health failures or successes to examining legal and institutional barriers.

My position in the literature was iterative, and evolved during the research process. Initially, I reviewed the literature generally to build a background understanding before starting data collection. As I shifted into data analysis, I engaged more deeply with sociological ideas, frameworks, and patterns to interpret and make sense of the emerging themes. In particular, the intersectional lens became central to my analysis, enabling a more nuanced and structural interpretation of the data and the literature.

This responsive engagement with literature reflects practice in qualitative research, which is often both inductive and abductive (Nowell et al., 2017).

I present my literature review into two sections. The first section, 3.2, examines international research relevant to MWSWs' experiences and perceptions of healthcare access. In Section 3.3, I discuss the theoretical basis of the literature I draw upon in my analysis.

3.2 A review of migrant women sex workers' experiences and perceptions of access to healthcare.

The literature review was conducted to identify the current understanding of how MWSWs use or engage with health services and support, particularly those factors that influence their experiences in accessing healthcare. The following question guided the review:

- **What is existing knowledge on MWSWs' experience of access to healthcare with regard to structural, cultural, and legal dimensions?**

This question guided the creation of the inclusion and exclusion criteria listed below, which align with MWSW experiences at the intersection of identity and health vulnerabilities.

3.2.1 Literature search methods

I used a search strategy across five academic databases and sought relevant grey literature to capture all relevant studies. I identified studies that indicate the gendered, cultural, and socioeconomic structures that inform MWSWs' access to care. The methodological quality of these studies was assessed using the Critical Appraisal Skills Programme (CASP) tool (Long et al., 2020).

I developed inclusion and exclusion criteria (Tables 3.1 and 3.2) to ensure methodological cohesion and relevance. This ensured a focus on studies that identify barriers, facilitators, and broader healthcare utilisation patterns in the MWSW population, and filtered out irrelevant research.

3.2.1a Inclusion and exclusion criteria

Table 3.1: Inclusion Criteria

Criterion	Description
Study focus	Studies explicitly related to access to healthcare services faced by migrant women sex workers (MWSWs).
Themes considered	Barriers, facilitators, and health service utilisation patterns; challenges to gendered, cultural, or language-based barriers and health disparities.
Methodologies included	Qualitative, quantitative, and mixed-methods studies.
Publication type	Peer-reviewed journal articles.
Publication date range	2012 to January 2025.
Language	English and Thai (if full papers are accessible).
Full-text availability	Full-text availability through academic databases or institutional access.

Table 3.2: Exclusion Criteria

Criterion	Description
Population exclusion	Studies focused exclusively on domestic (non-migrant) sex workers unless findings were transferable to migrant populations.
Topic exclusion	Studies that did not address access to healthcare for MWSWs.
Study focus exclusion	Excluded studies focused solely on economic or legal analyses of sex work unrelated to healthcare access.
Gender-specific exclusion	Excluded studies that focused only on male or transgender sex workers, unless they were included alongside women and contributed to healthcare access understanding.
Publication type exclusion	Excluded non-peer-reviewed sources such as editorials and non-academic articles.

Criterion	Description
Publication date exclusion	Excluded studies published before 2012 unless they were seminal to the topic.
Language and access exclusion	Studies unavailable in English or Thai or only accessible as abstracts or paid versions were excluded.

3.2.1b Search strategy framework empirical review

The search (Tables 3.3 and 3.4) was conducted in CINAHL (Cumulative Index to Nursing & Allied Health), MEDLINE (Medical Literature Analysis and Retrieval System), ScienceDirect, EMBASE (Excerpta Medica Database), the Web of Science, and Google Scholar. I used these databases to find peer-reviewed literature on MWSWs from multiple disciplines (including public health, social sciences, and migration studies).

I combined my searches with Boolean operators (“AND” and “OR”) and applied truncation (*) where appropriate to capture term variations. For example, I used "migrant women AND sex workers AND healthcare access" to narrow the searches while maintaining inclusive retrieved results.

In addition to scholarly, peer-reviewed articles, I sought grey literature to capture institutional and policy insights. I reviewed articles from the World Health Organisation (WHO), the Ministry of Public Health Thailand (MoPH), and the National Statistics Office of Thailand (NSO). I also examined papers produced by Thai non-governmental organisations (NGOs) that have direct engagement with MWSWs. I completed citation tracking and hand-searching references from key studies to provide a comprehensive review.

Table 3.3: PICOs search strategy

Component	Description
Population (P)	Migrant women sex workers (MWSWs), specifically women and female-identifying individuals.
Intervention (I)	Access to healthcare services, barriers, facilitators, and healthcare utilisation patterns.
Comparison (C)	Comparison with domestic (non-migrant) sex workers or general migrant populations when relevant.
Outcome (O)	Identifying structural, cultural, gendered, and systemic barriers to healthcare access.
Study design (S)	Qualitative, quantitative, and mixed-methods studies from public health, social sciences, and migration studies.

Table 3.4: Search terms

Category	Search terms
Healthcare access	"healthcare access" OR "health services accessibility"
Migrant status	"migrant" OR "immigrant"
Gender	"women" OR "female"
Sex work	"sex workers" OR "prostitutes" OR "sex work" OR "commercial sex workers"

3.2.1c Extraction of data and assessment of quality

I created a charting form using Microsoft Word to extract and present data from each article or paper. The data extracted from each retrieved study included the following information: author(s), year of publication, country of setting, aims, population and sample size, research methods and design, and key findings relevant to the literature review's aims (see Appendix A).

I used the Critical Appraisal Skills Programme (CASP) checklist to assess the quality of the studies (Long et al., 2020), concentrating on the clarity of the research aims, suitability of the study design, sample size, data collection methods, analytical rigour,

and ethical considerations. While studies were not excluded solely based on quality, the CASP assessment helped determine how findings were weighted and interpreted within the review. Studies with limited methodological transparency were still included, but their findings were considered with caution, and their limitations were explicitly noted in the synthesis.

Studies differed in how they were conducted and in the level of detail. Some described methods in detail, while others presented important insights despite a limited reporting scope. Instead of rejecting studies based solely on variability, I employed a gradient that ensured I included a breadth of perspectives and noted differences in methodological depth. This enabled a systematic and transparent synthesis approach, which provided an overview of the existing evidence base for healthcare access for MWSWs.

3.2.1d Search results

I adopted the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework to guide these efforts and help guarantee a rigorous and transparent selection process (Page et al., 2021). The PRISMA diagram depicts the key steps in the study selection process (see Figure 3.1).

I used the PRISMA flow diagram to illustrate the transparency and systematic nature of my literature search and selection process, even though this was not a full systematic review. Including the diagram helps demonstrate methodological rigour and clarity in how studies were identified, screened, and included in the review. A systematic screening and appraisal process allowed me to examine the data without focusing on studies where research design limitations affected the reliability of the findings or were unrelated to my research focus.

I also considered possible biases and limitations in the studies, such as self-reported health data and recall bias. These limitations were factors in several studies in this review. However, the use of triangulated methods, mixed-method approaches, or justifiable sampling methods lent further robustness and credibility to the findings.

Although the studies' methods were inconsistent, they met my initial inclusion criteria and provided me with much data on my research interests. Recognising these

differences helped me read the literature's strengths and weaknesses, which I tried to incorporate while interpreting the findings.

I did not use Covidence for this process. Instead, I took a structured approach to screen and manually manage the articles. I removed 3,115 duplicate records before screening, identified 4,125 studies across five academic databases, and reviewed 1,010 unique studies. I subsequently screened titles and abstracts against my inclusion and exclusion criteria, confirming they met my research focus on healthcare access for MWSWs in Thailand.

To track this process for each study, I created a Microsoft Word document that lists each study along with the title, author(s), year of publication, and key inclusion/exclusion notes. Of the 854 studies excluded based on the title and abstract, the final set was reviewed for full text. I understand that some of the processes could have been simpler using Covidence.

I am satisfied that the remaining 36 included articles from North America (Canada, USA) through Latin America (Mexico, Guatemala) across Europe (Portugal, Spain, Italy, Germany, Russia) into Africa (Kenya, South Africa) and Asia (China, Hong Kong, Singapore, Thailand) and Oceania (Australia, New Zealand) provide relevant and respected academic assistance to my inquiry into the challenges perceived and experienced by MWSWs in accessing healthcare within the Thai context.

To make sense of the findings across these diverse contexts, I conducted a thematic analysis of the included literature. Guided by my review aims and informed by both inductive insights from the literature and deductive attention to structural and social determinants of health, I identified four key themes that consistently emerged across studies: Structural and legal barriers to healthcare access; stigma and discrimination in healthcare; economic constraints and workplace conditions; and resilience strategies and alternative healthcare-seeking behaviours.

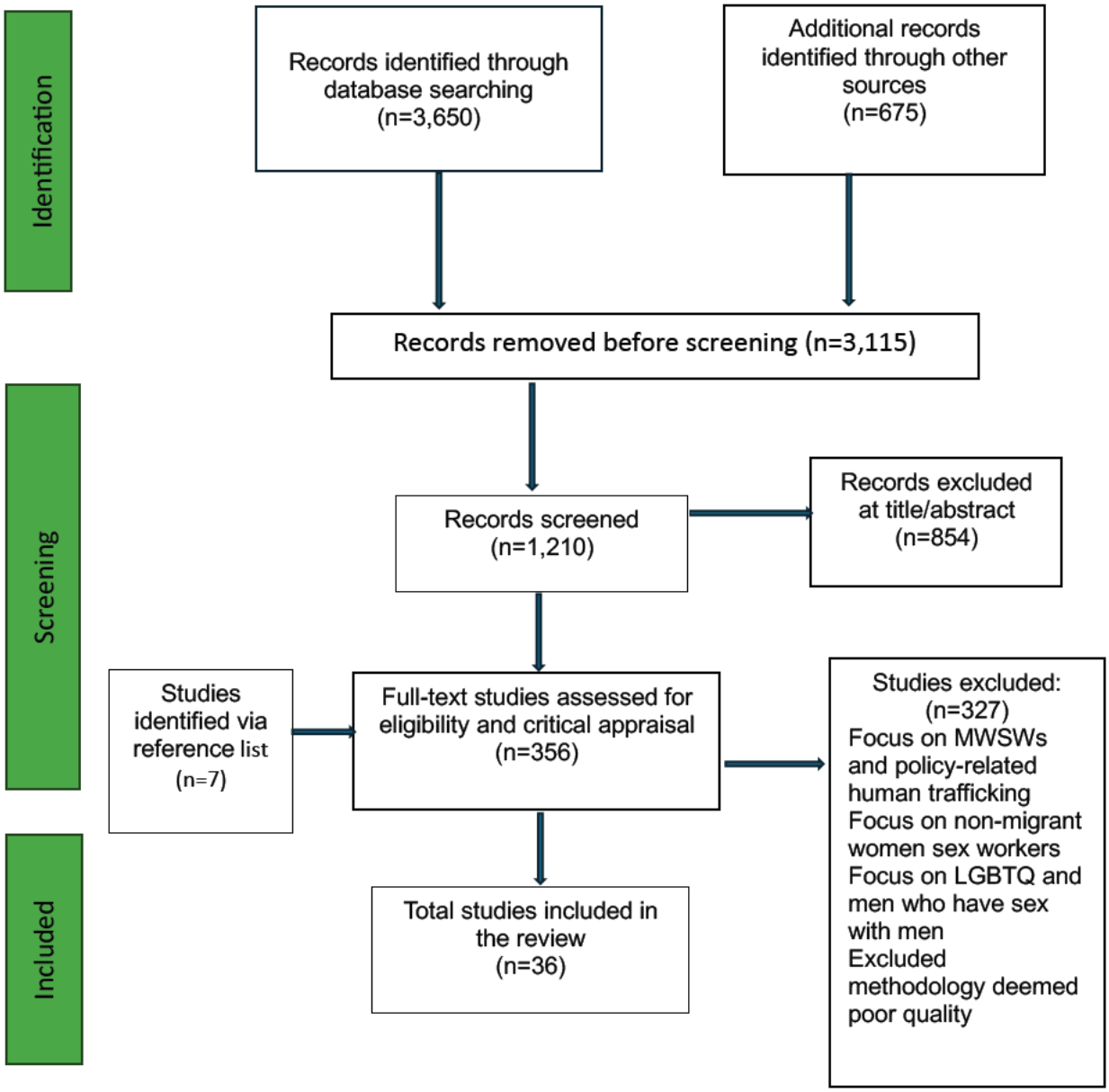


Figure 3.1 PRISMA flow diagram (PRISMA centre: https://www.prisma-statement.or

3.2.2 Healthcare access among migrant women sex workers: a thematic review

3.2.2a Introduction

Healthcare for MWSWs is a significant yet under-prioritised public health and human rights concern and remains a largely neglected issue (Lotysh et al., 2025; Roguski, 2013). Academics report that, despite a global movement towards universal healthcare and health equity, MWSWs face systemic barriers to adequate, practical, timely, and culturally competent medical care (Duff et al., 2016; Kriitmaa, 2023; Selvey et al., 2018; Socías, 2015). MWSWs live at the margins based on their migration status, work, gender, and class vulnerabilities, driven by deeply entrenched, interlocking legal, economic, and social structural designs (Davis et al., 2016; King et al., 2013; Lam et al., 2021).

My themes are established within a broader consideration of healthcare access, examining MWSWs worldwide through the lens of systemic discouragements and exclusions that extend deeper and wider than individual agency. These themes illustrate how legal, social, and economic factors are interwoven, forming significant barriers to accessing appropriate and effective healthcare.

I begin with structural and legal obstacles (Section 3.2.2b). Restrictive immigration regimes, sex work criminalisation, and state surveillance represent a risk to MWSWs when considering engaging with health institutions. They may fear detection, a fine, or deportation. The anxiety arises in the context of their vulnerability to workplace exploitation.

Secondly, MWSWs also refrain from seeking help because of experience of stigma and discrimination in healthcare settings, where attitudes of judgement and disapproval may discourage further engagement (Section 3.2.2c).

Thirdly, these legal and social structures are compounded by economic insecurity and intimidating working conditions, putting pressure on MWSWs to cede their healthcare autonomy and privacy to their manager or employer. Unstable income, the absence of labour protections, and financial dependence on clients or intermediaries compel them to prioritise survival over healthcare (Section 3.2.2d).

Finally, instead of framing them as voiceless and passive victims, I review the evidence of resilience strategies and alternative healthcare-seeking behaviours through peer-led initiatives, informal health networks, and community-based services (Section 3.2.2e). This final theme is critical in that it moves the narrative on from the formal and informal barriers MWSWs encounter to their agency.

3.2.2b Structural and legal barriers to healthcare access

Laws that criminalise sex work, limit migration, and link healthcare with law enforcement are exclusionary mechanisms found in various national contexts. Although such policies are often justified as promoting public order or preventing trafficking (Goldenberg et al., 2017), their impact is also institutionalisation of marginalisation, particularly in healthcare. This section analyses three dimensions of this structural exclusion: criminalisation and surveillance, immigration-based legal restrictions, and the fear of deportation.

Through criminalisation of sex work and restriction of migration, or other forms of social security, MWSWs are not only rendered structurally and legally marginal by the state, they also effectively lose their right to healthcare. They are exposed to a greater vulnerability to exploitation, violence, and untreated illnesses (Weine et al., 2013). Legislators or law enforcement officials commonly argue that such laws serve the state's interest in maintaining public order, are intended to combat trafficking, and regulate migration in the public interest (Goldenberg et al., 2017). Nevertheless, these policies consistently lead to the denial of life-saving medical care for MWSWs and expose them to greater health risks (Rocha-Jiménez et al., 2018).

Criminalisation, surveillance, and punitive immigration policies cultivate an atmosphere of anxiety and fear of consequences in which MWSWs feel they must choose between protecting their working life and protecting their reproductive health (Goldenberg et al., 2017). In some countries (including China, Kenya, and Canada), the health system is linked explicitly to law enforcement, creating fears around healthcare engagement which might lead to exposure, arrest, deportation, or forced rehabilitation (Davis et al., 2016; Kriitmaa, 2023). Consequently, in practice, many MWSWs will not visit hospitals or clinics, relying instead on informal networks of

uncertain quality healthcare, self-treatment, or leaving serious health issues untreated (Goldenberg et al., 2017).

Thailand offers an interesting paradox. It is praised globally for attaining Universal Health Coverage (UHC), despite effectively excludes irregular migrants and sex workers (Janyam et al., 2020). Unlike in Italy (Zermiani et al., 2012), where undocumented migrants have formal healthcare rights, or Singapore (Wong et al., 2012), where exclusion is explicit, Thailand's health exclusion is ambiguous for people working informally and illegitimately.

3.2.2b1 Criminalisation and the surveillance of health

The criminalisation of sex work does more than punish sex workers. A decision to engage with medical care makes them visible. From the Mexico-Guatemala border to China, Russia, and Singapore, state policy has sought to extend law enforcement and border control directly into public health facilities, converting hospitals into population monitoring stations (Davis et al., 2016; King et al., 2013; Lim et al., 2018; Rocha-Jiménez et al., 2018).

Rocha-Jiménez et al. (2018) use qualitative interviews with 31 migrant sex workers at the Mexico–Guatemala border. The primary finding of the study is that migrant sex workers make conscious decisions about healthcare-seeking by choosing not to attend for fear of deportation, arrest, or coming into contact with immigration authorities. Sexual health clinics often requested a health registration card that undocumented migrants have no access to.

Zermiani et al. (2012) reported the prevalence of HIV, syphilis, Hepatitis B (HBV), and Hepatitis C (HCV) in a total of 345 migrant female sex workers (FSWs) in Verona, Italy. Although Italy includes access to healthcare for undocumented migrants by law, in practice, fear of being reported to law enforcement kept many from seeking medical care. Exclusion is further compounded by language and cultural barriers between migrant FSWs and service providers. The study theorises a nexus of legal precarity combined with systemic disregard for FSW health that serves to keep many migrant FSWs untreated for the majority of STDs.

Lim et al. (2018) also applied a community-based approach via in-depth interviews and observations to show how law enforcement policies in Singapore discouraged 106

foreign female entertainment workers (FEWs) from providing condoms because the police use possession of them as evidence of criminal sex work. Fear of arrest and deportation prevents FEWs who work in massage establishments from using healthcare services, increasing the risk of HIV/STI transmission.

MWSWs exist in the shadows of healthcare settings to shield themselves from the risks of exposure, arrest, detention, or deportation. When they do become visible – by seeking medical care or reporting violence - their visibility can lead to consequences, when health providers are legally mandated or feel pressured to turn them into immigration or law enforcement agencies.

3.2.2b2 Immigration policy as a mechanism of medical exclusion

Legal exclusion from healthcare is often framed as an unintended consequence of migration control, but evidence suggests it is a structural outcome of policy design. A fear of the enforcement of immigration control inhibits or discourages MWSWs' access to regulated healthcare. In several countries (Portugal, Canada, and Germany), state policies and legal frameworks serve not to support but rather to dissuade MWSWs from accessing crucial healthcare services (Dias et al., 2017; Goldenberg et al., 2017; Lotysh et al., 2025).

Dias et al. (2017) used a cross-sectional survey (n=853) of female sex workers (FSWs) in Portugal. They compared the accounts of self-reported documented, undocumented migrant, and national FSWs to assess differences in healthcare service access and HIV testing. The study found that undocumented migrant sex workers were the least likely of the groups to seek out HIV testing or to use Portugal's National Health Service (NHS), even though healthcare is available by law to everyone. The study found that 25% of undocumented migrants had never accessed the NHS at all, while many had never been tested for HIV because they feared being stopped and deported.

In Canada, Goldenberg et al. (2017) used a mixed-methods approach, with 44 migrant sex workers (MSWs) and managers/owners in Vancouver's indoor sex industry to explore healthcare access, legal barriers, and workplace safety. One of the study's main findings is that sex work criminalisation in Canada and restrictive immigration policies act as deterrents to healthcare access for MSWs. 21.2% had experienced police harassment or arrest. Participants reported that mandated identification checks,

racial profiling, and a failure to protect the confidentiality of undocumented or precarious-status migrants made healthcare settings unsafe spaces.

Goldenberg et al. (2017) explain that under Bill C-36, MSWs in Vancouver became even more exposed to police scrutiny through increased workplace raids paired with immigration enforcement. While Canadian-born sex workers faced legal risks, police raids disproportionately targeted the owners/managers of indoor sex work locations such as massage parlours, where MSWs are more likely to be employed.

Lotysh et al. (2025) employed a qualitative semi-structured interview with 10 migrant female sex workers (MFSWs) in Berlin. The most substantial findings of the study are that Germany's healthcare system is structurally designed in ways that effectively exclude MFSWs, especially undocumented workers and workers with precarious legal status. Despite Germany's universal health coverage, access is complicated for migrants unfamiliar with the process. The ten undocumented MFSWs never go to medical clinics at all, instead seeking out unregulated, underground providers, or waiting until a health condition has escalated before seeking treatment. Germany's complex bureaucratic structure presents overwhelming obstacles, including long waits, financial barriers, and administrative exclusion, especially for gynaecological care, mental health services, and STI screenings.

3.2.2b3 Fear of deportation as a structural deterrent

The fear of deportation is one of the extremely pervasive and under-analysed obstacles to healthcare among MWSWs. For many MWSWs, engaging with healthcare is a calculated risk that could lead to arrest, detention, or forced removal from the country. Instead of acting as sites of care in response to need, hospitals and clinics are designed as receptive fronts of immigration control, generating a state of medical invisibility (Davis et al., 2016; Kriitmaa, 2023; Lim et al., 2018).

Lim et al. (2018) adopted a narrative and community-based perspective by applying in-depth interviews, observations, mystery client, and critical incident approaches to explore socio-organisational structures, sexual risk behaviours, and healthcare access among 706 foreign female entertainment workers (FEWs) in Singapore (376 Vietnamese, 330 Thai).

The study illustrates how the criminalisation of FEWs, sex work, and the stigma associated with it in Singapore produces a profoundly adverse climate for sex workers. One particularly salient finding in this study is the perceived weaponisation of healthcare as a tool of immigration enforcement. STI and HIV screening of FEWs is mandatory and is experienced as a form of state surveillance and control. Positive tests for HIV or STIs can be grounds for immediate deportation, making engaging with healthcare a danger rather than a service.

Many FEWs enter the country on short-term social visit passes and thus are not eligible for subsidised healthcare, so when seeking treatment for STIs, they often turn to informal providers, including Traditional Chinese Medicine (TCM) practitioners and general practitioners (GPs), rather than STI clinics. Furthermore, language barriers and financial constraints limit access to mainstream healthcare services, rendering them logistically and culturally impractical (Lim et al., 2018). They argue that systemic, legal, and social barriers inhibit access to STI prevention and healthcare services for FEWs, creating an environment that increases risks of transmission of infections (Lim et al., 2018).

Although Lim et al. (2018) do not specifically claim FEWs avoid healthcare based on fears of deportation, existing scholarship on global migration has established that individuals operating in legal and moral grey areas will go to great lengths to avoid detection by state authorities (Davis et al., 2016).

The situation in Singapore is comparable to that in China. In-depth interviews conducted by Davis et al. (2016) with 19 Ugandan MWSWs in Guangzhou found that they actively avoided hospitals for fear of police patrols and compulsory ID checks there. Many of the Ugandan MWSWs had overstayed their visas or entered China irregularly, meaning that if they engaged with the formal medical sector, they faced arrest, deportation, or imprisonment.

The study reveals how immigration enforcement policies, including visa overstay fines, routine police raids, and hospital identification checks, prevent and deter rather than protect. The majority of participants self-exclude and forgo hospital and formal healthcare and, if needed, seek care from unregulated pharmacies, informal providers, or self-medication, all with their attendant risk of undiagnosed infections, untreated sexually transmitted diseases (STDs), and preventable health complications.

Participants stated they had been made aware that getting a positive diagnosis could lead to immediate deportation. This policy creates a perverse incentive to avoid early detection and treatment at the expense of containing onward transmission (Davis et al., 2016).

Kriitmaa (2023) conducted semi-structured and narrative interviews (50 overall, with 15 Somali migrant female sex workers, [MFSWs]) in Nairobi, Kenya. The findings disclosed that MFSWs actively avoid healthcare facilities due to routine police harassment and the risk of deportation. More than that, many Somali MFSWs spoke of police demanding bribes for release and sexually abusing those without money to give. Hospitals and clinics became known as unsafe places for MFSWs to seek help, forcing them to avoid them altogether.

According to Kriitmaa (2023), fear of deportation is a structural determinant of healthcare that stops Somali MFSWs in Nairobi from obtaining vital health services, such as HIV prevention and treatment. Services may be legally available, but fear of being identified by police raids at clinics leads them to self-exclude from formal healthcare systems altogether and self-medicate or turn to informal providers or simply ignore their health needs.

The studies by Davis et al. (2016), Kriitmaa (2023), and Lim et al. (2018) are congruent in finding fear of discovery and deportation as a key barrier to health access for MWSWs. It is not simply a perception in the mind of MWSWs, but it is a structural exclusion mechanism. This does not damage only individual sex workers; it also risks public health with untreated infections, workplace injuries, and community transmission of preventable diseases.

3.2.2b4 Legal and structural barriers: the foundation of healthcare exclusion among MWSWs in Thailand.

The economy of Thailand is highly dependent on informal and migrant labour, especially in the service and entertainment industries (IOM Thailand, 2021, 2024). These matters of fiscal fact have generated research across a range of academic disciplines into the apparent legal, cultural, and political paradoxes.

The law criminalises sex work and excludes undocumented migrant workers from UHC and workplace rights and protections - a double erasure for many MWSWs

(Derkinderen, 2017). Migrants are necessary for the national economy. However, they cannot make claims for state protection (Suphanchaimat et al., 2019). This contradiction reflects a moral economy in which social order is maintained through selective inclusion – Universal Health Coverage for citizens and formal workers, exclusion for those whose labour remains informal, racialised, and feminised (Villar, 2019).

Healthcare exclusion in Thailand is embedded in legal and structural barriers. The legal framework of the country, which criminalises sex work and excludes informal migrants engaged in it from healthcare protections, is one of the significant barriers to healthcare access for MWSWs (Jirattikorn et al., 2022). The criminalisation of sex work also establishes an unfriendly environment within which MWSWs are constantly threatened by the risk of arrest, police violence, and deportation (EMPOWER, 2012; Villar, 2019).

The Prevention and Suppression of Prostitution Act (1996) criminalises sex work, leaving MWSWs vulnerable to fines, raids, and detention in government-operated ‘rehabilitation centres’ (Derkinderen, 2017). This legal structure pushes MWSWs into unmonitored, underground settings where they are unable to request even minimal labour protections like employer-based healthcare (Jirattikorn et al., 2022; Webber et al., 2012). While some entertainment establishments offer health checks to protect the workforce, the motivation is to protect clients. MWSWs are treated as potential disease vectors rather than individuals with full medical rights (Hongjaisee et al., 2020, 2022; O’Connor et al., 2022).

Marginalisation of migrants also compounds these exclusions. MWSWs in Thailand are mainly from neighbouring Myanmar, Laos, and Cambodia. They migrate from limited economic opportunity in their country of origin and enter sex work (Hongjaisee et al., 2020). Undocumented status, however, means that they have no access to Thailand’s Universal Health Coverage (UHC) scheme, meaning the only option is for medical needs to be met through out-of-pocket payments, even for basic healthcare (Hongjaisee et al., 2024; Webber et al., 2015). Even those who secure work permits under Thailand’s documented migrant labour schemes discover that healthcare access is conditional, bureaucratically complex, and often inadequate (Jirattikorn et al., 2022).

A key structural challenge is the high mobility of MWSWs, which disrupts the building of routine relationships within a single healthcare facility, anticipated by the UHC scheme. Such workers typically move between cities and work under short-term contracts, or in informal settings, making it impossible to maintain a continuous medical record or access long-term treatment for chronic, and pre-existing conditions (Ayuttacorn et al., 2021). As a result, MWSWs frequently experience a lack of continuity of care, poor medical history documentation, and fragmentation of treatment plans for health concerns such as HIV, STIs, and reproductive health issues (Jirattikorn et al., 2022).

3.2.2c. Stigma and discrimination in healthcare

The stigmatisation of MWSWs is one of the significant barriers to their access to healthcare services. Stigma operates at the individual, institutional, and societal levels to delay health-seeking behaviour, erode trust in healthcare providers, and heighten susceptibility to ill health (Davis et al., 2016; Lam et al., 2021; Weine et al., 2013). Studies show that healthcare providers are often moralistic or judgmental about sex workers, mainly migrants, stigmatising them further in the healthcare setting (Goldenberg et al., 2017; Rocha-Jiménez et al., 2018).

This is not just about judgmental attitudes of individual staff in individual facilities. Studies in numerous countries suggest stigma in medical environments is a structural barrier that prevents MWSWs from accessing preventive medical care. Discriminatory attitudes, moralising, and legal prejudices are frequently reproduced by healthcare providers, embedding indifference to MWSWs (Lam et al., 2021; Lim et al., 2018; Socías et al., 2015). Stigmatising attitudes are inherent in the legal, social, and institutional structures that define MWSWs as deviant, criminal, and carriers of disease.

Many MWSWs avoid hospitals and clinics due to fear of mistreatment, racialised moral policing, breaches of confidentiality, and being reported to immigration authorities (Folch et al., 2013; King et al., 2013). The result is delayed diagnoses, untreated infections, and higher vulnerability to poor health outcomes, especially in sexual and reproductive health, mental health, and chronic conditions. This systematic neglect exacerbates existing health inequities, particularly for communities already

experiencing legal precarity, economic precarity, and intersecting axes of discrimination.

3.2.2c1 Institutionalised healthcare exclusion: when systems function as barriers

Stigma promotes avoidance of medical services, concealment of sex work identity, and dependency on clinics financed by NGOs. In addition to individual discrimination, the stigma against sex workers is institutionalised in healthcare policies and healthcare service structures.

Ma and Loke's (2019) study investigated 22 female sex workers' (FSWs') experiences with stigma encountered in the healthcare context in Hong Kong, using in-depth structured interviews. Their research identifies three notable types of stigma affecting FSWs: experienced stigma (direct discrimination on the part of the health provider), anticipated stigma (expectation of being assessed and devalued), and internalised stigma (discrimination that FSWs perceive as a future threat when seeking help). Anticipated stigma and internalised stigma leading to self-blame and shame. In addition to individual discrimination, the stigma against sex workers is institutionalised in healthcare policies and healthcare service structures.

Ma and Loke (2019) reported that the majority of participants were afraid of moral judgment or that their data would be misused if they disclosed their status as sex workers. As a consequence they self-medicated, or sought care in sex worker-friendly NGOs. However, this avoidance often excludes them from comprehensive healthcare beyond their genitourinary focus. They often miss out on other critical healthcare needs, such as addiction treatment, mental health, and chronic disease management.

King et al. (2013) conducted a cross-sectional survey to determine the effects of HIV-related stigma, sex work-related stigma, and discrimination in healthcare settings on HIV testing participation among 139 street-based female sex workers (FSWs) in St. Petersburg, Russia. Using structured questionnaires, the study controlled for various forms of stigma to examine associations between perceived stigma and utilisation of HIV services.

The main finding of this study is that high perceived HIV-related stigma was significantly associated with low HIV testing uptake. Participants reported fear of being

stigmatised, mistreated by, or rejected by healthcare providers if they presented for HIV testing, resulting in avoidance of healthcare settings altogether. Fear of being discovered to be HIV-positive was compounded by concerns about a lack of confidentiality when (or if) FSWs engaged with Russia's healthcare system. Thirty per cent of all FSWs in the study reported being denied medical care. The number rose to forty per cent among HIV-positive FSWs, suggesting that HIV status exacerbates existing stigmas associated with sex work. FSWs with HIV were more likely to be fearful of acquiring medical care, creating a cycle of medical neglect and declining health (King et al., 2013).

A cross-sectional study among 705 MWSWs in Vancouver, Canada, between January 2010 and August 2013 reported how the universal healthcare system there systematically excludes migrant sex workers (Socías et al., 2015). The nexus between immigration laws and sex industry criminalisation results in institutionalised inequalities of health. Being in a high-risk group, migrant sex workers were 76% less likely to have had Hepatitis C (HCV) tests than non-migrants. Untreated Hepatitis C can cause chronic liver disease, liver cancer, or death. Being flagged as a "high-risk" has actual immigration consequences (Socías et al., 2015).

The studies from Hong Kong (Ma & Loke, 2019), Russia (King et al., 2013), and Canada (Socías et al., 2015) highlight the apparent contradiction in public health strategies. While governments claim to focus on the prevention of HIV and harm reduction or control of these diseases, their legal and institutional practices create conditions that amplify viral health emergencies.

3.2.2c2 Healthcare as a site of exclusion: the intersection of gender, race, and migration status among MWSWs

Studies from China, Portugal, North America, South Africa, and Russia identify an everyday reality that MWSWs are not only at the margins of healthcare systems but are systematically marginalised through the intersection of gender, race, and migration status (Davis et al., 2016; Dias et al., 2017; Lam et al., 2021; Richter et al., 2014; Weine et al., 2013).

Lam et al. (2021) used a qualitative research approach that incorporates ethnographic participant observation and survey data drawn from 106 Asian migrant massage

workers through two grassroots organisations, Butterfly (Toronto, Canada) and Red Canary Song (New York City, U.S.). Their approach is based on community-based participatory research, rooted in oral histories and interviews with workers, as well as documenting their lived experiences of policing, economic exclusion, and barriers to healthcare during the COVID-19 pandemic.

The researchers state that the refusal to provide healthcare services to Asian migrant sex workers in the USA is not incidental and not individual but rather systemic, founded on racialised stigma and discrimination. In these narratives, Asian women who migrate to Western countries are either hypersexualised as deviant, deserving punishment for engaging in unlawful sex work, or as powerless transnational trafficking victims in need of rescue. These perceptions influence their treatment by authorities, as well as by medical services. Instead of being neutral spaces, healthcare institutions often operate as a branch of the state's policing apparatus. Lam et al. (2021) track how, during COVID-19, Asian migrant massage workers were accused of being public health threats even while they were being denied healthcare services. Rather than focusing on bringing them under the COVID-19 treatment umbrella, police increased raids of massage parlours under the guise of public health enforcement, subjecting workers to harassment, fines, and deportation.

Davis et al. (2016) report similar patterns in China, where 19 Ugandan MWSWs experienced medical exclusion at the intersection of race, gender, and legal status. Considered already morally deviant from their work, the status of Black African women migrants further placed enquiry into their health needs below the ID checks that could precipitate arrest and deportation.

Dias et al. (2017) investigated the obstacles that undocumented MWSWs encountered (n=169) in receiving Portuguese Universal Healthcare. Even though Portugal has an inclusive healthcare system, undocumented MWSWs reported facing structural barriers such as challenges in the language, legal uncertainty, or fear of deportation that prevent them from seeking care. The study found that a quarter of the undocumented MWSWs had never made any contact with the NHS healthcare system at all (Dias et al., 2017).

Richter et al. (2014) used a cross-sectional survey of 1,653 female sex workers (FSWs) - 85.3% of whom were migrants - in Johannesburg, Rustenburg, and Cape

Town, South Africa. Their findings revealed that cross-border MWSWs were 41% less likely to access healthcare than non-migrants. The reasons were a combination of immigration laws, experiences of differential treatment, and encounters with law enforcement. MWSWs from Zimbabwe and Mozambique said they avoided clinics altogether, fearing arrest or notification to immigration authorities.

Besides concerns about discovery, discrimination within healthcare settings also leads to medical neglect. The MWSWs experienced hostility from healthcare workers, including denial of services based on nationality, verbal abuse, mockery of accents, and refusal to provide STI screenings or HIV treatment (Richter et al., 2014). Many MWSWs stated they cannot afford to pay for private healthcare, making the public system their only option, notwithstanding the perceived or actual barriers to access (Richter et al., 2014).

Weine et al. (2013) analysed HIV risks among female migrant sex workers (FMSWs) in Moscow, Russia. Their study uses a qualitative ethnographic approach consisting of minimally structured interviews with 24 FMSWs. Weine et al. (2013) contribute to Connell's theory of gender and power by demonstrating how migration status intersects with gendered vulnerability. The study highlights that gender, race, and migration status intertwine to create inequality among the FMSWs in Moscow. Specifically, women from Central Asia and Eastern Europe experience a form of racialised stigma that renders them vulnerable to mistreatment by clients, police, and health practitioners. Most are afraid of mistreatment, denial of services, or demands for bribes in medical settings, effectively forcing them out of the healthcare system (Weine et al., 2013).

3.2.2c3 Structural and institutional barriers leading to healthcare avoidance among MWSWs

Selvey et al. (2018) explore the barriers to accessing healthcare services for Asian migrant sex workers in Western Australia and report how combinations of legal precarity, structural exclusions, and racialised stigma impede their access to medical services. This study used mixed methods, including surveys (n=354 of whom 94 identified as Asian) and semi-structured interviews with sex workers (n=17, Chinese, Thai, and Korean), and key advisor interviews. Sex work is not illegal per se, but the criminalisation of brothel-keeping and street work and restrictive immigration laws

have created a culture of constant fear and distrust that discourages MWSWs from seeking medical care. The study found that only 43.5 per cent of Asian MWSWs were entitled to Medicare, and even among those who were entitled by their residency status, many did not know how to navigate Australia's complex healthcare system or did not feel confident enough to try (Selvey et al., 2018).

The study found further that the lack of culturally competent healthcare services and multilingual support renders the system unwelcome, inaccessible, and alienating. Language difficulties marginalise these women even more, with 93.6% of Asian MWSWs describing their English as poor, preventing them from properly communicating with doctors. Selvey et al. (2018) reported that the Asian MWSWs faced widespread discrimination in Australia, with healthcare workers presuming they are either trafficking victims or reckless disease spreaders, with doctors and nurses subjecting them to moral policing, judgmental attitudes, and humiliating questioning. Participants also reported their financial instability as a further reason that they do not prioritise healthcare in their lives if the choice is one day's earnings versus one day at the clinic (Selvey et al., 2018).

New Zealand's Prostitution Reform Act (2003) (PRA) decriminalised sex work, but Roguski (2013) argues that migrants were excluded from the defined industry. Thus, migrant sex workers work illegally, without legal protections or access to formal support networks. Roguski's mixed methods study (2013) investigated the occupational health and safety of migrant sex workers in NZ through qualitative interviews (n=12), a survey of migrant sex workers (n=124), and a review of clinic records (n=51). The study revealed the fear of deportation is among the strongest deterrents preventing the migrant women sex worker (MWSWs) population from using health services. They do not access clinics, even when they have STIs, workplace injuries, or serious complications of reproductive health, for fear of exposure to law enforcement. Some MWSWs who seek care feel that they must hide their occupation. Roguski (2013) documented the racialised moral judgement towards MWSWs from Chinese, Thai, and Vietnamese communities. Participants described being mistakenly assumed to have either been trafficked or to be drug users, making them feel profoundly unwelcome in medical settings. Some were purposely denied treatment, while others were treated with suspicion, humiliation, or outright hostility, with the result that they no longer look for formal healthcare at all.

These issues reflect international patterns in countries where migrant sex work is criminalised or precarious (Dias et al., 2017; Selvey et al., 2018) and contribute to the systemic hindrances to MWSW access to adequate healthcare.

3.2.2c4 Stigma and discrimination: the hidden costs of seeking care among MWSWs in Thailand

In countries such as Canada (Lam et al., 2021; Socías et al., 2015) or Germany (Lotysh et al., 2025), stigma coexists with legal rights of access to the healthcare system. In Thailand, stigma is both created by, and is a means by which legal exclusion takes place. The intersection of criminalisation of sex work, Buddhist-informed moral norms, and othering of migrants combine to construct MWSWs as dirty/unclean and illegal (Kidpromma, 2022), legitimising their effective exclusion from the public health sector.

Although Thailand has a comparatively developed public health system, migrant sex workers (MSWs), especially those from Myanmar, Laos, and Cambodia, are both excluded and discouraged from engaging with it, creating a cycle of medical neglect (Ayuttacorn et al., 2021; Webber et al., 2012, 2015). Various studies have identified healthcare provider bias, legal exclusions at the local, state, and national levels, and institutionalised discrimination, resulting in higher susceptibility to HIV, STIs, and untreated reproductive health issues (EMPOWER, 2012; Hongjaisee et al., 2020; Jirattikorn et al., 2022).

Jirattikorn et al. (2022) reported that Shan migrant sex workers from Myanmar with HIV in Chiang Mai frequently delayed treatment because they were afraid of being treated poorly by the clinic staff. Language barriers further hampered their access to care. Many were unable to communicate their symptoms and received inadequate or dismissive treatment. Others were afraid that seeking HIV treatment would reveal that they were undocumented and cause them to be deported.

Ayuttacorn et al. (2021) reported that female MSWs of the Shan ethnic group had limited access to the most effective HIV prevention drugs, PrEP and PEP, as a result of the historical exclusion of sex workers from Thailand's HIV prevention programming. This exclusion potentially has profound health implications for Shan MSWs since many indicated that they engaged in unprotected sex with their long-term partners.

Webber et al. (2012, 2015) found that beer promoters were routinely judged when seeking STI treatment, contraception, or abortion counselling in Thailand, Cambodia, and Laos. Healthcare providers assumed that beer promoters were also sex workers, making degrading comments that discouraged them from seeking the complete reproductive healthcare options they needed.

Thai anti-trafficking legislation compounds this discrimination. A report by EMPOWER called Hit and Run (2012) demonstrates that healthcare institutions are often in contact with law enforcement, putting MWSWs at risk of police raids or forced STI screenings whenever they seek medical care. When arresting (and detaining) sex workers, police often cite STI screenings as the catalyst for doing so, which, in turn, makes sex workers less likely to visit the healthcare system (EMPOWER, 2012). Although this report is now over a decade old, more recent literature and rights-based NGO advocacy suggest that similar patterns of surveillance and policing continue to shape MWSWs' experiences of healthcare in Thailand (Ayuttacorn et al., 2021; Jirattikorn et al., 2022). The report remains relevant in highlighting how institutionalised relationships between healthcare and law enforcement create structural risks that deter access to care.

Stigma and discrimination are not the same for all migrant sex workers (MSWs). Gender and economics influence healthcare access. Hongjaisee et al. (2020) found that male MSWs in Thailand are more than twice as likely to be infected with Hepatitis B (HBV) than female MSWs, but male MSWs were almost six times less likely to seek treatment due to the stigma around male sex work. Many were afraid to reveal their job, concerned that healthcare providers would refuse them services or accuse them of being disease carriers. Additionally, this study indicates that male MSWs are the highest risk population with HIV, which has permitted a discourse that has overlooked the extent of female MSW HIV infection and vulnerability.

3.2.2d Economic constraints and workplace conditions

For MWSWs, economic precarity is not merely about the need for money. It is a structural constraint to their access to healthcare or advocacy for safe working conditions in the industry in which they are exploited. The data from China, Russia, Australia, South Africa, and the Mexico–Guatemala border show that inequitable

conditions of economic exploitation ultimately drive the exclusion of MWSWs from healthcare. Healthcare becomes a privilege without financial security, labour protections, and legal work options, not simply a public health issue, but a matter of labour rights. The studies by Davis et al. (2016), King et al. (2013), Selvey et al. (2018), Rocha-Jiménez et al. (2018), and Richter et al. (2014) demonstrate how restrictive migration policies, economic exclusion, and labour exploitation perpetuate structural conditions in which the MWSW population is caught in cycles of financial precarity, unsafe working conditions, and healthcare neglect.

Economic instability is MWSWs' most significant predictor of poor healthcare access. Davis et al. (2016) report this reality among Ugandan MWSWs in Guangzhou, China, many of whom were trafficked on the false promise of work and then forced into sex work through debt bondage. Without legal status, they were vulnerable to economic exploitation, taking low pay with little prospect of negotiation, charging an average of $16 per client. Landlords exploited their undocumented status, charging up to $16 per day for rent. Daily living costs, combined with family pressure to send money home, put the cost of preventive care beyond reach, forcing many women to self-medicate, drive to underground pharmacies, or avoid medical treatment altogether.

King et al. (2013) reported that MWSWs in St. Petersburg, Russia, experience similar entrapment in an economic precarity that directly affects their health-seeking behaviour. Street-based sex workers, many of whom were migrants, suffered extreme financial insecurity and violence and were not even able to afford basic healthcare services. HIV testing was theoretically available at no cost, but many sex workers did not test because they could not pay for any follow-up treatment that might be required. Within the constraints of economic insecurity, MWSWs are driven to make dangerous compromises, whether it is to have sex without a condom for a higher rate, to postpone getting treated for STIs, or to work while desperately sick.

Richter et al. (2014) implemented a cross-sectional survey of 1,653 female sex workers (FSWs) in Johannesburg, Rustenburg, and Cape Town, South Africa. This study found migrant sex workers (MSWs) in South Africa are compelled to serve longer hours, take more clients, and accept higher-risk transactions to survive. It was found that whereas MSWs charged a higher rate per client ($20) than non-migrants ($13), they worked with almost double the number of clients per week (median =14), often

out of financial desperation. Workplace pressure allows no space for preventive care, recovery, or rest, leading to poorer health outcomes.

Similarly, Selvey et al. (2018) reported the exploitative economic and work conditions experienced by Asian MWSWs in Western Australia (WA). Seventy-eight point five per cent of Asian sex workers depended on sex work as their only source of income. They worked longer hours and had lower incomes than their non-migrant counterparts. They felt they could not afford healthcare, which was seen not as a necessity but as a financial burden. MWSWs in the study delayed medical visits, let STI symptoms remain untreated, and self-medicated instead of seeking help.

Rocha-Jiménez et al. (2018) conducted a qualitative ethnographic study using semi-structured in-depth interviews with 31 international MWSWs in Quetzaltenango (Guatemala) and Tapachula (Mexico). They found that economic and workplace exploitation at the Mexico–Guatemala border directly affected MWSWs' ability to access reproductive healthcare. Many women did not have the means to afford contraception, STI treatment, or pregnancy care, so they either self-medicated, travelled home for care, or avoided medical attention altogether.

In Thailand, Jirattikorn et al. (2022) carried out a qualitative narrative study which included in-depth interviews with eight Shan migrant female sex workers (MFSWs) from Myanmar living with HIV in Chiang Mai, Thailand, to explore their experiences with accessing healthcare, HIV treatment use, and economic survival strategies. They report that economic insecurity is the leading motivation for MFSWs to remain in the industry, even following an HIV diagnosis, for example. Many are supporting families back in Myanmar, and without legal work status in Thailand, they have limited, if any, options for employment. This aligns with Rocha-Jiménez et al. (2018), who reported that migrant sex workers at the Mexico–Guatemala border keep working despite health risks because formal employment remains an impossible option.

However, Jirattikorn et al. (2022) report that Shan women from Myanmar see sex work in Thailand as potentially a path to a legal livelihood and financial stability. Where sex workers in South Africa (Richter et al., 2014) or Russia (King et al., 2013) regard sex work as a matter purely of staying alive, some Shan women also see their involvement in sex work as opportunities to find a Thai partner in the name of social security and

advancement towards legal residency (Jirattikorn et al., 2022). This view rarely features in the literature around the world.

For many MWSWs, healthcare access is not just a matter of cost. It is about the impossible sacrifices and compromises they are forced to make. For many who exist from day to day without savings, the ability to pay for food or rent takes priority (Ayuttacorn et al., 2019; Villar, 2019). In contrast to formal workers, MWSWs have no sick leave, employer-sponsored healthcare, or financial protections, implying that healthcare is simultaneously a personal and economic burden (Webber et al., 2015).

MWSWs are not included in the Thailand UHC scheme. While the Thai government has made some progress in offering migrant workers healthcare, it remains bureaucracy-led, prohibitively expensive for undocumented sex workers (Hongjaisee et al., 2024; Jirattikorn et al., 2022), and mainly out of reach. This has resulted in MWSWs, even if eligible for state medical care, being unable to access it due to system-level impediments.

The attitude of employers and managers to testing varies according to the sex work type. Venue-based MWSWs, for example, those who work in Thai massage parlours, karaoke bars, or brothels, may be required by employers to undergo regular HIV/STI testing. Such screenings are in clients' interests and are a form of public health intervention and business protection. Rather than demonstrating a duty of care for women, it is a form of employee surveillance (Jirattikorn et al., 2022; O'Connor et al., 2022). These tests do not cover the cost of treatment if an STI is found and are not inclusive of comprehensive reproductive healthcare. Women lose patient confidentiality when directed only to employer-approved clinics.

Freelance and street-based MWSWs have more independence but much less access to healthcare than venue-based sex workers (Hongjaisee et al., 2020; Webber et al., 2015). This group is generally in the most precarious financial situation, with unpredictable earnings, unsafe housing, and negative interactions with the police. Their economic vulnerability drives many to engage in dangerous sexual behaviour, such as sex without a condom for increased payment, or delaying healthcare until the situation is critical (Surit et al., 2022; Villar, 2019).

3.2.2e Resilience strategies and alternative healthcare-seeking

Fear of deportation, stigma from healthcare providers, and restrictive migration laws mean that many MWSWs do not access medical services and instead rely on informal, unregulated, or exploitative healthcare options (Goldenberg et al., 2017; Kriitmaa, 2023). In the context of such systemic disincentives, peer-led and community-based interventions have become a secondary harm reduction alternative, offering healthcare models that are accessible, culturally competent, and delivered by trusted peers (Febres-Cordero et al., 2018, 2020; Zermiani et al., 2012).

In contrast to mainstream healthcare settings, peer-led initiatives and community-based programmes provide sex workers with a safe space to access medical care, STI/HIV prevention resources, and psychosocial support (Dias et al., 2017; Folch et al., 2013). These services, often delivered by sex worker-led organisations, NGOs, and harm reduction networks, address structural barriers by providing mobile health units, outreach education, and anonymous medical services that are tailored to the realities of MWSWs' lives. Peer educators who are current or former sex workers themselves are critical for building trust, providing practical health advice, and introducing migrant workers to safe, nonjudgmental healthcare providers (Duff et al., 2016; Roguski, 2013).

3.2.2e1 Peer-led and community-based interventions: a critical lifeline for MWSWs

This section discusses the importance of peer-led and community-based interventions to address healthcare disparities for MWSWs. I explore how peer educators and sex worker-led organisations deliver affordable, culturally tailored, and non-stigmatising healthcare. I also discuss how community-based healthcare initiatives help mediate legal and institutional barriers. I discuss the increasing impact of mobile health services, the details of harm reduction programmes, and the role of grassroots advocacy in addressing healthcare inequalities. Ultimately, I address some of the challenges and limitations of peer-led interventions in this context.

I argue that peer-led and community-based initiatives are not merely supplementary healthcare services; they are core. By centring the voices and agency of MWSWs, service providers and community organisations, including NGOs such as the

EMPOWER Foundation in Thailand, are often the only alternative for MWSWs excluded by hostile legal and medical environments. Nevertheless, peer-driven strategies tend to operate in survival mode and will not serve as long-term solutions to the healthcare needs of MWSWs.

The lack of responsiveness of formal care settings in providing a non-threatening, enabling environment for MWSW healthcare has resulted in the emergence of peer-led and community-based solutions that have responded to this need through the provision of culturally relevant, confidential, and non-judgmental medical services. Zermiani et al. (2012), Kriitmaa (2023), Dias et al. (2017), Febres-Cordero et al. (2018, 2020), Roguski (2013), and Duff et al. (2016) consistently report that such interventions are effective and lie at the heart of addressing the shortfalls of mainstream health systems.

In Italy, Zermiani et al. (2012), for instance, show that MWSWs in Verona tend to shun hospitals for fear of discrimination, lack of money, and fear of legal repercussions. As a result, programmes such as the Sirio Project deliver mobile and community-based health services, including free sexually transmitted infection screening and harm reduction services, to allow undocumented workers to receive medical attention without being exposed to any involvement with law enforcement.

Likewise, Kriitmaa (2023) illustrates how Somali MWSWs in Nairobi, Kenya, experience intersecting layers of exclusion of legal status, cultural stigma, and police violence. Community-based organisations (CBOs) have emerged as alternative healthcare providers, extending culturally competent support, HIV testing, and STI prevention into safe, private settings. The success of these programmes shows that healthcare engagement is more likely when sex workers trust the provider.

However, trust alone is only part of the battle for effective engagement. Peer-led outreach programmes in which trained sex workers and community educators hand out condoms, teach about preventing HIV, and direct women to safe clinics have been found to have a significant positive impact on engaging with health services. Dias et al. (2017) observed that Portugal's NHS and HIV testing are open to all. However, they conclude that healthcare cannot wait for women to find their way to it; it must get to the women who need it.

Febres-Cordero et al. (2018, 2020) document how MWSWs on the Mexico-Guatemala border operate peer-led safety strategies that help protect one another from violent clients and avoid police extortion. Those strategies include reporting dangerous individuals, checking in with sex workers after appointments, and taking clients' details for collective safety.

Self-reliance is all the more essential in environments where sex work is unlawful. Roguski (2013) records the significance that New Zealand's Prostitution Reform Act (2003) decriminalised sex work for citizens but not for migrant sex workers (MSWs). The New Zealand Prostitutes' Collective (NZPC) has become an important provider of STI testing, advocacy, and referrals to safe healthcare for MSWs.

In South Africa, Duff et al. (2016) describe the ways that the criminalisation of sex work and racialised discrimination push MWSWs into dangerous circumstances. In response, peer-led organisations, such as the Sex Workers Education and Advocacy Taskforce (SWEAT) and Sisonke, have mobilised and started to provide mobile health, legal, and harm reduction services.

Peer-led interventions can provide important support to marginalised MWSWs, but their impact is inevitably limited because they act within restrictive legal and economic frameworks. Febres-Cordero et al. (2020) identify several challenges that weaken the sustainability of peer-driven health programmes. MSWs are often mobile and work between different settings, creating discontinuity of peer support, as well as mistrust and competition. Economic precarity also drives inconsistency of engagement and competition between sex workers for support. It also drives digital exclusion. This study addresses that while mobile health (mHealth) strategies can extend outreach and help keep the peer network alive across multiple sites, many MSWs face forms of digital exclusion resulting from a lack of digital literacy, limited internet access, or concern over surveillance.

In response to the situation in Thailand, NGOs, sex worker-led organisations, and activist movements have stepped in to provide healthcare services, along with harm reduction programming and legal support (Janyam et al., 2020; Webber et al., 2015). Despite limited resources, these organisations have played a vital role in improving health outcomes for MWSWs, drawing on peer outreach workers' (current/former sex workers) visits to provide STI screening, condoms, and referrals to healthcare services

(EMPOWER, 2012; Villar, 2019). While NGOs are important in covering the healthcare access gap for marginalised sex workers, many are inadequately funded, and bump up against restrictive policies because sex work is still criminalised and politically controversial in Thailand (Derkinderen, 2017; Villar, 2019).

Where they do operate, organisations such as EMPOWER Thailand and SWING Thailand show that peer-led initiatives can be more effective in engaging MWSWs, particularly in terms of building trust, reducing stigma, and improving access to services compared to state-run programmes. MWSWs are more inclined to trust and interact with providers who have comparable lived experiences (Jirattikorn et al., 2022; Hongjaisee et al., 2020). This NGO presence is especially vital for undocumented MSWs, who tend to stay away from government hospitals out of fear of legal consequences (Webber et al., 2012, 2015). NGOs also form a part of the broader holistic picture of harm reduction.

Although NGOs play a much-needed role, their effectiveness is additionally limited by their lack of status in the Thai public health system (Jirattikorn et al., 2022; Webber et al., 2015). While NGO-run clinics provide HIV testing or STI treatment to sex workers they are later unable to provide follow-up care to those same sex workers at government hospitals due to bureaucratic restrictions, their lack of documentation, or discouraging attitudes by healthcare staff (O'Connor et al., 2022).

There is a complex interplay of determinants that influence MWSWs' experiences of healthcare across various global settings in the literature (section 3.2). Structural barriers and legal impediments, stigma and discrimination in health facilities, economic precarity, and the use of informal or alternative self-management resources are common themes across the studies. However, most of the available evidence was found outside Thailand. Research on migrant sex workers in Thailand has been mainly concerned with HIV/STDs studies (Ayuttacorn et al., 2019, 2021; Hongjaisee et al., 2020, 2024; Jirattikorn et al., 2022; O'Connor et al., 2022; Surit et al., 2018) and provided little insight into the lived experiences of MWSWs and the Thai healthcare environment. More specifically, there has been little qualitative exploration from MWSWs' perspectives, and little understanding of how Thai NGOs perceive and respond to this population.

These gaps shaped the design of my research question: *How do migrant women sex workers experience healthcare provision in Thailand, and what are their perceptions about accessing health care?* Building on the themes discussed in section 3.2, my study seeks to expand knowledge of perceived barriers and strategies for accessing healthcare among MWSWs, as well as Thai NGOs' perceptions of access to healthcare among this group. In this regard, it addresses the call for a more localised, intersectional, and experiential understanding of access to healthcare in Thailand.

3.3 Towards an intersectional healthcare framework

Here, I examine the way in which intersectionality theory functions as an analytic tool of this research. Initially, I employed a thematic analysis approach as my primary method of analysis to examine the accounts of MWSW participants regarding their experiences with accessing healthcare in Thailand, focusing on recurring patterns and themes that emerged from the data. However, as I examined my data further, I realised that what I had found both reflected and gave shape to complex and layered experiences beyond the reach of thematic analysis. This required more sophisticated analytical models that could account not only for the responses of MWSWs to their experience in healthcare settings but also their experiences connected to their legal status, migration status, gender, economic class, and workplace structure and culture.

Following a review of the relevant literature, I employed an intersectionality perspective in conjunction with thematic analysis to understand how intersecting social hierarchies and power relations shape the health-seeking experiences of MWSWs, both at the individual and structural levels. This new route opened a way for me to avoid restricting myself to naming barriers and facilitators to healthcare access. It instead allowed me to look deeper into how forms of oppression and privilege interrelate with one another.

Taking an interdisciplinary approach that weaves the experiences of my MWSW participants with the international and Thai data, this study offers a power-sensitive, nuanced understanding of the relationship between healthcare experiences and the complex discussions surrounding work, migration, and health equity.

An intersectional analytic perspective goes beyond the simpler, one-dimensional conceptualisations of healthcare exclusion by revealing how multiple axes of identity intersect to produce distinct patterns of healthcare exclusion (Logie et al., 2011). Intersectionality elucidates the interrelatedness of social categories which determine how and the degree to which legal status, race, and financial instability converge with one another to shape one's ability to obtain care (Crenshaw, 1989) as cited in Carbado et al., 2013).

These concepts are highly relevant in the Thai context, given overlapping exclusions organised through legal status, gendered, racial, and occupation-based codes governing health, immigration, and labour (Hung, 2023a, 2023b). This framework is essential for analysing healthcare access. It identifies structural barriers while validating the agency and resiliency of MWSW within healthcare systems.

Utilising an intersectional theoretical and methodological lens reveals the layers of marginalisation that shape the healthcare experiences of MWSWs. It also explores how healthcare systems could facilitate the insights of an intersectional approach to foster an inclusive and fairer healthcare system. An intersectionality-informed healthcare model would look beyond legal status or victimhood perspective, instead emphasising the structural underpinnings of exclusion while affirmatively sustaining the agency of marginalised populations.

3.3.1 Rethinking intersectionality in sex work research

Intersectionality theory, first introduced by Kimberlé Crenshaw (1989, cited in Davis, 2014), has shaped scholarly understanding of how overlapping systems of oppression, such as gender, race, class, and legal status, converge to produce unique and often compounding experiences of marginalisation.

Nash (2008) critically argues that intersectionality is frequently used as an extended and indefinite paradigm but lacks precision in how it is constructed and presented in research.

In my study, I will explain what I mean by intersectionality as an analytic tool. It is a lens through which I categorise my data beyond recording how MWSWs experience exclusion from the healthcare system. As a framework of analysis, intersectionality can be used to understand how multiple oppressions based on gender, migration

status, and labour and culture can interweave to form the health exclusion that MWSWs experience. It supports a subtler examination of how and in what specific ways intersecting factors affect their healthcare experiences.

Julie Ham (2020) makes an important intervention in the debate surrounding intersectionality and sex work, as well as its relevance to migrant and racialised women. Ham (2020) critiques research that fixes social differences into unchallengeable disadvantages and calls on academics to consider how people actively mobilise social differences in their everyday lives. She argues for a more dynamic view. Instead of seeing difference as a disadvantage forced upon them, she looks at how migrant sex workers shape and negotiate social differences within their living environment.

This is in direct opposition to mainstream policy and media representations that often generalise migrant sex workers as demoralised figures of victimisation or trafficking. It is especially important in response to Western feminist frameworks that assume sex workers are passive victims of structural oppression. Ham (2020) emphasises sex workers' agency in using their linguistic and work-based differences.

Although Ham's (2020) study is theoretically sophisticated and methodologically sound, based on 65 semi-structured interviews with migrant and racialised sex workers in Melbourne and Vancouver, it does not engage fully with the structural constraints on workers' agency. My analysis facilitates a more comprehensive analysis of the legal, economic, and migration structures that govern their labour conditions and, therefore, enables a more complete analysis of how sex workers navigate their environments.

Carbado et al. (2013) claim that intersectionality is an open-ended analytical practice rather than a closed theory, constantly adjusting to changes in social conditions and power relations. Traditional health disparity framing homogenises MWSWs as an 'at-risk' population and lists barriers to care (e.g., legal hurdles, language barriers, stigma) (Hongjaisee et al., 2024). Nevertheless, extending on Ham (2020), I contend that healthcare access is not a paradigm of disadvantage per se. Instead, I emphasise the need to pay attention to how MWSWs negotiate, contest, and resist structural and social barriers within Thailand's healthcare system.

I decided to conduct my examination of the legal exclusions, healthcare regulations, and the approaches of the medical team, along with informal care networks that all together restrict and facilitate access to medical care from the perspective of MWSWs in Thailand.

By rethinking intersectionality in this way, this study promotes a nuanced perception of healthcare exclusion - one that moves beyond listing categories of difference to analysing how power operates across societies. Intersectionality turns into both an indicative and reproductive instrument: it uncovers the systems of marginalisation and features the adaptive strategies that occur in response.

3.4 Chapter summary

In this chapter, I have provided an overview of the relevant literature on healthcare access among MWSWs, drawing on studies within Thailand and also in international settings. There are extensive findings of exclusionary structures shaped by legal and migration policies, stigma, and economic marginalisation. Although healthcare is widely recognised as a fundamental human right, the evidence suggests that this right is frequently inaccessible to MWSWs.

I started by looking at how criminalisation of sex work and limiting immigration laws combine to restrict access to healthcare. Criminal law not only criminalises sex work but, through interaction with healthcare spaces, converts clinics into sites of legal jeopardy for MWSWs. Thailand, Singapore, and Canada provide examples of how legal precarity combined with policing practices inhibits MWSWs from accessing the most basic health services. In Thailand, the exclusion of undocumented sex workers from the UHC system reflects a policy architecture that prioritises legal control over health equity.

My review also highlighted fear of deportation as a structurally embedded barrier. MWSWs often avoid formal healthcare services not out of neglect, but due to fears of arrest, detention, or state violence. These fears are reinforced by discriminatory medical practices and institutionalised stigma, including moralistic or racialised assumptions about sex workers' legitimacy as patients.

I also identified key deficiencies in existing literature. In the Thai context in particular, most of the studies that have been conducted are narrowly tailored to HIV or STD and do not appear to address broader individual health needs such as primary care, chronic disease, or reproductive health beyond STIs prevention. This fragmentary approach overlooks the complex, layered threats and multiple levels of vulnerability and disadvantages that MWSWs face in engaging with any healthcare.

Although intersectionality is increasingly cited within public health discourse, I found that it remains underutilised as a critical analytical framework in the literature on MWSWs in Thailand. In some cases, intersectionality is used to recognise intersecting identities, but it does not address how such intersections interact with power relations, structural marginalisation, or resistance. My study employs intersectionality as both an analytic tool for examining exclusion and as a framework for recognising agency, specifically, how MWSWs navigate, resist, and adapt within constrained social and legal environments.

Thus, this chapter lays out the gap in relevant literature that calls for the theoretical and practical underpinning of my study. I advocate for a more nuanced, intersectional, and structural approach to studying healthcare access among MWSWs in Thailand. Rather than merely cataloguing the barriers, my research aims to examine how power relations, legal systems, and everyday tactics of survival interact to shape MWSWs' healthcare experiences.

The next chapter details the methodological framework, epistemological positioning, and qualitative methods I adopted to investigate how MWSWs in Thailand experience healthcare and respond to healthcare exclusion.

Chapter 4: Methodology and Methods

4.1 Introduction

This research draws on data generated via semi-structured qualitative interviews with migrant women sex workers (MWSWs) and NGO service providers to explore MWSWs' experiences of healthcare access in Thailand. It is grounded in a social constructivist epistemology and mobilises intersectionality as an analytical approach.

In this chapter, I set out the reasons for choosing the qualitative semi-structured interview as my research method and for using the LINE (audio/video) application and telephone calls to conduct the interviews with my research participants. Notably, my research was conducted during the COVID-19 pandemic, and this had implications for my research approach.

I begin by outlining my research aim and questions in section 4.2. In section 4.3, I discuss my constructivist epistemological stance. I discuss my research design in Section 4.4, and in Section 4.5, I outline the data collection process, clarifying my study samples, setting, and recruitment. I then discuss my research participants, including the inclusion criteria, and the language used in the interviews. In Section 4.6, I discuss the interview process and the semi-structured interviews I conducted. Section 4.7 outlines my data analysis process, which includes translation, interpretation, and an initial, limited thematic approach. Then, I decided to develop a more sensitive framework that combines intersectionality analysis and thematic analysis to capture the complexity and nuance of my data. In Section 4.8, I discuss the ethical and methodological considerations of my study. I discuss the ethical and emotional challenges of researching such sensitive topics in sections 4.9 and 4.10, respectively. Finally, in Section 4.11, I outline the limitations of my study.

4.2 Research aims and question.

My study aims to explore the experiences of migrant women sex workers (MWSWs) in accessing healthcare services in Thailand, centering on the barriers they encounter

as well as the strategies they manage to navigate these barriers. Specifically, my study seeks to:

1. Understand the experiences of MWSWs in accessing healthcare services within the Thai context.
2. Identify and understand the barriers that affect access to healthcare from the perspective of MWSWs.
3. To understand the roles of local Thai NGOs in MWSWs to access healthcare.

The central research question is: **How do migrant women sex workers experience healthcare provision in Thailand, and what are their perceptions about accessing healthcare?**

4.3 Epistemological considerations

In this study, my epistemological stance as a researcher is grounded in constructivism, where knowledge is co-constructed through the interactions between myself and the participants (MWSWs and service providers).

I consider the experiences of participants (MWSWs and service providers) to be a source of invaluable information and insight. Their first-hand accounts are vital to address my research questions. As a researcher, I need to clarify the epistemologies that are consistent with my position, so I can conduct research from that standpoint and present the findings in a way that allows them to be evaluated suitably (Madill et al., 2000). The worldviews and beliefs of the researcher should not be biased or interfere with the qualitative research process (Willig, 2013). However, all qualitative methodologies are guided by varying epistemological assumptions; they all have in common a concern for the people in their social worlds.

For MWSWs, healthcare access is a complex and multifaceted experience shaped by the intersections of their identities and social structures (Crenshaw, 1989, cited in Carbado et al., 2013), including healthcare policy and structures, sex work laws,

migration laws, and healthcare staff's attitudes about migrants and sex work. All those elements influence their direct experience and broader perceptions of access to healthcare. My research aims to record and understand those multiple realities. As such, I decided that immersion in the social world of participants and healthcare settings was essential to understanding how these MWSWs participate in and engage with Thailand's healthcare facilities.

Epistemology concerns the nature of knowledge and how it is acquired (Crotty, 1998). According to Guba and Lincoln (1994), two primary epistemological perspectives have emerged: objectivism and constructivism. Objectivist epistemology suggests that reality occurs independently of human perception, while constructivist epistemology, adopted in this study, emphasises that realities are constructed by individuals, or collectively by groups (Guba & Lincoln, 1994). I aim to grasp how healthcare access is experienced and viewed by MWSWs and service provider participants. I posit that knowledge about healthcare access is co-produced between the researcher and participants in adopting this constructivist epistemology.

Following a constructivist perspective, knowledge is created based on the researcher's and participants' interactions (Guba & Lincoln, 1994). I explore how MWSWs experience healthcare access, acknowledging the subjectivity of their experiences and how they are transformed and shaped by their individual life histories, beliefs, perceptions, and social context (Guba & Lincoln, 1998). As a researcher, I actively create knowledge under the constructivist paradigm. I considered that participants' accounts directed my data analysis, and as a result, the stories they created extended through their descriptions (Creswell, 2014). This involved an interpretive process. The subjective stories told by the research participants are set within the power structures of Thai society at large. The knowledge generated, whilst not generalisable, offers an in-depth contextual understanding of participants' specific and localised experiences (Guba & Lincoln, 1998).

4.3.1 Reflexivity on epistemological stance

Insofar as my epistemological position is based upon constructivism, whereby knowledge is co-constructed through interaction between the participants and me, I

am not a detached, objective observer. Rather, my presence, questions, and interpretations are part of the knowledge produced. While working with MWSWs or service providers, I moved through a process of shared sense-making. Understanding was not passively handed over but co-created. I do not just 'try to understand' their perspectives; I intervene in how to interpret their responses, where to go with follow-up questions, and how I could further refine my own conceptual understandings based on their insights. Simultaneously, they shaped my understanding by questioning my assumptions, reframing problems, and providing new perspectives on the issues at hand. This dynamic exchange reframed knowledge production so that it was not unidirectional but rather a dialogical engagement. Their experiences were not mere data points but acted as primary sources of insight that shaped both the methodological direction and conceptual framing of the study.

My identities as a Thai woman, a registered nurse, and now a post-graduate student heavily guided my approach to this research. My cultural background helped me access some participants who may have been beyond the reach of an outsider. I will discuss this further in the following section, 4.3.2. This connection allowed for more complementary, more candid conversations. The participants felt they were talking to someone who was familiar with their own cultural and social background. We had a common language, and I had knowledge of cultural norms. These helped reduce communication barriers and opened the door to in-depth exploration into sensitive topics, especially themes relating to stigma, healthcare access, and survival strategies. My background as a nurse and former midwife meant that I was positioned as someone who is already familiar with Thailand's complex healthcare systems. Participants may have drawn on this to share their experiences in ways they might not have done with a researcher who might need more explanation as the interviews went along. This unpacking of familiarity and professional identity created and also complicated the construction of quality in the data captured, and also the process through which each of the participant's narratives was interpreted. I played an active role within the knowledge production process. My own position impacted the research dynamic and the derived insights. However, whatever similarities in our life experiences I could identify, I have never faced the day-long, daily vulnerabilities of the MWSWs in my study. I worked conscientiously to come to their experiences with an open perspective rather than a preconceived notion about what I might find there.

As a post-graduate student researching an understudied and marginalised population, I was also aware of the power differential between MWSWs, service providers, and myself. As the one doing the research, I held power in multiple ways. I shaped the research agenda by determining what questions would be asked, directed the flow of conversation during interviews by framing follow-up questions, and ultimately interpreted and represented participants' stories in my findings. Dynamics such as these mean that participants' voices are inevitably interpreted through my analytical lens, further highlighting the need for reflexive sensitivity in my process. To address these power dynamics, I worked hard to create an interview space in which participants felt respected, safe, and supported, so they would feel able to share their experiences freely. I also used an open-ended, participant-driven approach to interviewing, ensuring participants had the agency to shape the conversation rather than just answering a pre-determined series of questions. I was also aware of how my position as a researcher backed by respected institutions could influence responses or that participants might feel more, or less, inhibited to disclose sensitive information. Although I could not control these external factors completely, I tried to provide the most participatory and ethical research environment and experience possible.

Constructivist research embodies the researcher's sense of responsibility to understand the interrelationship between their own positionality and that of their participants (Guba & Lincoln, 1994). This reflection served as a means for me to recognise my imprint on my research process. I therefore strive to report the findings in a rigorous, transparent way that recognises the extent to which the knowledge presented is a co-constructed process between the participants and me. This method adds value to the trustworthiness and authenticity of the research since it acknowledges the participants' voices.

4.3.2 My insider and outsider positions in this study

In this qualitative exploration of healthcare access among MWSWs and service providers from local Thai NGOs, my positionality as a researcher can be understood through both 'insider' and 'outsider' perspectives. These positions shape my interactions with participants, data collection, and interpretation of findings.

4.3.2a Insider position

My insider status is not just a matter of identity but a source of empathy and understanding that I bring to the research. As a Thai woman, I share a cultural background with the service providers working within Thai NGOs and the larger socio-political context in which the study occurs. This gives me an insider's understanding of Thai societal norms, legal systems, and healthcare policies. It also enables me to better understand the social and structural challenges that MWSWs experience when they seek medical care. This cultural commonality can help to build rapport and trust with participants and NGO service providers, and help me pick up subtle nuances within the narrations and descriptions of participants' experiences.

As a registered nurse with experience working in public and private hospitals, I have insider knowledge of the Thai healthcare system. This allows me to recognise the logistical and institutional barriers that both healthcare providers and MWSWs encounter within healthcare facilities. I can more easily engage in discussions with NGO service providers about healthcare delivery processes, medical protocols, and the challenges of providing care to undocumented MWSWs.

My background as someone who grew up in a rural rice-farming community in northeastern Thailand gives me an empathetic understanding of socio-economic hardship. Poverty is never forgotten. Many MWSWs come from similarly marginalised rural backgrounds in neighbouring countries like Myanmar and Laos. While my insider knowledge here is limited to rural Thailand, it provides a framework for understanding structural inequalities that transcend national borders, such as poverty and its limited access to education and healthcare.

4.3.2b Outsider position

Despite several points of insider alignment, my outsider position is evident in key areas that may influence my interaction with the participants and my analysis of their experiences in accessing healthcare.

As a researcher with no prior engagement or direct experience working with MWSWs, I hold an outsider status to the specific realities of this group. MWSWs from neighbouring countries, many of whom are undocumented and work in a criminalised

sector, face unique vulnerabilities such as the constant threat of arrest, deportation, violence and exploitation. Lack of direct personal experience within these communities may create challenges for any researcher in fully grasping their lived experiences, particularly concerning the multiple layers of stigma and legal marginalisation they endure.

I am also an outsider in the working world of local Thai NGOs in contact with undocumented migrants and sex workers. These bodies can find themselves balancing on the point of a legal pin, at one moment actively intervening to provide vital support and services, and at the next, mindful of government interference or legal challenge. My outsider status here may inhibit my initial comprehension of the existential problems facing these service providers, in the context of Thailand's prohibitive laws concerning sex work and undocumented migration.

As a Thai citizen with legal status and as a healthcare worker, my socio-legal position stands in plain contrast to that of undocumented MWSWs who engage in an illegal and highly stigmatising occupation. These women are frequently without legal rights and are subjected to police intimidation, exploitation by employers and clients, and restriction of basic needs such as healthcare. Being an outsider to these intersecting vulnerabilities, I have an obligation to be reflexive and sensitive in interpreting their experiences.

4.3.2c Navigating insider/outsider positions

My dual positionality as an insider and outsider offers advantages but also requires careful navigation. The intersectionality lens I adopt in my research plays a key role, allowing me to recognise the multiple, overlapping systems of oppression that shape the healthcare experiences of MWSWs and service providers.

My insider position as a Thai national and healthcare professional allows me to understand and communicate with service providers more effectively. My own cultural background offers me valuable perspectives on customs and practices in terms of structure and institutions in Thailand.

As an outsider to the specific experiences of MWSWs, especially regarding their undocumented status and engagement in sex work, I approach data collection with

utmost sensitivity and reflexivity. This requires an understanding of how my social, professional, and legal privileges might shape my interpretation of their experiences.

I employ an intersectionality analysis to help navigate my positionality. Intersectionality highlights that the experiences of MWSWs in relation to healthcare are not monolithic but are informed by multiple layers of overlapping identity (migrant, women, and sex workers). These identities intersect with healthcare policy, cultural dishonouring attitudes, lack of access to healthcare (especially for undocumented individuals), and economic barriers (Fisher & Olsen, 2019). Similarly, service providers' actions are influenced by their professional roles, the societal stigma attached to sex work, and the legal challenges they face when assisting undocumented migrants (EMPOWER, 2016).

Complexity is not inevitably to be taken as shorthand for 'difficulty'. It can also describe a fruitful space for exploration and comprehension.

I have the power to reach both the inside and the outside of healthcare provision. Both shape my engagement with this study. Although insider status is helpful to understand Thai culture and healthcare systems, the outsider status, in relation to MWSWs' non-citizenship and sex work, must be taken into account reflexively in interpretation. By keeping such dynamics in mind and remaining reflexive, I hoped to do justice to the complex realities of access to healthcare for MWSWs and service providers in the Thai context.

4.4 Research design

Qualitative research is grounded in interpretive traditions, enabling the exploration of the meanings that individuals or groups assign to social problems (Creswell & Poth, 2018). This method is necessary for my research, which aims to explore how MWSWs and service providers view the healthcare access experiences of MWSWs in Thailand. My approach did not have a predetermined hypothesis and thus aligns with Creswell and Creswell (2018), whereby the process of research design is not rigid but somewhat more open and circular/iterative. Thus, I could work from a constructivist stance, where my data was shaped responsively by the participants'

accounts. Open-ended questions invited participants to share their lived experiences.

The flexibility of the qualitative research approach enables it to capture the social context as signified by Denzin and Lincoln (2011). Instead of merely cataloguing the barriers and opportunities they encounter, qualitative research enables me to investigate how they navigate the healthcare system, how their lived experiences shape their access to care, and how they make sense of these challenges on their own terms.

From a qualitative perspective, I drew on various approaches to inform this study's design, particularly Interpretative Phenomenological Analysis (IPA), grounded theory and ethnography. IPA had initially appealed on the grounds of its emphasis on lived experience. Still, I decided it could not adequately address my research question, which sought to investigate structural and institutional patterns rather than to produce an idiographic account of a single meaning-making process (Pietkiewicz & Smith,2014; Smith, 2021). Though I also considered grounded theory, I did not aim to develop a truly inductive theory (Holton, 2008); rather, I sought to engage with existing frameworks in concert with this thesis: namely, intersectionality and social exclusion. While ethnography provided an opportunity for thick contextual understanding (Field-Springer, 2020; Watts, 2008), the sensitivity of my research context and participants' vulnerable legal and social status raised substantial ethical/ practical challenges (Shaver, 2005). Thus, I chose thematic analysis using an intersectional framework, which allowed for a flexible yet theoretically informed analysis of participants' experiences and an ethically sensitive approach.

4.5. Data collection process

In this section, I clarify the study settings and how I gained access to prospective participants. I also discuss the research participants and the inclusion criteria. Lastly, I clarify the language used during the LINE application (audio/video) and telephone interviews.

The fieldwork for this study took place during the COVID-19 pandemic, which impacted data collection. I had initially planned to arrange face-to-face interviews so I could build some trust and rapport. But since the lockdowns and other public health measures in Thailand, that was no longer an option. I therefore adjusted my strategy and conducted remote interviews using LINE (audio/video calls) or telephone, depending on the participants' preferences and circumstances. Although this transition constrained in-person rapport building, it made it possible to host interviews safely and with greater flexibility and privacy.

4.5.1 Study samples and setting

This study was conducted online in Chiang Mai, a northern province of Thailand, with borders to Myanmar and Laos, using the LINE (video/audio) application and telephone platforms. I collected my data between February and June 2022 in Thailand, with follow-up interviews until August 2022 from the UK. The fieldwork in Chiang Mai was during heightened restrictions and closures due to the fifth, 'Omicron', wave of COVID-19 infections. Most sex work and sex entertainment venues were partially or fully closed. Migrant 'informal' workers (not in registered employment), including sex workers, were excluded from Thailand's pandemic health scheme support, which included COVID tests, food, and lodging. Migrant informal workers groups, including sex workers, were the last of the population to be called up for the COVID-19 vaccination programme (Janyam et al., 2020). Sex work and sex entertainment venues in the main red-light cities in Bangkok, Phuket, and Pattaya were closed by law. However, pubs, bars, go-go bars, massage parlours, and restaurants were permitted to reopen under specific regulations in smaller red-light districts, including Chiang Mai. Most MWSW participants had relocated there for the time being.

4.5.2 Access and recruitment

I started seeking potential access for recruitment early in my research formulation. I first contacted the EMPOWER Foundation in September 2020. I introduced myself and explained my interest in their work over the phone. After my first-year annual review, I formally emailed an EMPOWER representative to present my project in

October 2021. She was aware of my interest in the sex worker community and indicated support for my research.

Following approval from the School of Health in Social Sciences ethics committee in January 2022 (see Appendix B), I sent my full study information and contact details (2 February 2022) to two NGOs (SWING Thailand and EMPOWER Foundation) that assist and help sex workers in Bangkok, Phuket, Pattaya, sometimes known in the media as “the red-light cities”. I received a reply from EMPOWER, agreeing in principle to participate and support my research. The EMPOWER representative mentioned that little academic work was being conducted on migrant sex workers, particularly concerning the health and well-being of women. Despite several follow-up emails, I never received a reply from SWING Thailand, perhaps due to their office being closed during the pandemic.

This study involves hard-to-reach populations and sensitive or hidden communities, namely, migrant women sex workers. Typically, gatekeepers are required to find these research participants (Dewey & Zheng, 2013). With that in mind, I contacted the local EMPOWER Foundation, which works for sex workers' rights in Thailand, via email and online meetings. This first point of contact was important for building trust in the purpose of the research, and also in me as a researcher.

EMPOWER does not have a formal ethics board; however, I presented them with the university's ethical clearance approval. This allowed EMPOWER to have a clear understanding of the purpose, risks, and potential benefits of my proposed research. The EMPOWER management made an informed choice to support the research by providing recruitment information to potential participants (Sinha, 2017).

They gave permission for their workers to leave my research information sheet and contact details in the EMPOWER reception areas and outreach clinics. They then hosted a meeting (February 3, 2022) from their office via Zoom to introduce my research and to offer the opportunity for me to answer questions from individuals interested in participating in my research. Fifteen MWSWs and four service providers attended the meeting. Three MWSWs, who could not read Thai, were still able to communicate in Thai effectively. EMPOWER staff supported them during the session.

Support involved clarifying or rewording to attain a better understanding of specific Thai words or academic terminology, which the participants found hard to take on board. Some of the concepts were translated by EMPOWER staff or simplified to make them more familiar. One of the EMPOWER staff members used one of the local languages that was also spoken by the MWSWs. This process took time, but contributed to everyone on the call being able to clearly understand the content of the study. Such culture and language-sensitive support was essential to facilitate informed involvement with the study and to foster trust.

Following this meeting, those still interested in participating informed the EMPOWER representative, who gave them my contact details. To maintain privacy and professional boundaries, I used a separate phone and SIM card specifically for the research, distinct from my personal number. Individuals contacted me at this number, and we discussed my research further before initial verbal consent was given to participate (see Appendices C and D). After the meeting, I had several individual discussions with two EMPOWER staff who work as coordinators and human rights workers. They provided insights and advice to help prepare me for how to conduct research with MWSWs without exploiting them (Sanders et al., 2009).

I was uncertain about the number of MWSW participants I would need to recruit to achieve data adequacy or saturation (Braun & Clarke, 2021) for my research. Once data collection had begun, several of the MWSWs I had spoken to recommended other MWSWs they knew. It was a snowballing technique in practice. Participants informally spread the word about my study to other MWSWs in their circles. Those interested then contacted me directly through the research phone number that study participants currently in the project had shared. This approach enabled participants to be the agents of recruitment, as well as ensuring that contact was on a voluntary basis and kept confidential (see Appendices E and F). Those additional MWSW participants did not come directly through the EMPOWER gateway (from the online meeting on 3 February 2022), though they had previously received support via outreach teams in their workplace. I continued sampling until the data provided answers to my research questions (Malterud et al., 2016).

In all, 39 participants volunteered and satisfied the research criteria. Seven were service providers, four were service provider/sex workers, and 28 were MWSWs (Tables 4.1 and 4.2).

Table 4.1: Socio-demographic characteristics of Migrant Women Sex Workers (MWSWs) (N=32)

Characteristic	Details	Number of Women
Age	Median (range) 36 (24–50)	
Country of origin	Myanmar	31
	Laos	1
Migration status at time of interview	Documented	23
	Undocumented	9
Health insurance status at time of interview	Migrant Health Insurance Cards	11
	Social Security Scheme	6
	Uninsured	15
Education level	Primary School	11
	Secondary School	10
	High School	3
	No Formal Education	8
Years working as a sex worker in Thailand	Median (range) 8 (3–29)	
Place of work	Bar	11
	Massage Parlour	5
	Brothel	5
	Freelance	4
	Ago-go Bar	4
	Karaoke	3

Table 4.2: Socio-demographic characteristics of Service Providers (SP), (N=7)

Characteristic	Details	Number of Women
Age	Median (range) 48 (30–67)	
Education level	Primary School	2
	Secondary School	2
	Bachelor's Degree	3
Years working with sex worker groups	Median (range) 10 (8–30)	
Organisations		
	MAP and EMPOWER Foundations	1
	EMPOWER Foundation	6

4.5.3 Research participants

The key participants in this study were MWSWs and EMPOWER service providers (staff/volunteers). Four of the participants were self-identified active MWSWs who also worked with the EMPOWER outreach team.

Dewey and Zheng (2013) suggested that it would be more beneficial for interviewees if the interviewer were of the same gender when discussing women's health issues, including reproductive health. The same research challenges applied to my decision to limit my research to female sex workers rather than include male sex workers, placing them beyond my study focus.

Sanders (2006) highlights the distinct challenges faced by female researchers when conducting research on female sex workers, particularly in negotiating how the researcher's gender and identity interact with their dialogue with participants, and subjectivity in the analysis. During my research, I practised ongoing reflexivity by writing a research journal (see Appendix G), in which I documented my interactions, affective responses, and how these modified over time (section 4.10). This practice

has also been important for examining my assumptions, biases, and how my identity as a Thai woman and registered nurse has impacted participant engagement and data interpretation.

This process of reflexivity made me acutely aware of the power relations in my role as a researcher. It led me to try to mitigate researcher intrusion by enabling participants to take more control over the interview process and prioritise their narratives over my own lenses of analysis. Reflexivity also aided in refining my questioning techniques as I ensured that I was open-ended and not leading, to capture accurately participants' descriptions of their healthcare access. This reflection has more broadly shaped my practice by instilling an ethically aware, participant-centred approach whereby, rather than imposing an external analytical lens, I strived to adapt my methods better to reflect the lived realities of MWSWs.

Inclusion criteria

The study's inclusion criteria for staff/volunteers were their experience delivering care and outreach work to MWSWs. There was no formal education requirement. However, I recognised that a combination of social workers, health providers, and volunteers was suitable for drawing out the breadth and fullness of this group's interpretations, perceptions, and opinions.

MWSW participants had to have had previous contact with EMPOWER Foundation, whether direct or agency-connected. This criterion was placed to ensure at least some shared consciousness or involvement with sex work advocacy, rights, or support mechanisms. The EMPOWER Foundation is one of the leading agencies that has built up relationships with MWSWs in Thailand over many years (EMPOWER, 2012). I hypothesised that due to the established position of EMPOWER and their support for my research, participants recruited through their network would feel a sense of trust, safety, and openness on sensitive issues, such as stigma, discrimination, and healthcare access. Though such a relationship alone could not ensure participants' trust, it facilitated a friendly research environment, which probably afforded comfort to the idea of taking part in the study.

Nevertheless, I am also aware that my snowball sampling method resulted in the recruitment of several sex worker participants who had little or no direct experience with EMPOWER. Although these participants did not strictly adhere to the original inclusion criteria, I found their insights helpful in understanding any variations in access and support experienced by MWSWs outside of advocacy groups. This led me to refine my sampling strategy to include some participants representing these viewpoints, while maintaining a larger pool of individuals with some knowledge of EMPOWER's advocacy and service.

The inclusion criteria for staff/volunteers were:

- Working as a service provider (social worker, health provider, volunteer) in EMPOWER
- Female aged 18 years or older (Under Thai law, a person under the age of 18 is classified as a minor.)
- Has some experience in delivering services to migrant women sex workers (to find trends and see patterns among women sex workers)
- Volunteers to participate in this research
- Thai speaker

The inclusion criteria for sex workers were:

- Lao, Burmese (Myanmar), and Cambodian migrant women living in Thailand for at least 1 year. I used this one-year period to recruit MWSWs who will be conversational in Thai, sufficient to elicit meaningful insights into experiences in accessing healthcare. The one-year criterion avoided the inclusion of potential participants who might be more vulnerable (e.g., recent arrivals who may be less able to speak the Thai language, be unfamiliar with healthcare systems, or be more fearful of trafficking). This criterion aimed to protect participant safety and autonomy.
- Female aged 18 years or older
- Conversational Thai speaker
- Has been selling sexual services regularly for money or goods for one year or longer

- Volunteers to participate in this research.

4.5.4 The language used in the interviews

The MWSW participants spoke Thai well enough, at least conversationally, which rendered a translator unnecessary. I interviewed one service provider participant from Australia in English. The initial interviews, which included four service provider participants, helped me situate my understanding of the way healthcare is accessed and discussed between healthcare providers, advocacy workers, and sex workers. Although sex workers themselves best describe their experiences and terminology, these early conversations helped me pinpoint the ways in which institutional language may not align with sex worker perspectives. This preparation allowed me to develop a more supportive and responsive interview environment for MWSWs and conduct conversations better attuned to how participants conceptualised their own experiences (rather than imposing external language on them).

The University Ethics Committee approved my interview guide questions (see Appendix H). I then translated them from English into Thai. I field-tested the interview questions with one service provider (a registered nurse) and one former sex worker from the EMPOWER Foundation to ensure the language was understandable and relevant to MWSWs. These field-test interviews were conducted separately and are not included in the total of 39 interviews used for data analysis. The EMPOWER worker confirmed that sex workers would recognise the terminology I used and that my phrasing was consistent with how participants speak about their experiences. Working with the service provider on my field testing, I realised that some of my wording from the original draft, mainly medical terms related to sexual health and healthcare services, may be too technical or unknown to MWSW participants. Consequently, I simplified specific medical or clinical language to more familiar terms. I also reworded a few of the questions to ensure they were concise, clear, and more conversational, steering clear of jargon and overly formal sentence structures that might serve as barriers to open discussion. These refinements helped to ensure that participants would quickly understand and be able to engage with the questions, making for a more fluid and accessible interview.

I also compiled a glossary of terms identified by the EMPOWER worker to ensure consistency and accuracy in interpreting responses. Though it took time, each stage was essential to my understanding of the ethical and cultural context in which I was building my research. At the beginning of the MWSW interviews, the use of certain words to describe sex work in Thailand was agreed upon by both the participants and me to improve my understanding and ability to capture data while maintaining ethical standards during the research (Sanders, 2006). MWSWs stated that they were comfortable with words like '*service worker, ' service girl* and '*entertainment work* or *entertainment industry*' to denote their occupation. Throughout the interview, I used as simple words as possible, primarily with the MWSW participants, to ensure they understood the questions easily.

When MWSW participants were hard for me to understand, I asked them to repeat or explain in more detail. Similarly, if the participant did not understand me, I encouraged her to ask me to explain in another way. Another technique I employed to check the interviewee's understanding was follow-up questions. Bryman (2008) advises that interviews in non-native languages can result in misunderstanding. Even though the MWSWs understood some Thai, some of the words, including medical terms, were unfamiliar to them. This highlights the importance of conducting interviews that respect participants' contexts, ensuring that the conversational nature allows for the full expression of their experiences (Bryman, 2008).

4.6 Methods of data collection.

4.6.1 Semi-structured Interview

I conducted semi-structured interviews (n = 39) with open-ended questions, using the interview guide for MWSWs and service providers (see Appendix H) to gather rich data on participants' experiences. I created different interview guides for service provider participants and MWSWs based on my research aims. Highly subjective, open-ended questions allowed participants to tell their own stories with minimal interventions from me to achieve as complete and accurate data on their perspectives as possible. My interview guide covered facilitators and barriers to accessing general healthcare for MWSWs and recommendations/suggestions for improving access for the benefit of individuals and public health. It also contained

questions on specific healthcare access and health needs of MWSWs. Open-ended interviews increase credibility because the research participants answer questions in their own words and terms, verifying their experiences (Seidman, 2013, cited in Serrat, 2021). Similarly, Bryman (2008) argued that this approach helps interviewees to discuss specific topics or issues in more detail. The interviewer can also create additional questions and probes related to the participants' answers (Elmir et al., 2011). The processes of the interview were co-constructed between the participants and me as an interviewer. This flexible approach enabled participants to describe their experiences in their own words, and for me to respond and prompt from a perspective that reflected theirs. Hence, the interviews made possible a rich and personal narrative that was co-produced with a participant's life-narrative and helped in exploring the research questions from within participants' lived experiences.

I chose the LINE application and telephone interviews for several reasons. Firstly, the COVID-19 restrictions limited movement and social interaction. I could not go to participants' workplaces for face-to-face interviews. Importantly, interviews could be arranged at times that suited participants, such as MWSWs' work patterns and some staff/volunteers who worked at night in outreach clinics. Most MWSW participants selected their own room, park, or coffee shop as their location for the online or telephone interviews. Remote interviews reduced travel costs, especially for MWSW participants during the pandemic restrictions. Most of them were earning less income than during normal times.

Another main reason I used the application LINE/ telephone was my awareness of the legal and social insecurity of MWSWs, in terms of their migrant status and involvement in illegal sex work. Interviewing them in their work or home environments might have attracted scrutiny and unwanted attention from authorities, or potential conflicts with employers, clients, or family members. Moreover, discussing sensitive topics in an unmediated environment may have raised their emotional upset, or in which they did not feel safe to be open about their experiences. As a researcher, I also needed to weigh up my own safety within fieldwork, notably travelling into unfamiliar locations might have been high-risk.

By collecting interviews through LINE or over the phone, I mitigated these risks while guaranteeing the privacy of participants and maintaining their confidence in the process. This approach was consistent with the ethical principle of minimising harm and protecting vulnerable populations (Shaver, 2005) and established respect for the principle of voluntary involvement in a non-coercive environment (Mealer & Jones, 2014). I was careful to ensure that participants felt safe to express themselves in our interviews without fear of pressure from the world outside. It is ethically appropriate and creates a climate where they can share their experiences without fear of punishment or risk.

4.6.2 Interview process

Fieldwork was carried out at a time of continued COVID-19 restrictions and widespread suspicion of social interactions. This complicated the task of scheduling interviews that I had initially planned to conduct in person. However, the limitations also revealed the resilience, innovation and flexibility of my participants and myself to find solutions within the challenging situation.

While all fieldwork interviews took place online or by phone, I installed myself in a hotel in Chiang Mai to get a picture of the local communities where many MWSW participants were living and working. I felt it was necessary to get to know the sites and references, such as the bars, massage shops, and go-go bars, where many were working at the time of my study.

Similarly, the office of EMPOWER is located in Chiang Mai, and I had an interest in seeing how MWSWs engage with this NGO, and how the physical location and neighbourhood environment affect their access to support and services. Although I could not meet with EMPOWER staff or participants in person, given restrictions, actually basing myself in the city provided me with a more vivid picture of the world my participants live in, and it made my interviews and ensuing interpretation of data all the richer.

Participants could select their interview method, whether online, using LINE (audio or video), or through a mobile phone. I interviewed 39 participants, 37 of whom were

interviewed via LINE in video mode and two via telephone. I gave participants full control of their visibility so they could choose to have their phone camera on or off at any point during the conversation.

The ability to turn off video was a significant advantage to this platform. For some, establishing video contact at the start of the interview may have facilitated initial trust and rapport, whilst switching it off later created a sense of safety and anonymity when discussing more vulnerable aspects of their experiences. The flexibility facilitated greater openness regarding discussion points, as participants could self-regulate their emotional and psychological comfort levels during the interview. The interviews were recorded using an external recorder. Interview lengths varied, with an interview lasting on average about 60 minutes (a minimum of 34 minutes and a maximum of 120 minutes).

One interview with a MWSW participant lasted about 4 hours, including a brief 10-minute break. She wanted to share her life story in depth. She spoke very candidly and openly about her experience. The prolonged duration, which was rather unexpected and even emotionally overpowering for me as a researcher, highlighted the necessity of creating space for the participant's story. In the context of not being able to leave the house and with everyone in pandemic isolation, I realised that her interview also became a moment for contact and expression for her. I saw this as an ethical issue and, in the spirit of qualitative research, as a place where participants' experiences are heard. This experience also enriched my awareness of the emotional and structural complexities experienced by MWSWs and illustrated the importance of compassion when conducting research with vulnerable populations.

I was aware that researching sex work could touch on some sensitive topics (Sanders et al., 2009), especially concerning Thailand's legal and social context. Sex work is criminalised, and nine of the MWSW participants were undocumented immigrants, putting them in a doubly marginal and vulnerable position. This made recruitment ethically and politically complex due to their legal and social vulnerabilities (Sanders et al., 2009). I needed to consider confidentiality, informed consent, and participant safety while recruiting participants and collecting data. I discuss these ethical considerations in more detail in my ethics section (Section 3.8), where I elaborate on

the measures I put in place to minimise the risks to participants from my study, including secure means of communication and storing anonymised data.

MWSWs' marginalised and legally precarious status complicated the application of conventional recruitment practices. Most potential participants were reluctant to participate in research formalities for fear of exposure, stigma, or legal consequences. This meant I used a trust-based recruitment approach, drawing upon existing networks within the EMPOWER Foundation, leveraging peer referral through a snowball sampling approach. Such orientations were important to minimise recruitment barriers while allowing participants to feel secure in their decision to participate in the study.

In the interviews, I framed participants as experts about their own experiences and helped to ensure that the process was more participant-led than rigidly structured. I used open-ended questions like: "*What brings you to Thailand*? and "*Can you tell me about your experiences in the sex work (service work) and entertainment industry?*" before delving into more issue-specific debates on healthcare experiences. Follow-up questions were revised according to participant answers, so discussions could flow freely and naturally, allowing time to elaborate on issues that they deemed significant.

This semi-structured, narrative-driven method blurred the lines of any researcher-imposed directionality that might occur while participants shared their personal experiences, goals, and visions in a way that allowed trust and rapport to be established with participants. In addition, encouraging participants to guide the conversation was an ethical research practice that respected them as agents and avoided a sense of interrogation or external judgment (Brinkman & Kvale, 2018).

Initially, I interviewed four service providers and then six MWSWs. After these interviews, MWSW participants referred me to further MWSW individuals who were interested in my research. I received direct inquiries from ten MWSWs. I knew they had all been supported by the EMPOWER outreach team, either directly or indirectly, at some point before my research. However, some had distanced themselves from the organisation because of the nature of their sex work venues or their personal circumstances. Some asked me not to disclose their involvement to EMPOWER, underscoring some power dynamics in their relationship with advocacy organisations.

This was despite them having received support in the past and implied that they wanted to determine their participation free of the influence or visibility of the outside world. Some may have feared that they would be judged and surveilled or that an institution they were no longer in touch with might be too involved in their lives. Others might have wanted to remain fully anonymous in discussing their access to healthcare and their experiences with it. I assured them that their interviews would remain confidential, separate from EMPOWER, and would be completely voluntary. They could shape their own narratives and control how their data would be used.

The majority of MWSW participants expressed fears that I would ask for their photos or addresses. Others worried I might send the authorities to them. These were undocumented migrants from Myanmar who had been in hiding for up to 15 years from the Thai authorities, but they wanted to come forward to give first-hand accounts of how challenging it is for them to access healthcare in Thailand.

Seven MWSW participants contacted me after their initial interviews, requesting a follow-up interview. These second interviews were not part of my original research design. However, at the end of each first interview, I informed participants that they were welcome to contact me again if they had any further questions or wished to share more. It was an open-ended invitation that some chose to take up. The follow-up requests were entirely participant-driven. The reasons were as varied as the people behind these voices. In general, they all wanted to revisit something they had said during our first conversation, or pursue the conversation further from where it left off, or they wanted to go deeper into their back stories and share new reflections that had popped up after our initial interview. These later interviews took place after I had returned to the UK and were online interviews.

Participants had not seen my initial analysis or transcripts, so their follow-up engagement was not a response to my interpretations but rather a participant-driven effort. However, the richness and depth of the second interviews led me to revise some of the initial topics and emerging themes. This revision was based on the new insights participants provided, particularly around issues such as identity, emotional labour, and informal healthcare networks that were not fully captured in the first interviews.

These follow-up interviews led me to ponder the possible utility of providing a second interview to other participants within a more revisiting and dialogic approach for qualitative data collection. Although I was unable to do so for the entire sample due to timing and logistical constraints, this process provided clear evidence of the value of allowing participants agency and flexibility as part of the research design.

4.7 Data analysis process

In this section, I discuss translation and interpretation, and my concerns during the translation process. I reflect on how I conducted the initial thematic analysis and then how I refined my analysis framework by combining thematic and intersectionality analysis.

4.7.1 Translation and interpretation

There were some challenges throughout the translation process as I interviewed in Thai and presented my findings in English. I acknowledge how essential it is to illustrate honestly what the participants experienced so that readers can also understand (van Nes et al., 2010). In this context, translation involves more than simply converting words from one language to another. It is a complex process that requires interpreting the meaning of the original Thai statements and bringing that meaning into English without distortion (Suriya, 2022). During the research process, I maintained the analysis in Thai for as long as possible to ensure that the transcript remained genuine and contained original content.

General challenges of the translation (Thai into English) are encountered, especially in the grammar of the languages. For example, English requires a specific tense for every verb. Thai takes a more contextual or time marker-based approach to verb tenses. Therefore, I needed to meticulously build an intelligibility bridge between the languages to capture the essence of the insights and experience being revealed by my participants. For example,

เมื่อก่อนฉันไม่เข้าใจภาษาไทย [Thai transcription]

Before, I don’t understand Thai. [word-by-word English translation]

I didn’t understand Thai before. [my translated data]

Here, the verb เข้าใจ (understand) is again in the present tense in Thai, but in English, grammatical rules dictate that it should be past tense (did not understand) to be in keeping with the time marker “before.” The obligation of my translations is to convey the original element in its context.

I aimed to communicate faithfully participants’ lived experiences while staying as authentic as possible to the essence of their words. To remain true to translation and interpretation, I cross-referenced my translated transcripts with surrounding dialogue in the audio recordings, sought out implicit cultural references, and eliminated or corroborated ambiguous phrases. This process facilitated the retention of linguistically accurate and nuanced meanings from participants’ stories.

I stay reflexive and open about the consequences of my decisions as a researcher and translator, recognising that translation is not a neutral act but a process that necessarily influences the representation of participants' narratives about their healthcare access. To avoid this, I cross-referenced translations with the original Thai transcripts, considering their context, tone, and intent to represent participants’ voices as closely as possible.

Reflexivity is critical in translation. As van Nes et al. (2010) suggest, I first analysed data in Thai, which I believe helps retain the original context, and when I had formulated some insights, I conveyed them in English. Following Temple and Young (2004), I note an interpretive influence during the translation process. I strive to be transparent about this, noting my translation decisions in my translation diary and also being able to regularly consider how my own culture, language, ways of thinking, and expression influence my interpretation.

A further challenge in translating is to balance confidentiality with accuracy. Temple and Young (2004) emphasise the ethical need to protect participant voices without compromising confidentiality. In translating quotes from Thai, I anonymise specifics but select vocabulary with precision to ensure that readers receive the meaning the

participants want to convey. As a translator, I kept asking myself*: "What is the participant telling me that she did or felt?*

The data was first organised following transcription using NVivo (version 12). I anonymised participants using number codes at this stage of the transcription and translation (Thai to English). However, as I started to follow up on my preliminary findings and find themes, I felt that participants deserved to have a name, both for confidentiality and also in the sense that they are here with me for the research. This modification was made to adopt a more humanising and positive way of representing participants' stories.

While I did investigate the feasibility of trying to learn and implement NVivo in relation to coding and managing the data, I discovered that understanding such a program is a complex matter and would have added too much time on top of translation/interpretation during my review. I therefore opted to manually work with my data, using Word documents to code and sort themes. This was an approach that helped me remain close to the data, and that afforded me greater freedom in developing my thematic analysis. NVivo did do some of the early organisation, but the majority of my analysis was carried out in a manual way that probably suits my working and interpretative style better.

4.7.2 Thematic analysis as an analytical framework

I initially employed thematic analysis (TA), following the processes outlined in Braun and Clarke's (2022), *Thematic Analysis: A Practical Guide*. However, as I continued to explore the often delicate and multilayered stories of the MWSWs, I encountered a number of challenges that led me to adopt an intersectionality analytical approach to better capture the depth of the data. In this section, I discuss my challenges during the analysis, reflecting on the stages of familiarisation, coding, theme development, and writing up, as framed by Braun and Clarke's (2022) work.

All participants' identifiable information was coded and available only to me in transcript form. I translated four full interviews into English for my supervisors to review and for us to establish a preliminary understanding together. However, I worked with the Thai language datasets in the data analysis process. I intentionally only translated

the quotations explicitly connected to my final codes and themes into English so that the most relevant findings could be communicated without compromising the richness of what the participants expressed in their original language.

Braun et al. (2019) suggest using the TA method, which can identify patterns of meaning across a dataset, to address a research question. Patterns are determined through systematic data familiarisation, coding, generating themes, and review. The TA approach was appropriate for my first sweep of analysis. It opens up a descriptive dimension based on how the participants make sense of their world, which enables them to give more open answers to my research questions.

The initial thematic analysis process

Step 1: Familiarisation with the data

In the initial stage, I read and re-read, and re-listened to each participant's accounts to familiarise myself with their experiences. This allowed me to discover both nuanced personal stories and the structural and systemic elements that convey how social and political contexts impact access to healthcare for them. This iterative process revealed a common set of perceived or experienced barriers, including language limitations, dependence on peer navigation, and variability in healthcare professional empathy.

Step 2: Generating initial codes

I coded my data manually in Microsoft Word form and used the NVivo program 12, with an emphasis on the shared culture of the participants and the ways their experiences differed from mine. Taking a constructivist and relativist approach, I did not extrapolate beyond each account and recorded them as context-specific narratives.

I recorded my reflections and thoughts during coding and documented initial impressions. I kept in mind how differently I might see a phrase like “reluctant to seek treatment” from my experience as a Thai healthcare professional. For example, participants might have reasons behind their decision to seek healthcare or avoid it that would not be obvious to me as a nurse. This reflexive practice helped me identify

potential biases and ground the analysis in the participants' voices rather than my professional assumptions.

The coding process provided a directed approach to identify and define essential facets of healthcare access as expressed by each participant, but also to detect similar and different themes across each dataset. This enabled me to record details of the participants' experiences, including language barriers, dependence on informal support networks and degrees of discrimination in healthcare encounters. I did this using both semantic coding (focusing on what was explicitly said, e.g., "*language barrier*," "*reliance on translation assistance*") and latent coding (examining what was meant e.g., "*fear of seeking help*," "*perceived neglect*").

I was concerned about potential bias in interpretation due to my familiarity with Thailand's healthcare system, particularly those narrated experiences concerning empathy, support, and perceptions of neglect. I therefore made it a discipline to focus only on the voices of participants during the entire process of coding. Recurring codes in the sample, such as *"language barriers*" and "*confidentiality*", indicated structural barriers that were unfamiliar to me as a Thai citizen, but relatable as a professional. As I aimed to honour the participants' voices when interpreting findings and limit the impact of my healthcare experience, I used emic terms deriving from participants. For example, the first NVivo code, "*didn't understand what they talked about*", came directly from participant pseudonym, Ratchanee, and allowed her voice to remain at the forefront.

In order to strengthen an approach rooted in participants' accounts, I continually revisited the verbatim transcripts. I went back and forth, refining the codes over several rounds to ensure depth and specificity and that they were as closely aligned as possible with my research questions. Nonetheless, I became aware of tension between this pre-determined approach and my reflexive, iterative approach as my analysis progressed. I created three main groups of codes, conveying the participants' diverse perspectives.

Table 4.3: Emerging Codes

MWSWs' narratives	The codes reflected individual challenges MWSWs faced in healthcare access, such as *language barriers, fear of seeking help,* and *dependence on translation assistance.*
Support systems and peer assistance	The codes highlighted external support, such as *peer support*, *translation services*, and *community organisations,* that helped MWSWs navigate the healthcare system.
Service providers' perspectives	The codes illustrated institutional responses and challenges providers encountered when supporting MWSWs, such as *service adaptations*, *provision of language support*, and *discrimination awareness*.

Semantic and latent coding enabled me to identify the explicit challenges MWSWs faced (such as *language barriers*) and the underlying issues (such as *social stigma and fear*) that framed their experiences.

Step 3: Searching for themes

Through the coding process, I was then able to identify themes that could demonstrate broader patterns across the datasets, including experiences with language, social stigma, and immigration status. I tried to anchor each theme within the data as much as possible, letting the participants speak through it. This resulted in a theme like *"Healthcare system navigation challenges and communication barriers*". To keep the analysis focused on the participants' lived realities, I avoided clinical terminology as much as possible, as it could create distance between participants and their labelled experiences, instead using descriptive, participant-centred labels (e.g. *Feeling left out of medical conversations*). Seven central themes emerged (Table 4.4)**.**

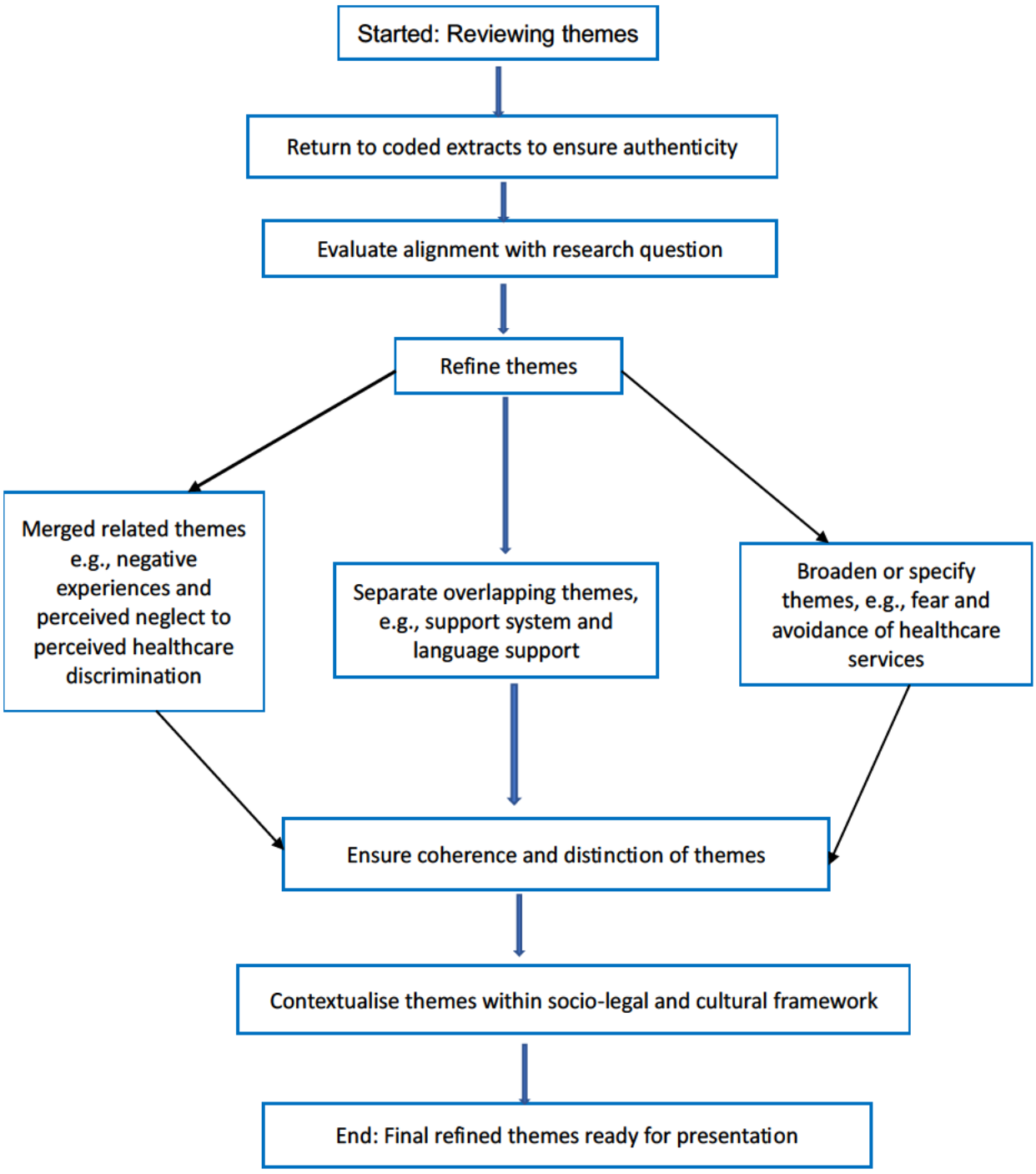
Table 4.4: The initial analysis themes

Language as a barrier to access	Challenges related to language differences affect the participants' comprehension and healthcare access.
Fear and avoidance of healthcare services	MWSWs' reluctance to seek care due to past negative experiences, social stigma, and language obstacles.
Support systems and peer assistance	The role of peer networks and external organisations in helping MWSWs navigate healthcare access challenges.
Perceived healthcare discrimination	Instances where MWSWs felt marginalised by healthcare providers, often due to their migrant status.
Availability and impact of language support	The importance of language assistance in enabling adequate healthcare access.
Accessibility and adaptability of services	Improving healthcare access, including mobile outreach programmes and workplace health visits.
Experiences of empathetic and supportive care	Instances of empathy from healthcare providers, showing the positive impact of compassion on MWSWs' experiences.

I made visual thematic maps to visualise how these themes intersected with each other to impact healthcare access, for example, the connection between *"Language as a barrier to access*" and *"Fear and avoidance of healthcare services".*

Step 4: Reviewing themes

I reviewed each theme to assess applicability, clarity, and consistency, see Flow diagram 4.1. To this end, I returned to all coded extracts at the latter stages of my analysis.



Flow diagram 4.1: Reviewing and refining themes

I examined whether each quoted extract reflected the participant's authentic experiences and whether the themes answered the research questions linked to them (Braun & Clarke, 2006). This resulted in the refinement, combination, or separation of

themes to capture the complexity of the data. Each participant's unique story was framed by social constructs such as healthcare policies, language, and the illegality of sex work. so I used both the individual narratives and each participant's broader socio-legal and cultural context as a guide to isolate their similarities and differences. For example, participant Arisa mentioned avoiding healthcare because she did not speak Thai well enough and had no documentation. Rather than making broad statements, I opened up the space for the compound experiences of each woman. This approach supports a constructivist perspective that each experience is socially constructed and contextualised.

As Braun and Clarke (2022) described, I ensured each theme was coherent within itself and that themes were clear and distinct. The iterative nature of the review process allowed me to avoid over-inclusion or over-specificity.

Step 5: Defining and naming themes

After the themes were identified, I outlined definitions for each one. I aimed to make labels consistent with what participants would highlight within the context of social, political, and other conceptual influences on their experiences. I used the theme names to display the participants' experiences and underscore structural elements that influence their experiences.

Each theme needed careful definition in order to be clear and precise enough to pick out the relevant aspects of participants' practical and emotional experiences. During my analysis, I strived to balance richness of description - how participants spoke about their discomforts around healthcare providers - and interpretative depth. I gave context to participant quotes with explanations, for example, of healthcare policies, language barriers, and documented/undocumented status. Using this analytic style brought out how structural aspects affected the care of each participant without my bias influencing their stories.

Step 6: Producing the final report

I included an integrated narrative of themes from participant datasets into a draft findings chapter. The quotes presented were representative of shared experiences as well as areas that differed. They also conveyed how language barriers, discrimination,

and empathy interplay to shape MWSWs' experience of access to healthcare. I present the TA themes in Table 4.5.

Table 4.5: The final TA themes.

Before accessing healthcare	After accessing healthcare services
Language as a barrier to access	Experiences of discrimination and unfriendly attitudes
Fear and avoidance of healthcare services	Consequences of miscommunication on health
Lack of accessible healthcare information	Perceived healthcare discrimination
Support systems and peer assistance	Availability and impact of language support
Need for support services (e.g., Translators)	Accessibility and adaptability of services
	Experiences of empathetic and supportive care
	Inconsistency in healthcare support
	Confidential and inclusive healthcare

Inductive thematic analysis was well-suited to highlighting recurring features, including the barriers to using healthcare, fear of healthcare, and perceived discrimination. However, I sensed that it did not capture and convey the underlying interconnections of the participants' experiences. In the 'limitations of TA', I commented that although TA organises experiences around themes, it risks oversimplifying diverse and complex data. For example, *"Language as a barrier to access*" draws attention to communication challenges, but it fails to capture how this intersects with gender and migration status to create a distinct, compounded exclusion. In the same way, *"Fear and avoidance of healthcare"* is driven by language barriers as well as by stigma surrounding sex work and fear of criminalisation.

I shared my preliminary analysis with my supervisors, and we decided to embed an intersectional perspective into the thematic analysis. Instead of coding an additional analysis, I introduced the intersectionality perspective and theories. I used them to

develop and deepen my understanding of the themes emerging from the data. This approach enabled me to account for the varying, intersecting forms of marginalisation experienced by MWSWs, resulting in a more refined appreciation of their lived experiences.

In doing so, I moved beyond simply summarising participants' accounts to understand better the complexity, reflexivity and trustworthiness of their narratives against the backdrop of broader social, legal and structural realities. I describe this combined thematic-intersectional analytic approach in detail, including how this lens opened a more granular, and contextually positioned reading of the data.

4.7.3 Re-analysis process using thematic and intersectionality approaches.

Although my initial thematic coding framework highlighted recurring patterns across the data, bringing in an intersectional lens enabled me to code the data more sensitively by foregrounding how multiple forms of marginalisation shaped participants' access to and experiences of healthcare. Intersectionality prompted me to refine my codes to reflect not just more prominent themes but also the specific intersections between gender, migration status, illegal work, and conditions at work. This led to a coding process that was much more contextually situated and critically minded so that power dynamics and systemic inequalities were adequately embedded in my thematic structure, as opposed to being secondary observations.

The data revealed that power systems, such as legal contexts (sex work and migration), social rules (regarding sex work and sex workers), and public policies (regarding the Universal Health Coverage schemes), do not operate in isolation. Instead, these interact with each other to exacerbate the marginalisation of already vulnerable MWSWs in this study. An integrated approach assists in understanding not only barriers but also opportunities these MWSWs may discover among themselves and which could contribute to the development of structural changes within Thai healthcare policies. The following section discusses how my re-analysis process uses the dual analysis framework.

Step 1: Familiarisation with the data: Language and cultural nuances

The personal experiences I collected were full of linguistic and cultural complexity. Since my research participants were interviewed in Thai, transcribing and analysing the data required meticulous attention to meaning, tone, and cultural context. Whereas thematic analysis enabled me to record generalised trends in healthcare access, it was through reviewing the data through an intersectional lens that I began to capture the nuanced complexity of these accounts. I recognised how language itself is a site of power and exclusion that shaped how MWSWs expressed their healthcare experiences.

For example, participants frequently characterised their engagement with services in terms that embedded their intersecting vulnerabilities as migrants, as sex workers, and as people facing legal and social impediments. Their accounts of barriers to healthcare were not just logistical or policy-related. Instead, they were illustrations of how multiple systemically marginalised identities influenced their fears, coping strategies, and what they expected from healthcare providers. All these nuances would likely have been flattened as generic barriers had I not applied an intersectional lens to this research.

Step 2: Generating initial codes: balancing inductive and deductive approaches

The challenge during this phase was coding sensitive narratives in a manner that was able to contain the complexities of intersectional realities. Since I had first approached the data inductively - allowing codes to emerge from participants' words and experiences - it was hard at first to see patterns of intersectionality because participants did not often discuss their lived experiences in terms of multiple, overlapping oppressions. Instead, the challenges they described were fragmented: They talked about gender discrimination, their legal status, and their occupation separately rather than connecting them in their narratives.

Whereas thematic codes presented themselves somewhat organically from the data, an intersectional analysis necessitated that I take a more deductive, theory-based approach to acknowledge how these experiences intersected with and compounded one another. If I had created a single "intersectionality" code, it would have been too reductive because intersectionality is not an individual theme but rather a lens through

which to view relationships among various forms of marginalisation. I returned to my codes. I reworked them with an intersectional lens to ensure I did not treat themes as discrete categories but as woven structures that informed participants' experiences of the healthcare system.

Braun and Clarke (2022, chapter 3) detail the necessity of recursive, iterative coding, which weaves a narrative inductively interpreting into specific insights contributing to broader, overarching conclusions. Indeed, this flexibility was crucial as I often revisited my codes to locate them across a kaleidoscope of MWSW experiences. This simultaneous multi-dimensional analysis was both time-consuming and mentally taxing to do while coding.

Aspects such as "*language barriers*" and "*reliance on others to translate*", were just some codes that demonstrated how communication was an important part of participants' healthcare experiences. Although I was aware of power imbalances in a medical context as a nurse, the intersectional lens I brought to the data exposed additional ways in which men's and women's experiences may differ due to their gender, legal status, and migrant identity. When MWSWs with little or no Thai in an acute medical setting relied on translators, healthcare providers often missed or minimised their concerns, especially if the translator was not a professional or was their brothel or bar manager with their own interests to protect. These scenarios were important facets of linguistic and occupational disempowerment.

As a Thai woman from a rural farming family and raised within a Buddhist community background, I understood that stigma and discrimination are not only individual acts and prejudices but are also deeply embedded in cultural structures. This awareness allowed me to appreciate how participants' expressions of exclusion from healthcare were not solely framed around gender or sex work but were also shaped by healthcare providers' and their own internalised conceptualisations of factors such as their migrant status, their precarious economic situation, and their legal vulnerability connected to sex work. It also helped me frame why these structural and cultural factors, combined, make MWSWs' healthcare struggles distinct from those of other marginalised populations. In coding, I tried to mirror these nuanced experiences by

making sure themes were not siloed, such as “language issues” or “discrimination”, but instead informed complex access to healthcare.

Step 3: Searching for themes: finding, losing, and constructing themes
As I moved into theme development, the difficulty of capturing more complex intersectional identities and experiences became apparent. Participants often described their healthcare experiences in ways that reflected multiple intersecting layers of discrimination, making it difficult to categorise them into clear-cut themes.

In Chapter 4, Braun and Clarke (2022) discuss how the theme development is not linear and requires researchers to move beyond simply summarising the data. The process of “*finding, losing, and then finding your way again*” (Braun & Clarke, 2022, p.75) accurately described my journey, as I constantly refined and reworked my themes. I found that each participant's identity was a complex intersection of their context and time. This grounding demanded a more interpretative, reflective method than initially planned.

I patterned codes to reflect the social construction in the experiences described by participants as a step towards finding themes. Being aware of how my background may affect the way I identify themes, I included analyses of the Thai healthcare system, the details of migration policies, and the cultural perceptions about sex work.

For example, in developing the theme of *Speaking through silence: structural exclusion and healthcare navigation*, I considered how migration policies and healthcare regulations worked together to produce an interlocking set of barriers for non-Thai-speaking migrant sex workers. This identified that some obstacles were language-related but by logical extension rooted in legal and institutional contexts.

In tracing these interconnections, my analysis presented participants’ difficulties not just as private challenges or failures to find their way through the Thai healthcare system but as positioned within a broader system of structural constraints.

Step 4: Reviewing themes

When I was reviewing themes, I ensured that they represented the complex, essential, and layered nature of the participants' experiences. To acknowledge how these are affected by Thailand's migration policies, I created a broader theme which combined two distinct but interrelated issues, *language barriers,* and *legal vulnerabilities*.

Aspects such as "Empathy as an Exceptional Experience" relate to my understanding of healthcare dynamics. Coming from that perspective, I realised I had to treat this topic critically, as systemic factors (including limited time, institutional restrictions, stigma, and medicalisation of care) often dictate how healthcare providers interact with all patients. Instead of attributing variation in care to the attitudes of individual providers, I could place these gaps into the larger context of healthcare systems in which institutional constraints make it difficult for providers to deliver uniform, empathetic care.

This angle made it possible for me to comprehend how some MWSWs met compassionate providers, and others faced neglect or discrimination, not as chance or incidental events but as symptomatic of a healthcare system that structurally prioritises efficiency, bureaucracy, and normative patient-provider interactions. Understanding those systemic influences helped me view empathy as the aspirational standard of care rather than an anomaly, and simultaneously see why it may appear only when circumstances allow within the constraints of the healthcare system.

This reflection shows my constructivist stance. I acknowledge that social context shapes participants' experiences and that my positionality shapes my interpretations. As such, the analysis went beyond identifying themes to analysing the power and social relations that shape access to healthcare.

Step 5: Defining and naming themes

I continuously worked to ensure my interpretations captured how participants viewed issues and incidents, frequently using their descriptions to provide definitions that reflected their lived experience rather than my outsider view.

This approach is evident in the themes that emerged from my data, such as "*Speaking through silence: structural exclusion and healthcare navigation"*, which illuminates how language exclusion, legal uncertainty, and administrative design render these women misrecognised, depersonalised, and disempowered in their interactions with formal healthcare systems. Another theme was titled "*Excluded in plain sight: structural, symbolic, and social barriers to healthcare."* I discuss how participants navigate healthcare systems that are formally available but are perceived as threatening or inaccessible. Many women described being excluded not through direct denial of service, but through fear of exposure and possible deportation, language barriers, past mistreatment, and bureaucratic rigidity.

Step 6: Producing the redrafted findings chapter: balancing participant voice with analytical interpretation

Writing thematic analysis is not just recounting the stories within the data. It is an interpretative process whereby the researcher needs to construct the analytical story (Braun & Clarke, 2022). Writing up my findings proved difficult because I wanted to include rich participant quotes while needing to sufficiently interpret all quotes within my intersectional framework of TA. I wanted to be clear where the experience illustrated a structural problem. However, I also needed to illustrate how participants resolve and negotiate their way through those challenges to access healthcare services.

I was also charged with reporting potentially significant research findings that could challenge aspects of care provided by one or more of the healthcare providers. In Table 4.6, I present the final themes of thematic and intersectionality analysis, which are explored in detail in Chapters 5 and 6.

Table 4.6: Final thematic and intersectionality analysis themes.

Chapter 5 findings themes	Chapter 6 findings themes
Speaking through silence: structural exclusion and healthcare navigation *Subthemes:* • Exclusion through communication disempowerment • Symbolic misrecognition: being present but not seen • Systemic inaccessibility: institutional expectations vs. everyday realities	*Excluded in plain sight: structural, symbolic, and social barriers to healthcare.* *Subthemes:* • Structural fear and access are shaped by the interaction of formal policy and informal risk perception • Stigma, silence, and social risk: healthcare avoidance as survival
Survival and resistance: navigating through stigmatisation and discrimination *Subthemes:* • Hierarchies of exclusion in healthcare spaces • Stigma as structure—how healthcare marks and marginalises • Layered exclusion: gender, migration, and sex work in clinical encounters	*Informal care, peer networks, and dignity in the gaps* *Subthemes:* • Exceptional encounters with care providers • Peer-led navigation and informal support

While the addition of intersectionality deepened my analysis, it also made it more complex as I worked with it to ensure that I did not analyse themes in isolation and lose focus on particular intersections. While this analysis framework would need to balance depth and clarity to keep such intricacies manageable, it ultimately offered a more holistic view of systemic health inequalities within Thailand's healthcare system

for MWSWs. My analysis allowed me to identify and advocate for structural changes that might act on individual factors as well as structural, social, and legal inhibitions.

4.8 Ethical and methodological considerations

The data indicate that MWSWs are at the intersection of two marginalising processes stemming from the stigmatisation of both their occupation and migration status. As a result, they may not feel safe engaging with law enforcement, public institutions, or other official authorities because they fear being discriminated against, deported, or experiencing judicial sanctions (WHO, 2016). Given these realities around their life in Thailand, participation in research about their experience might add to their sense of vulnerability.

In response, I put various preventive protocols in place to keep individuals safe and cause no harm. I used confidential recruitment methods, secure communication channels for interviews, and anonymised data storage to eliminate identifying connections to the study participants. I also ensured that I sought informed consent, assuring that participation was voluntary, confidential, and that participants could withdraw from the study without any consequences. As such, I intended to mitigate the potential risk of exposure within a safe, non-coercive research environment and commit to ensure my study would not further marginalise or endanger participants (Bradbury, 2015; WHO, 2016).

I sought an ethical review from the University's Institutional Review Board (IRB) and then EMPOWER's agreement to engage and assist. The ethical approval reference number is NUST015 (20 January 2022). My research participants' wellbeing is at the core of my research strategy and was the driver for me to work with EMPOWER Foundation to reduce potential harm and offer support if needed (Sinha, 2017). To address risks linked to the undocumented status of participants, I carried out all interviews privately and confidentially, utilising secure communication lines via the application LINE/telephone and anonymising all identifiable data during the transcript and analysis stage. For participants who disclosed that they were experiencing trafficking, were HIV positive, or were using substances, I was able to offer them referral pathways through EMPOWER's support services if they wished to seek legal,

medical, or psychological care. I adapted my methodology to account for vulnerabilities with physical and emotional health that might have been exacerbated by the COVID-19 pandemic by conducting interviews remotely. By taking these protective steps, I hoped to reduce harm while preserving participants' autonomy, confidentiality, and access to support services during the research.

Additionally, MWSWs constitute marginalised groups in relation to the broader Thai community and may experience stigma (Bradbury, 2015; WHO, 2013). Thus, after contributing to my research, I needed to take special care of any aspects that might make them more vulnerable. I clarified my approaches to minimise risk and protect participants. I clarified ethical considerations, including informed consent, confidentiality and anonymity, the researcher's role, and the fundamental principle to "do no harm".

4.8.1 Informed Consent

Informed consent is a primary ethical consideration in research. Shaver (2005) emphasises the fundamentals of obtaining genuine consent, which can be complex. During my research, I was aware that there might be potential power imbalances between me and the participants and between the EMPOWER team and MWSWs, which might influence the consent process (Shaver, 2005). I was conscious, for example, that MWSW participants might feel pressure on account of the assistance they receive from the EMPOWER Foundation. I clarified that participation in my study was entirely voluntary and distinct from EMPOWER support, and that participants were not obliged to take part, emphasising that refusal would not affect their assistance from EMPOWER.

Although all MWSW participants who participated in my research could understand Thai at a conversational level, the majority (20 out of 28 MWSWs) could not read or write Thai. I recognised this as an issue when obtaining informed consent for this study. First, I offered participants the information sheets and informed consent forms in Thai. I then read the information sheets aloud to ensure the participants understood them. I offered time for participants to ask any questions or raise concerns about my research.

I decided to obtain verbal consent instead of requiring signed consent forms. Firstly, MWSWs might be unwilling to write their names on any printed form for fear that it might, at some time, be used against them in connection with their work or migration status. Sex workers usually work under false names because of their unlawful labour and migrant status. I asked for confirmation of their consent in audio at the beginning of each interview.

Dewey and Zheng (2013) contend that informed consent cannot be characterised as a one-time agreement to take place only at the beginning of a study. Instead, it is a developed process requiring constant revisiting and redefinition during research. This perspective of dynamic, informed consent guided my approach throughout. Some research participants can disclose significant private, personal information, which might compromise an individual's confidentiality (Sanders, 2006). Participants in this study disclosed very personal information, including their HIV-positive status, being trafficked, sexual violence, and experiences with managers and clients. At these moments, I reflected and asked participants whether they preferred those specific details to be included or excluded before continuing, that is, securing informed consent within interviews as well as at the beginning. That has driven my practice of informed consent as a relational, iterative process which values the participants' autonomy and protects their data throughout. My duty is to protect participants from further marginalisation while ensuring that my research does not impair their current vulnerabilities (Sanders et al., 2009).

4.8.2 Confidentiality and anonymity

I uphold the anonymity of the participants and the confidentiality of the data/information I collected during my study. To ensure the anonymity of all participants, identities, including names and workplaces, are replaced with numbers and pseudonyms. During data collection in Thailand, all data and research materials were kept in a locked filing cabinet and password-protected storage on my laptop. Later, after the field research was finished, they were moved to Edinburgh University. Recordings are securely stored for seven years after research completion, following university policy.

The audio recordings, transcripts, and fieldwork journal are stored in an encrypted container. The majority of these files are compressed with a 7-Zip program and are

password-encrypted for solid protection. Also, there is a Virtual Private Network (VPN) for secure communication between my computer and the university network. In other words, all my files, audio recordings, and transcripts are encrypted and stored on the university server. All associated documents from the fieldwork journal were scanned as PDF files and encrypted with robust password protection. Only I can access the recordings and transcripts. The confidentiality and anonymity of the participants have been preserved with utmost privacy. Their personal data will not be presented or published (Dewey & Zheng, 2013). The study results may be published in some academic journal or at a conference, but the names of participants will be replaced by pseudonyms at all times.

4.8.3 Do no harm

This section discusses how I practice and maintain participants' confidentiality. According to WHO (2016), following rules associated with ethical principles and basic human rights is essential to protect participants who may be vulnerable in the research process. Ethical approval was obtained from the University of Edinburgh Ethics Committee. The EMPOWER Foundation did not have an ethics committee, but their working group accepted that my research had been reviewed and approved by the University Ethics Committee.

Even so, the EMPOWER team were concerned with the rights of sex workers when taking part in research. One staff member who works as a law consultant stated that several researchers previously worked with migrant sex workers without being mindful of ethical considerations. She noted that I had been following ethical rules and expressed confidence and trust in my approach to working with the sex worker group. She stated that previous researchers did not share research information, and some migrant sex workers joined the research without explicit details of its purpose. Notably, some sex workers participated in a previous study without informed consent.

After the ethics approvals were obtained but before the research took place, potential participants were fully informed about why they might be suitable for inclusion in this study and that I would manage their information confidentially during this study, including the transcripts, translating, and presenting data.

As a small reward for participants' time and insights, I offered an incentive of 500 THB (approximately £10) for internet top-ups at the end of each interview. The amount was identified within ethical guidelines on participant compensation, which suggest providing practical assistance without overly influencing responses. Research elsewhere demonstrates that incentives that are too high can lead to biased participation or non-representative responses (Largent & Lynch, 2017). Thus, my approach contains an implicit negotiation to find the right balance between requiring acknowledgement of participants' contributions and undue coercion or incentive.

In creating this compensation model, I adhered to ethical principles of fairness, autonomy, and inclusion, aiming to make participation in the study voluntary and without financial pressure. As I interviewed them via LINE/telephone, participants required internet and phone credit to connect with me. This helped break down the financial barrier to participation (especially because many MWSWs are economically precarious) and ensured that the integrity of the participants' stories was not affected.

The £10 internet top-up was meant to cover connectivity costs. In this case, my rationale shows how compensation can be adjusted ethically to fit the specific circumstances of conducting remote research during the COVID-19 pandemic while ensuring that justification and equity exist for participants, and minimising any potential biases from collected data (Largent & Lynch, 2017).

4.9 Trustworthiness of this study

Following the principles of trustworthiness proposed by Leung (2015), I ensured that this study's process and findings were credible, transferable, dependable and confirmable as a researcher who operates within a social constructivist paradigm. Instead of triangulating for a singular truth as is traditional in qualitative research, I looked for methodological coherence, reflexivity, and transparency in my analytic process to ensure that the multiplicity of participant perspectives was represented during analysis.

I used two techniques to stay reliable in my responses.
(a) Documenting my rationale for what I was interpreting from the raw data would exhibit the subjectivity of the analytic process (Padgett, 2012) but help readers understand how I moved from raw interview material to interpretive themes.
(b) Reflexive engagement with my own positionality by tracking my thoughts through reflective notes before and during the stages of data analysis (Peddle, 2022). This enabled me to recognise and critically assess how my own background and prior knowledge of MWSWs' access to healthcare in Thailand might influence the way I interpreted the data. Instead of "triangulating" data to produce one truth, I leveraged the diversity of MWSW participants, as their experiences are informed by their unique intersections of gender, migration status, and labour conditions. In this regard, there was no aim towards consistency across participant narratives; instead, my analysis was directed at identifying themes and acknowledging contradictions and variations (Nowell et al., 2017).

Moreover, I contextualised participants' healthcare experiences through detailed connections between their narratives and the broader socio-political realities, existing literature, and policy frameworks (Braun et al., 2019). It did not aim to validate individual participants' specific claims but rather to frame their lived experiences within broader systemic structures, substantiating credibility without undermining the integrity of their accounts.

The schedule for semi-structured interviews was approved by the University of Edinburgh ethics committee. This ensured that the interview questions did not present a risk to any of the participants. Then, I carefully translated the interview schedule into Thai to make it more understandable for all participants. I also had a conversation with the EMPOWER team regarding my interview guide questions to ensure that we aligned on words and terms which were standard among sex workers.

When conducting interviews, it is essential to ensure the data is trustworthy (Ghafouri & Ofoghi, 2016). Thoughtful interviewing requires the ability to prompt, track answers, and continue interviews (Brinkmann, 2013). At the same time, participants might experience anxiety or be distressed due to some questions raising emotions during the interview process (Sanders et al., 2009). Should a circumstance like this occur, it

was in my plans that participants would be given an option as to whether or not they wished to continue with their interview, pause, or withdraw from the study (Dewey & Zheng, 2013).

I reflect on the emotions raised by sensitive topics in interviews, and my research positions before analysing participants' data to ensure the trustworthiness of this research in the following section.

4.10 Emotional work in sensitive topics

Even though I prepared myself by practising mindfulness and meditation throughout my data collection process, conducting interviews with migrant women sex workers (MWSWs) has, over time, affected me emotionally. Many of the participants I interviewed had challenging accounts to listen to. Their lives were bound by poverty and powerlessness. I found some comfort in the shared experiences of other researchers who also reported that their research led to emotional distress and anxiety (Shaver, 2005; Sinha, 2017).

I interviewed participants who bravely shared intimate personal experiences connected with the healthcare system. My work took form through fieldwork, centred on learning to trust interview participants when discussing private aspects of their lives. I needed to learn essential details, including their behaviour patterns, daily routines, and relationships with bosses, clients, immigration officers, police, and healthcare providers. The key was balancing empathy with rigorous data collection.

Some shared the hardships they have faced: starvation, poverty and little family support in Thailand. Others described being trafficked into the sex entertainment industry. I was almost in tears as stories unfolded. One shared how she travelled from Myanmar to Thailand. She had been abused for years, sold into brothels at 14, and had stayed in the sex industry for over two decades. She was in her late thirties when we discussed her life history. Her story was heartbreaking and heartwarming in equal measure, all the more heartbreaking for the years that healthcare professionals had stigmatised her. She shared honestly and openly, and our conversation continued for four hours. Her courage in sharing these experiences was genuinely inspiring.

As I interviewed more MWSWs, those who had already participated directed others to contact me, some of whom were undocumented migrants. These MWSWs wanted an opening for their stories and were thankful to have someone listen. One MWSW told me that, in 18 years of sex work, nobody had ever asked her about the experiences she shared. It made her cry, but she appreciated my interest in her life. Afterwards, I gave her the information for EMPOWER support events, and she contacted them to connect with an additional support group. This led to more participant referrals through her trust, and I realised that my research has the potential to be a positive thing in these MWSWs' lives.

When collecting data, I was more invested in the participants' stories and how my background informed my positionality in the research. Though I was sympathetic to their experiences, sympathy is insufficient for establishing insider-outsider status. Material and structural factors mediate such relationships.

In some ways, my identity as a Thai woman from a poor rural farming community made me an insider. I understood some of the cultural norms and values, and the economic struggles that participants described. This also helped build trust. However, I realised a significant difference between my experiences and those of the MWSWs I interviewed based on my educational and professional training as a midwife, a nurse, and later as a post-graduate student. This measure of privilege - especially around safety, access to health and knowledge, and socioeconomic mobility – rendered me an outsider in many ways.

However, my culturally shared background with participants allowed for rapport and engagement in interviews through linguistic familiarity, cultural awareness, and a contextual understanding of the stigma surrounding their lived experience. This establishes the relationship between open dialogue and trust in the research process (Bradbury, 2015). Instead of solely considering insider/outsider status, I was reflexive about how my key intersecting identities shaped how I interacted with participants and interpreted data in this research project, allowing participants’ voices to remain central in the research process.

Many MWSWs commented that nobody has ever asked them about their life experience in Thailand, nor have they been asked to discuss healthcare. By the fourth

interview, I was comfortable asking participants personal questions, which they freely answered. It was very emotional for several participants, but no one asked me to stop or reschedule, although I offered to do so. Participants were provided with a contact number available for free online mental health support before I interviewed them. I contacted participants again afterwards to see if they wished to reach out for mental health help. None requested further support.

However, I found that the interviews were an emotional process for me. I contacted a private mental health support in Thailand during data collection, and this approach helped me manage my emotional status. I took three weeks off to get back on track with my mental health, as suggested by my supervisors.

I approached each interview with care to avoid tempting MWSWs into a dialogue. I led them through a participant-led interview process, where they shared their lived experiences at the rhythm and pace they felt comfortable with. Open questions freed the discussion of their sex work job roles, their sex work stigma, and healthcare access challenges. Open questions allowed the participants to guide the conversation. Holding stories back became just as important in guiding the conversation as sharing them. This practice helped reduce power differentials in the research process and reaffirmed participants' autonomy in representing their narratives.

Conducting interviews via the LINE application and by phone presented some challenges. Poor internet connections interrupted the conversation on two occasions, but we were able to reconnect and complete the interviews. One MWSW spoke to me from a garden. I could hear birds and cars going by. We were interrupted twice, yet she called me back each time. She had left her room to ensure her privacy. In her account, she was financially responsible for her mother, who had been paralysed for five years, and she had worked as a sex worker for eight years. We talked for over two hours, and she expressed how she was lonely and overwhelmed because of her position as an undocumented sex worker. I appreciated her faith in me and my research.

Most participants, especially MWSWs, bravely related their experiences. They were frequently involved in prohibited actions and encountered substantial trials in their life, but they exhibited remarkable resilience. One disclosed her HIV status and

her history of sexual violence, detention, and deportation. Others who had been undocumented workers for ten years or more walked through the challenges of seeking medical treatment or living a life in Thailand. They were so determined in the face of all obstacles that it was an inspiration.

The interviews also became quite an intense journey, during which I observed how the participants' language, emotions, and silence manifested themselves. Some researchers argue that discussing personal matters can lead to stress for participants (Shaver, 2005), whereas others imply that this sharing might be therapeutic and empowering (Dickson-Swift et al., 2006; Gilbert, 2000).

As a researcher, I also experienced the narratives of very brutal, violent, and emotionally painful stories, as intense, heavy, and sometimes troubling (Clift et al., 2023; Dewey & Zheng, 2013). I was conscious that, in these respects, I was an outsider. I have never lived through experiences of the kind many of the participants (particularly MWSWs) described. These acknowledgements influenced the way in which I conducted the interviews, with humility and sensitivity, recognising how incredibly strong those participants were to be able to tell their stories openly to someone whose life was so very far removed from theirs.

To maintain professional neutrality, I followed feminist research guidelines, not offering advice or engaging in friendly relations with participants (Dickson-Swift et al., 2006). Of course, hearing these stories brought out my sympathies, and I did what I could to communicate empathically yet neutrally. That fine line kept me grounded in the data and research while simultaneously allowing me to understand rather than ignore or try not to empathise with the emotion involved (Clift et al., 2023). I was not a therapist, however. One MWSW participant was in tears as she talked. I stopped the audio recording and offered her a break. This small moment of empathy provided a space until she felt safe and comfortable enough to resume her narrative. Participants' courage in sharing such sensitive, private, and repeated upsetting experiences was admirable.

Hearing words of pain, anxiety, and solitude in the participant's own language was disheartening at times, but I never wanted to lose my focus. The interviews were incredibly raw, but I felt an extreme responsibility to my participants in providing their

genuine voices, while also maintaining academic rigour. My intention behind sharing this is to reflect on how a difficult conversation takes place, and my process of self-growth during those times.

4.11 Limitations of this research

The limitations of my study relate to the complexities of the topic, and methodological features regarding sex work being socially sensitive, stigmatised and largely criminal in Thailand. Using a mixed purposive sampling and snowballing technique could restrict potential participants to contacts from the NGO's network. Therefore, my research findings may favour MWSWs who are enthusiastic about NGO-based services.

Another limitation was that the range of participants was restricted to MWSWs who could speak and understand conversational Thai. MWSWs who did not speak the language at all were not included in the study. This study does not include MWSWs who are new to the country and have been working for less than one year. The result is also solely based on the MWSWs volunteering to participate in the study. MWSWs in the most challenging situations might be less likely to volunteer during COVID-19 restrictions, so the findings might represent the more confident and enthusiastic women. The outcomes may also overlook MWSWs with acute healthcare needs. The fieldwork was restricted to Chiang Mai. Although some shared their experiences from Pattaya, Bangkok, and Phuket, I cannot assume the findings would replicate identically in each of the ‘red light cities’.

Conducting a thematic analysis that considers intersectionality is complicated. Intersectionality argues that gender, along with other social identities such as migrant status, ethnicity, and sex work, combine to produce experiences in the delivery and receipt of healthcare. MWSWs' data is usually complex and “thick” in nature, which poses a challenge to integrate into themes that retain the nuanced interpretation needed for intersectional analysis. This complicates how findings are structured and communicated. Greater complexity can create ambiguity. As such, it was somewhat challenging to adequately describe how MWSW's personal experiences are inextricably linked with the larger social and systemic barriers they face without either

oversimplifying or becoming inaccessible. The following chapters explore in depth my findings and analysis.

Chapter 5: We Were There, But Not Seen: Navigating Exclusion and Resistance in Healthcare

5.1 Introduction

In this chapter, I present my research findings. Migrant women sex workers' (MWSWs) problematic access to effective healthcare is formed by an interaction of structural barriers and individual discouragements, shaped by the intersection of gender, migration status, and sex work stigma. The data that reveal how MWSWs encounter, resist, and navigate such barriers are organised into two themes.

Theme 1 is *Speaking through silence: structural exclusion and healthcare navigation* (see 5.3). It illuminates how language exclusion, legal uncertainty, and administrative design render these women misrecognised, depersonalised, and disempowered in their interactions with formal healthcare systems. Participants' data resonate with Bak's (2018) notion of symbolic exclusion, which describes how exclusion can occur not in terms of formal denial, but rather in the dismissive tone in which it is denied. Participants recount examples of mispronunciation of their name, absence of eye contact or disapproving looks, and how they are not acknowledged, greeted, or recognised as individuals. It is symbolic because it works through meaning and social signals rather than direct denial of service.

Theme 2 is *Survival and resistance: navigating through stigmatisation and discrimination* (see 5.4). These findings expand upon the experience of MWSWs in which the actual provision of care becomes discriminatory and sub-optimal and reinforces stigma and social hierarchies.

5.2 Who are my participants?

I collected basic demographic data from the 39 women participants in this study, which is summarised in Tables 5.1- 5.3. My MWSW participants have a median age of 36 years (range, 24-50 years). The majority of the women have been involved in sex work for most of their adult lives. All but one migrated from Myanmar, the other from Laos. This balance reflects wider migration in the region, where economic and social pull

factors draw many migrants from Myanmar, including women who pursue work across Thailand's informal sectors, including domestic work, as well as sex work and the sex entertainment industry.

Migration status is one of the main factors affecting healthcare engagement among MWSW participants. At the time of the interviews, twenty MWSWS were documented with a valid visa, while twelve were undocumented. This is a central distinction. Those with undocumented status may be limited not only in access to public health services but also to broader lawful protections and social care.

Eleven of the 32 MWSWS had Health Insurance Cards, six were participating in the Social Security Scheme (SSS), and almost half of them (n = 15) were uninsured. The majority stated that their requirement for regular access to healthcare services, including those related to sexual and reproductive health, was especially relevant due to the nature of their work. Most of the MWSW participants working in bars, massage parlours, go-go bars, and brothels had their sexual health checked frequently, ranging from once a week to 1–4 times a month. Testing is a condition of their employment. The majority (28 of 32) of MWSW participants reported that their employer or manager required access to their STD/HIV test results. The four MWSWs who were freelance/online sex workers mentioned that they check at the sexual and reproductive health clinics 2–3 times per year. These women believed their work carried less risk of infection, so their decision on how often to be tested was a matter of their own sense of responsibility.

Education levels may influence participants' pathways to seeking healthcare and engaging with healthcare information. Eleven MWSWs had completed primary education, and ten had completed secondary school. Eight women had no formal education in their home country. Education level may impact health literacy, such as the ability to understand and apply available information to sustain and enhance health (Naing et al., 2020; Yu et al., 2022). All MWSW participants understood Thai at a conversational level at the time of the interview. Only five reported being able to read and write Thai for simple day-to-day information. Only three women expressed confidence in reading, writing, and understanding Thai beyond a basic level.

The mean time participants had been involved in sex work was eight years, with the maximum stated as 29 years. The length of involvement indicates that, for most participants, sex work is a primary source of income rather than a temporary stage in their lives.

Workplaces are listed in order from most common to least common as follows: bars (11), massage parlours (5), brothels (5), online/freelance (4), go-go bars (4), and karaoke (3). These different work environments carry different levels of occupational risk and workplace protection. MWSWs in brothels or massage parlours may have more robust peer networks and employer-facilitated health monitoring. Freelances may have more autonomy but face greater exposure to health risks including untreated STIs/HIV and violence.

Service Providers (SPs) play a critical role in supporting MWSWs, mainly through health education, advocacy, and direct support. Data on the service provider participants included in this study showed that the median age was 48 years, and the median number of years working with sex worker communities was 10 (range 8–30 years). Their educational backgrounds ranged from three with bachelor's degrees, two with secondary school education, and two with primary school education. The broad range of educational attainment amongst service providers highlights the potential that lived experience and prolonged interaction with sex worker communities may be critical to understanding how to frame support. The organisations they are affiliated with - primarily the EMPOWER Foundation (six service providers) and Migrants Assistant Program (MAP) Foundation and EMPOWER (one service provider) - are recognised for their work in rights advocacy for sex workers and for providing support services, such as healthcare referrals, harm reduction programmes, advocacy, and legal support.

Biographical data of participants

Table 5.1: Service provider participant group

* 'SP' refers to service provider, and 'SW' refers to sex worker

*Code	Pseudonym	Age	Role in NGO	Years of work	Organisation	Education
SP01	Supatra	51	Policy coordinator, Health educator, Languages teacher, Counselling	18	EMPOWER	Secondary school
SP02	Monthira	41	Law counselling, Languages teacher, Health educator, Research coordinator	10	EMPOWER	Bachelor
SP03	Lalita	60	International coordinator, English teacher, Counselling nurse	30	EMPOWER	Bachelor
SP04	Kanokwan	67	Registered nurse, Health counselling for NGOs	30	Ministry of Public Health (MAP/EMPOWER)	Bachelor

*Code	Pseudonym	Age	Role in NGO	Years of work	Organisation	Education
SP05	Duangchan	36	Thai language teacher, activist	10	EMPOWER	Secondary school
SP06	Chonticha	30	Activist	8	EMPOWER	Primary school
SP07	Busaba	48	Activist	8	EMPOWER	Primary school

Table 5.2: Service provider/migrant sex worker group

*Code	Pseudonym	Age	Role in NGO	Years in sex work	Site of work	Country of origin/ Education	Migration status
SP/SW01	Amporn	36	Thai language teacher, Activist	10	Freelance	Myanmar/ High school	Documented
SP/SW02	Suneerat	27	Activist	8	go-go bar	Myanmar/ High school	Documented
SP/SW03	Malinee	26	Activist	8	go-go bar	Myanmar/ High school	Documented
SP/SW04	Wipavee	49	Activist	20	Massage parlour	Myanmar/ Primary school	Documented

Table 5.3: Migrant sex worker group

*Code	Pseudonym	Age	Years in sex work	Site of work	Country of origin	Education	Migration status
SW01	Yada	30	16	Freelance	Myanmar	Secondary school	Documented
SW02	Thidarat	33	10	Karaoke	Myanmar	Secondary school	Documented
SW03	Suda	48	20	Massage parlour	Myanmar	Secondary school	Documented
SW04	Panida	30	7	Karaoke	Myanmar	Secondary school	Documented
SW05	Orapin	36	8	Bar	Myanmar	Secondary school	Documented
SW06	Rasamee	30	7	Karaoke	Myanmar	Secondary school	Documented
SW07	Nitaya	36	22	Massage parlour	Myanmar	Primary school	Documented
SW08	Malai	34	18	Bar	Myanmar	Secondary school	Documented
SW09	Ladda	45	27	Bar	Myanmar	Primary school	Documented
SW10	Kanya	46	29	Brothel	Myanmar	None	Undocumented
SW11	Jintana	42	4	Bar	Myanmar	None	Undocumented
SW12	Darika	39	3	Bar	Myanmar	None	Documented

*Code	Pseudonym	Age	Years in sex work	Site of work	Country of origin	Education	Migration status
SW13	Benjamas	44	3	Massage parlour	Myanmar	None	Undocumented
SW14	Chalida	35	5	Brothel	Myanmar	None	Documented
SW15	Wichuda	32	11	Brothel	Myanmar	None	Undocumented
SW16	Urai	34	4	Brothel	Myanmar	None	Undocumented
SW17	Thippawan	43	23	Brothel	Myanmar	None	Undocumented
SW18	Pavinee	25	3	Bar	Myanmar	None	Undocumented
SW19	Ratchanee	32	5	Bar	Laos	Primary school	Documented
SW20	Orathai	40	5	Bar	Myanmar	None	Documented
SW21	Kamonrat	50	20	Bar	Myanmar	Primary school	Undocumented
SW22	Jiraporn	37	4	Bar	Myanmar	None	Documented
SW23	Arisa	24	5	Bar	Myanmar	None	Undocumented
SW24	Benjarat	35	15	Bar	Myanmar	Secondary school	Undocumented
SW25	Dawan	33	3	Bar	Myanmar	None	Undocumented
SW26	Suranee	40	10	Brothel	Myanmar	Primary school	Undocumented
SW27	Namthip	42	4	Bar	Myanmar	Primary school	Documented
SW28	Siriporn	25	5	Freelance	Myanmar	None	Documented

Table 5.4 below shows the participants whose narratives are core to each of the subthemes explored in this findings chapter. However, most of the experiences they identified were shared broadly among all MWSW participants.

Table 5.4: Participant data contributing to the themes

Theme	Subtheme	Participants (Main stories drawn from)	Reason for Inclusion
Section 5.3 Theme 1: Speaking through silence: structural exclusion and healthcare navigation	Section 5.3.1 Exclusion through communication disempowerment	Wipavee, Malai, Rasamee, Thidarat, Arisa, Suranee, Rattchanee, and Suda	Demonstrated how limited Thai proficiency and the absence of interpretation led to confusion, fear, and unsafe outcomes during medical care.

Theme	Subtheme	Participants (Main stories drawn from)	Reason for Inclusion
	Section 5.3.2 Symbolic misrecognition: being present but not seen.	Pavinee, Jintana, Busaba, and Darika	Illustrated how non-verbal cues, tone, and staff behaviour signalled that MWSWs were unwelcome or unrecognised in healthcare settings.
	Section 5.3.4 Systemic inaccessibility: institutional expectations vs. everyday realities	Benjarat, Namthip, Kanya, and Kanokwan	Demonstrated how structure-provided expectations of systemic expectations: calling clinics, reading medical forms, advocating -escaped those lived by MWSW
Section 5.4 Theme 2: Survival and resistance: navigating	Section 5.4.1 Hierarchies of exclusion in healthcare spaces	Lalita Orapin, and	Explained how class, gender, migrant status, and sex work interact to push

Theme	Subtheme	Participants (Main stories drawn from)	Reason for Inclusion
through stigmatisation and discrimination		Jiraporn	MWSWs to the lowest rung in healthcare hierarchies.
	Section 5.4.2 Stigma as structure—how healthcare marks and marginalises	Thippawan and Dawan	Shared experiences of being mistreated or spoken down to once identified as migrants, reflecting interactional stigma.
	Section 5.4.3 Layered exclusion: gender, migration, and sex work in clinical encounters	Amporn, Benjamas, Siriporn, Panida, Suneerat, Malinee, and Yada	Their stories exemplify verbal and moralised harassment and gendered abuse from healthcare providers.

5.3 Theme 1: Speaking through silence: structural exclusion and healthcare navigation

Participants' data analysed in this theme set out the accounts of MWSWs as they navigate the Thai healthcare system. The data show how language barriers, identity-related stigma, and healthcare practices informed their experience. While some MWSW participants had access to health services in a practical sense, their reports suggest that this engagement was limited, contingent, and suboptimal.

5.3.1 Exclusion through communication disempowerment

The language barrier is one of the biggest reported obstacles to accessing and participating in healthcare for MWSWs. In the sections below, I categorise the findings thematically. Each sub-theme explores how care was informed not only by what was provided but also by how it was delivered, entered, and experienced.

Although they were physically present in medical settings, MWSWs were frequently unable to understand or answer questions, to ask questions themselves or consent fully to the treatments and medications they received. Drawing on Bak's (2018) conception of relational and epistemic exclusion, I discuss that inclusion without understanding or voice creates a structural disregard. In these instances, healthcare operated less as a setting of support and more as a location where MWSWs' knowledge, dignity, and autonomy were lost.

"I couldn't understand them; they only spoke Thai." (Wipavee)

Wipavee is an activist and a migrant woman who has worked in a massage shop in Thailand for approximately two decades. She understands everyday conversation in Thai, but the language barrier played a significant role in preventing her from receiving the kind of care that she needed after surgery.

> *"I had an operation and got a wound infection after I got home. I wasn't happy with the healthcare team in that hospital. They weren't nice at all, and I couldn't understand them; they only spoke Thai. So, after I was discharged and arrived home two days later, my wound got red and very painful, and I got a high fever.*

> *They told me to go back if anything wrong happened. Yet, I didn't understand them either because I felt like they didn't understand me. So, I just waited and hoped that I might feel better ... Yes, I thought communication was a big problem for me." (Wipavee, 20 years of sex work in a massage parlour/activist, documented)*

The healthcare issue identified in Wipavee's story is the failure of the clinicians to ensure their instructions for postoperative care were understood. As a consequence, her ability to manage her own recovery safely was compromised, demonstrating how communication problems can directly affect patient care.

Malai has worked in a bar for 18 years and recalled her visit to a hospital in the middle of the night.

> *I was in pain and lots of bleeding after work one night…it's late 3 am. But I didn't know where to go. And I didn't understand much Thai back then. Yes, all things were more difficult years ago. I didn't know where to go. A girl at my bar told me where to go for a doctor. So, I went to a private hospital nearby. I didn't understand what they asked or told me. A doctor gave me medication anyway. I didn't know what was wrong with my body that night…Yes, it was really hard without understanding Thai. (Malai, 18 years of sex work in a bar, documented)*

Wipavee and Malai demonstrate how language serves as an embedded structural barrier to effective healthcare. While their circumstances and the specific healthcare facility they attended are different, their stories converge in demonstrating that there are direct health risks to the patient as well as emotional cost, leaving a feeling of vulnerability and powerlessness.

In both stories, language operates not as a passive barrier to communication but as an active agent of exclusion, inevitably leading to health disparities between patients.

These accounts and perceptions are consistent with studies with sex workers in other parts of the world such as Goldenberg et al. (2017) in Canada who found participants who are not confident in English found it challenging not only to find a job but also to

get healthcare, legal support, or information concerning their rights, arguing that language barriers intersect with wider structural exclusions.

Lotysh et al. (2025) conducted research with MWSWs in Berlin. Their results described the challenge of complex bureaucracy and the absence of multilingual, culturally competent communication as structural obstacles. In New Zealand, where sex work is decriminalised, Roguski (2013) reported that language barriers remained as obstacles to healthcare access among 124 migrant sex workers.

"We don't speak the same language (Suda) … I never dared to ask" (Rasamee)

For many participants, the lack of understanding extended even to regular sexual health visits. Rasamee has worked in a karaoke bar for about 7 years.

> *"I visited that healthcare centre about three or four times a month for my check-up. It's a health centre for those who work like me. They never told me what they checked for me, and I also never dared to ask because I didn't understand Thai. And I felt they were not really interested in people like me. They all know about my work. The GP told me I was "OK today" That is what he told me. I got my result and gave it to my boss. I wanted to ask more about my body, like how my work might affect my body, that part, you know. But I didn't understand Thai well enough to ask anyway." (Rasamee, 7 years in sex work in a karaoke bar, documented)*

Rasamee's experience suggests that access to a healthcare facility is limited in efficacy without autonomy. Even though she is documented and attends sexual and reproductive health checkups, her involvement is mostly passive, present but not seen.

Ratchanee, a bar sex worker, described her experience of healthcare disempowerment in an emergency room encounter:

> *"I went to an emergency room because I got pain in my stomach in the middle of the night. And then, a GP came and asked me some things. Although I couldn't read and didn't understand what the GP said, he gave me some medicine anyway. When I got home, my pain was still not getting better, and I*

> *went back again. The same GP looked annoyed and said something to a healthcare provider. I couldn't understand what they talked about. Yes, it was very hard for me." (Ratchanee, 5 years of sex work in a bar, documented)*

Ratchanee was treated but felt unwelcome. She could not understand the conversation or ask questions about her care. She felt the GP's irritation, which made her feel excluded, not only from the healthcare process but from the clinical space itself.

Suda has worked in a massage shop for 20 years. She shared her emergency care experience, and how she was compelled to navigate a healthcare system that could not conduct the kind of clinician-patient interaction that is the essential basis of examination, diagnosis, and treatment.

> *"I had stomach pain most of the days because of my work (sex work), and I couldn't eat properly. I visited a clinic near my place. It's faster. But I didn't understand what a GP said. He also didn't know what I said. I cried and pointed to my stomach. So, he figured out that I was in pain. He gave me an injection and some pills to take home. I felt better when I got home, but at night, the pain got worse, so I went back to the same GP again. It isn't easy because we don't speak the same language. He said many things that I didn't understand." (Suda, 20 years of sex work in a massage parlour, documented)*

At its simplest, Suda's health care experience as a migrant woman sex worker felt lower in quality than that of a Thai citizen or Thai speaker with the same symptoms. She believed the pains in her stomach were directly linked to her sex work. However, if the attending doctor was curious about the source of the pain or its connection to her work, he did not pursue the possibility of an investigation due to the language barrier. Suda was present but not being understood or engaged with in the consultation**.** Her body itself emerged as the primary mode of communication - pointing, crying, gesturing.

"We can't say, and we don't go." (Suranee)

Several MWSW participants stated that fear of asking questions was rooted in more than their lack of Thai language competence. They internalised a deep-seated sense of disempowerment. Thidarat describes her experience whilst recalling her monthly visits, as required by her employer, for sexual health checks at a local STD/HIV health centre.

> *"We are migrant sex workers who went in a group of five or six of us for our tests (STD/HIV), like every month, at a local women's health centre. They (healthcare staff) gave us a paper, but we couldn't read Thai. So, we also never dared to ask what it was about. Yes, we got our result and just gave that paper to our boss". (Thidarat, 10 years of sex work in karaoke, documented)*

Thidarat has been a sex worker for 10 years, but states she still feels like a spectator when dealing with the team at the sexual health clinic. Language is an obvious barrier, but her tone conveyed how she feels as an outsider, her sense of 'other'.

Arisa also described her sense of vulnerability:

> *"When I first visited that sexual healthcare centre alone, I remember that the service providers weren't very nice to me, and my Thai wasn't good enough to understand what they told me. It took years to understand these things; yes, it was not easy for us as migrant sex workers here."* (Arisa, 5 years of sex work in a bar, undocumented)

Despite attending a healthcare setting ostensibly designed for women like her, Arisa remained passive, rather than participatory in her own health. Arisa's status as an undocumented migrant woman who sells sex places her at the intersection of several axes of social disadvantage. The intersections of gender, immigrant status, informal labour, and language barrier combine in her sense of exclusion.

Suranee has been in Thailand for ten years. Inability to speak and comprehend Thai initially made the whole healthcare experience a lot more challenging. It discouraged her from seeking healthcare at all. Her Thai language skills have improved,

nevertheless, she remained apprehensive about contacting formal women's health centres.

> "*There are many things that we can't say, that we can't ask, and we don't go because we don't speak Thai. They told me to get my blood and vagina exams, but I never went there (sexual health centre). I can't speak their language, and I'm breaking the law here working in this job (sex work), and I don't have a visa." (Suranee, 10 years of sex work in a brothel, undocumented)*

Suranee describes her voluntary withdrawal from healthcare. She feels her undocumented status, along with outlawed sex work, renders her vulnerable to her legal and social risk. *"We don't go*", indicates a shared withdrawal with her peers. Fear of exposure, shame, or misunderstanding can discourage women from participating in systems supposedly established to support them.

The accounts of Thidarat, Arisa, and Suranee are consistent with the findings of Lim et al.'s (2018) research among Female Entertainment Workers (FEW) in Singapore, where a gap exists between the English spoken by the healthcare team and the first languages of the FEWs, who are mainly from Vietnam, Thailand, and the Philippines. Lim et al. (2018) stated that FEWs are unwilling to ask questions or request an explanation, as they worry that they might be identified as undocumented by the healthcare team. This results in an overly passive approach to healthcare, wherein FEWs frequently exit a medical consultation with relatively poor or incomplete knowledge about their own health status. This, in turn, complicates their ability to understand and follow treatment plans, which often leads to misdiagnosis or undertreatment of the individual, but also poor public health data collection (Lim et al., 2018).

The fear of asking questions is not only a language issue. It is a signifier of more substantial structural inequalities stemming from the power dynamics in the relationship between MWSWs and healthcare staff, in which anxiety connected to their precarious migration status is ever present. Language inability translates into silence. In healthcare terms, silence risks missing basic clinical information and undermines patient autonomy regarding their health, treatment choices, or potential medical risks.

5.3.2 Symbolic misrecognition: being present but not seen

Although some MWSWs in this study may physically attend public healthcare services in Thailand, the accounts of Pavinee, Jintana, Busaba, and Darika expose how they can be rendered socially invisible once inside. Their narratives demonstrate that exclusion is not always something direct or confrontational. Instead, it plays itself out in the small but significant moments of disregard and misrecognition (and by silence) which send them a sign that the healthcare space is not where they belong. This kind of symbolic misrecognition (Bak, 2018), being present yet not recognised, diminishes women's more general sense of belonging within the system.

Pavinee gave one example.

> *"When a staff member called out my name, she shouted it very loudly. I wasn't sure that was me because she called my name in a Thai accent ... . She actually called my name wrong. I didn't get that it was me. They should have someone who works as a translator who can help us when we visit a hospital, you see." (Pavinee, 3 years of sex work in a bar, undocumented)*

Calling out the wrong name in a reception area might seem small. For Pavinee, it was more than a pronunciation issue; it told her she was an outsider. Her experience resonates with Goffman's (1963) framing of stigma as a relational act in which mispronunciation and public shouting function as subtler forms of interactional disgrace and cultural exclusion, erasing the person behind the name.

Jintana has worked in a bar for 4 years. She shared her experience when she went for the COVID-19 vaccination.

> *"I went for my COVID-19 jab in a vaccination centre, among other Thais, I didn't understand what they told me. I waited 6 hours outside that building, and no one helped me as a migrant. I was afraid to ask for help because I wasn't good at the Thai language. I just waited and waited" (Jintana, 4 years of sex work in a bar, undocumented).*

Jintana waited six hours for her COVID-19 vaccination. She was afraid to ask for help. Her silence was not consent. It was a creation of fear, uncertainty, and invisibility.

Busaba is an activist with EMPOWER foundation who supports sex workers as well as working herself in a bar. She explained her experience when she took a group of MWSWs to a health centre.

> *"…Most of the time, migrant women sex workers who visit a women's health centre or medical clinics will sit and wait … but the staff never look at them or explain anything. They just take the paper and say, 'Go there.' The women didn't know what to do…They just followed the line." (Busaba, 8 years activist with EMPOWER/ sex work in a bar, documented)*

Darika recalled her sexual health visit.

> *"…They didn't smile, didn't ask anything. After hours of waiting, someone just gave me papers and told me to wait. It felt like they didn't want to talk to me, like I was not welcome…maybe they know about my work and I'm a migrant." (Darika, 3 years of sex work in a bar, documented)*

All four women's stories above emphasise that they were there in health settings, but they felt undermined by the services. MWSWs frequently sit waiting in medical settings where staff may not communicate with them openly, smile or make eye contact, but speak to them as if they are a duty to be processed rather than an individual to be engaged with.

Taken together, these accounts demonstrate how symbolic exclusion is rooted not in what is said, but in what is not said - in the lack of eye contact, warmth, empathy, or essential forms of interaction. These women were not denied care outright. They felt they were denied recognition. The intensity with which the MWSWs recalled these incidents conveyed how painfully they had internalised the negative responses as unescapable or normalised.

Internationally, Lam et al. (2021) also reported that, during the COVID-19 pandemic, migrants who worked in massage jobs were one of the earliest racialised groups and the last to be institutionally supported. Others were ineligible or chose not to access public health relief due to a lack of documentation, informal work, or fear of endangering immigration claims (e.g., under the U.S. "public charge" rule). Moreover,

those who qualified for help did not use it, fearing discrimination or monitoring. This exclusion was intensified by sudden unemployment at lockdown and added stigma associating Asian bodies with contagion. Public health crises can further aggravate structural exclusion when access to care and resources depends on legal or employment status. Instead of seeing Asian massage workers as members of the public to be cared for, the state treated them as a public health threat, further entrenching historic forms of racialised exclusion.

In the Southeast Asian context, Wong et al. (2012) analysed these parameters through the relationship between migration, sex work, and healthcare engagement among Singaporean foreign female entertainers. In an environment of sex work criminalisation, fear of stigmatisation, state surveillance, and deportation played a role in undermining trust in formal health facilities. Consequently, only 22% of migrant sex workers came forward to be tested for STIs.

This instrumental exclusion is reflected in Roguski's (2013) research with migrant sex workers in New Zealand, where decriminalisation did not remove the barriers to healthcare engagement. Notably, even with a relatively liberal legal system, language remained a formidable barrier, inhibiting sex workers from seeking mainstream services for fear of being ridiculed and misunderstood.

Together, these studies demonstrate that language is not a neutral technical matter, but rather a fundamental component of structural inequality. When combined with criminalisation, racial discrimination, and precarious migration status, linguistic inaccessibility makes migrant sex workers invisible to the systems that are established to engage with them.

5.3.3 Systemic inaccessibility: institutional expectations vs. everyday realities

In this section, the participants' data illustrate how the Thai healthcare system discriminates against MWSWs by imposing institutional demands that do not align with their lived experiences.

Thai healthcare is designed around an ideal user, one who is fluent in Thai, literate, and confident enough to navigate the national and local bureaucratic systems. Expectations that a patient will identify and call clinics, read instructions, or supervise their own follow-up were often not suitable for MWSWs in this study.

Namthip explained it at its simplest level.

> *"They told me about a clinic, but I have to call, and I can't do that because I don't speak Thai.".* (Namthip, 4 years of sex work in a bar, documented)

Kanya's evidence presents a robust understanding of exclusion from maternal healthcare services:

> *"It was 12 years ago…. I got pregnant with my first son while I worked at the bar. I learned recently that Thai people went to that ANC [antenatal] clinic to check and get vaccines, ultrasounds and many other things. I never knew it existed back then. With my second child, I went to that ANC clinic twice. A healthcare provider told me to follow my ANC book, but I didn't understand it and couldn't read it. So, it never happened." (Kanya, 29 years of sex work in a brothel, undocumented)*

Exclusion for Kanya arises from local informational and procedural gaps that mirror inequalities on a larger scale. The Thai ANC book, a tool designed to enable good care for mothers and the unborn child, became itself a feature of exclusion. *"I didn't know it way back then"* is an insight into the structural invisibility of migrant sex workers in maternal health policy and outreach efforts.

This finding is similar to the study by Deering et al. (2015), which investigated the uptake of HIV testing over 6 months among street and off-street sex workers (SWs) in Vancouver, Canada. The study found lower HIV testing rates among migrant and new immigrant sex workers. This inequity was exacerbated by language barriers, which limited access to services despite their structural availability. A large proportion of these women were located in street-based or off-street venues, where outreach was challenging, and concerns about being identified, stigmatised, or arrested further hampered engagement with testing.

Kanokwan, a service provider participant working directly with sex workers, gave an account that helps explain Namthip and Kanya's fear, uncertainty, and structural exclusion that weave in and out of MWSWs' decision-making. Healthcare is not just accessed or avoided but brokered through a prism of risk, cost and legal insecurity.

> *"People know their own country's healthcare … So when people are migrants, they'll ask themselves, 'What is the health system here? How much is it going to cost?' If they don't know, they'll likely put it off because they don't want to spend the money on themselves, yes? … There's more now on mobile phones and these kinds of things. Information is more available, but they now also want to know, 'What's the risk of going and getting healthcare? Will they help me if I don't have the documents? Will the healthcare places bring the police?' … these kinds of things. So, there's lots of fears. … It doesn't happen to everybody, of course, but a large group of women, whether sex workers or other migrant women workers, will wait as long as they can. So, of course, their condition becomes more complicated to treat, right? They'll put it off because they're worried about the money. And if they don't have any documents, they'll be worried about that." (Kanokwan, 30 years working with sex workers)*

Kanokwan's observations, spanning decades of work, capture a persistent theme in MWSW narratives: that a decision to seek care is often filtered through uncertainty over economic realities, fear of surveillance, and distrust in institutional systems.

Kanokwan's narrative resonates with Goffman's (1963) concept of anticipated stigma, which suggests that legal concerns and worrying about being judged mean that migrant women may postpone or avoid healthcare altogether and internalise the belief that they are unworthy or at risk of deportation. It is within Kabeer's (2000) framework of relational exclusion and institutional discrimination, in which healthcare systems, in their technical availability, are structurally misaligned to the lived realities of undocumented, marginalised women. Such women self-exclude for fear of financial, legal, and emotional harm.

Benjarat's account as a migrant woman sex worker with 15 years in a bar conveys how silence, fear, and structural neglect are linked to generate disempowering feelings about healthcare access.

> *"I'd worked in a brothel for 15 years, moving from place to place. I couldn't understand Thai, so I did what my boss told me. She never told me to protect myself and never got us tests for HIV or anything. One of the girls got very ill, and it turned out she had AIDS. She was sent home, and someone told me that she died last month. I was terrified of taking a test until now. I might already have that disease. I don't know what to do or where to go, and I'm not good at Thai."* (Benjarat, 15 years, sex work in a bar, undocumented)

Benjarat has lived outside health systems for many years. Her description, *"moving from place to place,"* indicates long-term engagement with the informal sex work sector, but that mobility is out of step with Thailand's public health structure, which expects individuals to register with their nearest facility. The death of her co-worker brings the systemic cost into sharp focus. This memory is not merely a personal anecdote; it represents a form of social and institutional rigidity. The suggestion is that when sex workers fall dangerously ill, they may be quietly removed from visibility, building a wall of fear and silence around the sickness for individuals.

Benjarat's vulnerability is not defined by any single signifier, but by multiple overlapping disadvantages. As a migrant, she suffers institutional invisibilities; as undocumented, she experiences an absence of legal protections; as a sex worker, she navigates criminalised, unregulated, and undercover spaces; and as a woman, she is expected to obey and be silent in a hierarchical structure of control at work by her boss.

Benjarat's story is illustrative of Goffman's (1963) notion of stigma as internalised fear and silence, where her lack of legal identity and language prevents her from seeking care, fearing she will be shamed and refused, and reinforces her notion of herself as unworthy and shameful. According to Kabeer (2000), her situation exemplifies the concept of adverse incorporation. She is integrated into an informal labour market in which healthcare is mediated through dependence, neglect, and a lack of control, such that her incorporation is exploitative and disempowering.

Febres-Cordero et al. (2020) reveal how structural violence, linked to the criminalisation of sex work and migration, erodes health, safety, and agency among migrant women engaged in the sex industry. Women were afraid to apply for health permits, go to clinics, or join peer-led health programmes, leaving them with little protection.

Goldenberg et al. (2017) shed even more light on how criminalisation has perverse and damaging impacts on workplace safety and sexual health. Making sex work illegal, not just for the sex worker but also the manager and venue, creates a perverse incentive not to support health. Managers tended to shy away from having condoms on the premises or speaking freely about HIV/STIs because they feared getting into legal trouble. This created an environment of silence and concealment, where life-saving harm reduction practices were rejected and ignored. These analyses question the value of criminalisation as a mechanism for protecting social order and general public health in the country. Rather, they suggest that laws that keep sex work in the shadows perpetuate the individual and public health deficits the laws were intended to resolve.

Folch et al. (2013) and Selvey et al. (2018) studies in Spain and Australia, respectively, found that MWSWs struggle to trust providers when they are met with discriminatory attitudes, poor communication, or a lack of understanding of their realities. Likewise, in my study, MWSW participants seeking healthcare reported feeling unwelcome, misunderstood, or disregarded. Kriitmaa (2023) exemplifies that criminalisation of sex work and undocumented migration status together create a chronic climate of fear, rationing access to healthcare among Somali migrant female sex workers (FSWs) in Nairobi, Kenya. This aligns with structural stigma models, similar to findings from Ma and Loke (2019) in Hong Kong, whereby anticipated stigma informs avoidance behaviour among female sex workers.

The stories of Benjarat, Kanya, Namthip, and Kanokwan, together, provide insight into living with systemic barriers. Each account reflects different experiences - HIV fear, antenatal and postnatal care, procedural limits, and general avoidance. What emerges is the subtle but destructive nature of exclusion, not through explicit denial but through design, language, silence, and anxiety.

Reflecting through, and across, my findings (5.3.1 - 5.3.3), I conclude that systemic exclusion in Thai healthcare is not always a product of a lack of services but instead can be a result of how services are arranged and encountered. Language barriers, especially, are not simply logistical barriers but were part of structural silencing practices tending to delegitimise MWSWs.

5.4 Theme 2: Survival and resistance: navigating through stigmatisation and discrimination

Recording the experiences of migrant women sex workers (MWSWs) accessing Thailand's healthcare services, it becomes evident that they do not undergo discrete forms of marginalisation but experience a pattern of intersecting oppression. The participants' testimonies illustrate that every aspect of their identity is a separate but interconnected marker of marginalisation. Their gender, class, migration status, and occupation are not experienced in isolation. Instead, they interweave to marginalise them further into social invisibility in healthcare spaces.

Crenshaw's (1991) intersectionality theory discusses that stigma does not exist in a vacuum. The MWSWs in this study are marginalised not just because they are sex workers, or migrants, or women, but because they are all three at once. Intersectionality enables me to consider how various axes of power (gender, race, class, legal status, and labour) interweave to produce different forms and levels of exclusion.

5.4.1 Hierarchies of exclusion in healthcare spaces

Perhaps the most impactful insight from the data is that MWSWs are placed at the bottom of the social hierarchy when they enter a healthcare setting. Here, Lalita, the service provider who has worked alongside the sex worker community, both Thai and migrant, for over three decades in the EMPOWER, explains the sequence of perceptions that place them on the bottom rung, based on her experience and observation.

> *"So, the first thing is that you're a lower class for sure; you're working class. They don't know you're a sex worker yet, but you're just local, so you're lower*

> *class. So, you're already dropped. And then, you're a woman, so you're a little bit dropped more by gender, right. And then, oh, you're a migrant, you can't communicate, you don't understand Thai, you don't understand anything. So, you've dropped again. And then, if you have to say that you're a sex worker because you think it's important for your healthcare, you drop again." (Lalita, service provider, 30 years working with the sex worker community).*

Lalita first emphasises how class is the first, albeit superficial, defining factor determining access to care: *"So, the first thing is your lower class for sure, you're working class*". In her view, the extent and quality of care an individual receives frequently depend on the economic capital one has.

Class, however, is not the sole determinant. Lalita moves to gender: *"So then, you're a woman, so you get dropped a little bit more by gender, right".* Marginalisation is not only further compounded by their gender, but even the structures within healthcare that have developed around them are shaped by Thai patriarchal norms. Women who are viewed as financially precarious or morally dubious, in particular, may be subject to condescension, dismissed, or restricted from making medical decisions for themselves.

The compounding layer of exclusion is when migration status and language barriers are introduced. *"Oh, you're a migrant, you can't speak, you can't understand Thai, you can't understand anything. So, you drop again."* Linguistic exclusion acts as a gatekeeping mechanism that inhibits MWSWs from asserting their health needs. It is not just miscommunication. The role of Thai language as the language of healthcare, at least in the public healthcare sector, underlies a systemic denial of agency – an unstated assertion that only those whose identities conform to the ideal patient paradigm can expect top care.

Finally, sex work per se introduces the important element of stigma: *"And then if you have to say that you're a sex worker because you think it's important for your healthcare, you drop again"*. It reflects the place sex work occupies socially and culturally outside of general acceptance.

Many MWSWs in this study keep their work hidden due to the fear of stigma or moral judgment from others. Once a MWSW goes through the doors of a healthcare facility, she is not just a patient; she is a collection of social denotations, each one burdened with stigma and marginality. Therein lies a survival calculation. Concealing one's work may succeed in stigma management, but at the price of receiving suboptimal care.

Bak (2018) notes that exclusion is often perpetuated through fluid and structural processes—perceptions, presumptions, and institutionalised cultures—that comprehend and accelerate the risks faced by some groups more than others.

Lalita's observation exemplifies Kimberlé Crenshaw's (1991) seminal insight that marginalisation cannot be understood through single-axis frameworks. Rather, access and outcome are shaped by the interaction of multiple identities in the social sphere. Here, sex work, class, gender, nationality, and language are not just additive; they are multiplicative. Each identity intersects with institutional norms and social biases in a way that marginalises MWSWs more completely.

This analysis also illustrates the co-existence of invisibility and hypervisibility. Migrant women sex workers are, on the one hand, invisible within the design of policy and the expectation of language. On the other hand, they are hypervisible deviants from the norm in each individual contact with a clinical facility. Lalita's narrative reframes exclusion as a social sorting mechanism that begins the moment a woman enters a healthcare space.

Here, Orapin, who has worked in a bar for 8 years and understands Thai at a conversational level, illustrates the everyday ways social exclusion can be experienced in healthcare, and how it can be resisted. Her observation that registration staff "shouted" or "talked poorly" to her when they saw her card or name shows that exclusion is not only bureaucratic but also symbolic and personal, in the attitudes of healthcare gatekeepers.

> *"I think the registration staff wasn't friendly to me. When they see your card or your name, they know you're a migrant. So, they'll not look nice to you, mainly most of the time. They often shouted at me and talked poorly to me. I didn't*

> *understand why. I want to seek care, that's all."* (Orapin, 8 years of sex work in a bar, documented*)*

As a migrant, Orapin is already identified as an outsider by her interaction with staff at the clinic reception. Any hope of privacy evaporates. Instead of respect or compassion, she feels she has entered a hostile environment. Orapin's reflection captures not just the outward discrimination but also an internalised sense of inferiority. She begins to ask whether she deserves respectful care at all.

These encounters breach essential ethical principles of equal care and non-discrimination in healthcare. When administrative staff react with unfriendliness based on an individual's migrant status, they add to an informal culture of exclusion that may undermine rights to dignity and equitable care guaranteed in national and universal health policies.

Jiraporn, who also understands Thai at a conversational level, explained further.

> *"Once they knew that I was a migrant, they would change their manner and words. They would talk down to and shout at me, sometimes making me feel so low. I also saw how they treat Thais differently from me, especially when they look at me."* (Jiraporn, 4 years of sex work in a bar, documented)

Jiraporn's account serves as a poignant instance of relational exclusion and symbolic misrecognition within the healthcare system, resonating especially with Bak's (2018) conceptual framework and demonstrating the intersecting impacts of nationality, gender and occupation. Her experience highlights that healthcare encounters can serve as sites through which social hierarchies are reaffirmed by tone, body language, and discriminatory treatment, rather than being levelled through the quality and equality of care.

In the following subsection, data captured the experiences of MWSWs who set out how their healthcare interactions were shaped by their multifaceted identities of being migrants, sex workers, and women.

5.4.2 Stigma as structure—how healthcare marks and marginalises.

MWSW participants had few experiences to share of culturally safe, migrant-centred care. As discussed in Section 5.4.1 above, the majority reported uncomfortable or detrimental interactions with healthcare staff. Many explained that they do not disclose their sex work to healthcare providers in order to avoid stigma and judgment.

Thippawan has been a sex worker in the country for 23 years. Her bar owner required all workers to show their STD/HIV results every 4 weeks to continue working. Regular STD/HIV testing is often needed in provinces where sex work is established and structured by the Ministry of Public Health. The conditions differ depending on the venue, type of work, and location. Thippawan's narrative highlights how various components of oppression, based on gender, migration status, and sex work identity, interact to produce unique interactions and humiliations.

> *"Well, actually, if I went to the public sexual health service for a blood test or a Pap Smear, they'll already have a register book there, you know. That book will separate me from others like a wife, housekeeper, maid, waitress, etc. When I got there, the staff would ask me: "What is your job?". I would say, "I work in go-go bar". So, they'd give me a pink card while giving others a blue one. So, it's already identified me as different from others. People would see, and they might learn that I might be someone who works in a sex work. And the staff would ask me like later, like emmm, "How many men did I have sex with last night, or when was the last time I had sex?". I thought it was not their job to know about these. I think it's just their personal attitude about me, you know. So, I was identified as working as a sex worker initially. But then, I would show the staff my passport. And then, people who were waiting for the test would have seen that I'm a migrant woman. So, I could feel that they already hold a negative view of my work, plus I'm a migrant. So, the staff would treat me differently from others. Sometimes, they called me: "That girl with a pink card with syphilis." Well, I was very humiliated. I was insulted and very angry. I think their negative view of sex work and migration makes it uneasy for me." (Thippawan, 23 years of sex work in a brothel, undocumented)*

Thippawan's account offers a glimpse into how stigma and judgement are embedded in the administrative processes before even the clinical purpose of her attendance begins. The power inequalities between patients and healthcare providers begin at the reception desk. The colour-coded registration system, in which sex workers receive a pink card. At the same time, everyone else getting blue is humiliating by exposing her sex work status to those around her at the registration desk and waiting area, and she feels that it subjects her to unnecessary scrutiny. The colour-coded cards function not merely as administrative instruments but as visible tokens of social hierarchy, keeping her apart from patients considered more "respectable" such as wives, maids, and housekeepers. Such categorisation is more than bureaucratic; it is also performative, rendering her identity a subject of public speculation and judgement.

Thippawan's story provides a powerful illustration of Goffman's (1963) stigma as a public mark and a spoiled social identity through institutional indicators. From Kabeer's (2000) perspective, this is adverse incorporation, in which she is incorporated into healthcare on terms that reproduce social hierarchy and exclusion, on the condition of enduring symbolic violence and structural degradation. Card colour, labelling health conditions in public, and judgmental questions are not merely interpersonal failings; they are exclusionary modes of operation ingrained in public health practice.

Thippawan further feels that invasive inquiries into the details of her sexual activity beyond strictly necessary case history also convey moralistic and discriminatory attitudes. It becomes an institutional form of social humiliation. This is consistent with the broader sense described earlier by Lalita, in which healthcare facilities see sex workers as a group and primarily in terms of sexual risk rather than as individuals with individual health needs.

Thippawan feels that she has been defined by her job at the outset. That risks closing down the normal open-ended enquiry about her health that another patient might expect. Then, once her migrant identity comes into view via her passport, her social positioning becomes even worse. The staff description of her as *"that girl with a pink card with syphilis"* is more than a breach of patient confidentiality; it shows how these dual stigmas are interwoven and result in humiliating and dehumanising treatment. These are not singular attitudes but instances of relational exclusion within a frame

described by Bak (2018) in which individuals exist within systems but are not counted as legitimate players.

From an intersectional perspective, Thippawan's experience embodies the layered discrimination confronted by MWSWs. Her first mention of working in a go-go bar prompts assumptions and intrusive questions. Her passport — an emblem designed to normalise her being where she was serves to incriminate her further, to single her out and label her a foreigner, a deviation, and an outsider. She is more than patient. She is a representation of deviance where gender, sex work, and migration status intersect. Her story is a powerful demonstration that exclusion is not only about access to services; it is also about the fundamental right to be included. Drawing on Goffman's (1963) concept of the "spoiled identity," it becomes clear how certain identities — such as being a sex worker — invite social scrutiny and stigma. When compounded by another marginalised identity, such as being a migrant, the stigma intensifies, resulting in layered exclusion and emotional harm. Intersectionally, this produces what I refer to as a "fall of marginalisation" — a cumulative descent into deeper social and emotional exclusion as overlapping stigmas interact.

Similarly, Dawan has worked in a bar for three years, sharing her encounters. Her manager requires her monthly STD/HIV test results.

> *"At the health centre (sexual health centre), we got to go there because it's not too expensive for us. I paid around 100 THB each time for a blood test. If a GP gave me some medicine for any vagina infection, I sometimes paid an extra 300 THB. Yes, it's better than private clinics, for which I probably pay around 1,000-2,000 THB each time. But I got to go through the system that gives different colour forms, and people probably knew that I was a sex worker. It's really humiliating for me. I often felt sad, but where else could I go? We (sex workers) all have to go there and feel the same. It's sad".* (Dawan, 3 years of sex work in a bar, undocumented).

Dawan's experience reveals the calculations within healthcare access that MWSWs make. Public clinics are a relatively inexpensive option on one side, but they institutionalise stigma through administrative mechanisms such as their colour-coded forms that humiliate and 'out' sex workers. There is a substantial private health sector

in Thailand that can provide treatment and testing, but at several times the cost to the individual.

Dawan's account offers a deep ambivalence. She is grateful for the affordability of sexual healthcare within the public health setting, but, as previously described by Dawan, she describes that access as emotionally painful and humiliating.

"It's really humiliating for me…where else could I go…It's sad" (Dawan).

Dawan's account highlights the paradox of MWSWs' access to healthcare. While 'healthcare' may be offered, it is compromised by conditions that diminish dignity and produce shame, an illustration of how inclusion can involve exclusionary practice. Despite that, she and others like her still end up at the clinic:

"We're all going to go there and have the same feeling". (Dawan)

This is the collective resignation to a system that fails to serve their emotional or social needs, yet is the only alternative within reach. This aligns with a pivotal point in Bak's (2018) argument, which suggests that authentic inclusion also requires recognition and equality. Without those, it is just a more refined version of exclusion.

In international research, the exploration by Rocha-Jiménez et al. (2017) in Guatemala revealed that the Cartilla, a mandatory identification card for sex workers, had a dual role. On the one hand, it afforded free and routine STI/HIV testing, which several participants respected for being a means of health surveillance and personal care. On the other hand, the Cartilla also served as a means of surveillance, where workers were subjected to being labelled, monitored, and having their personal information compromised. Some sex worker migrants were worried that holding the Cartilla identified them as sex workers in public, positing that the Cartilla acted as an additional stigmatising and discriminatory factor.

Rocha-Jiménez et al. (2017) research suggested that despite the Cartilla's intended use as a public health intervention, the association of care with formal registration and documentation detaches health itself from an institution of protection and care into the apparatus of state surveillance. This hampers the voluntary nature of care and

exposes sex workers, in particular migrants, to precarity in relation to their approach to healthcare, which can be linked to social or legal penalties.

5.4.3 Layered exclusion: gender, migration, and sex work in clinical encounters

While MWSWs in this study were officially permitted to access sexual and reproductive healthcare, women such as Amporn, Rasamee, Namthip, and Panida described encounters that were anything but respectful or safe. Instead, care became emotionally distressing and morally charged, markedly when gender, migration status, and occupational stigma overlapped.

In each case, intimate medical procedures such as Pap smears and vaginal exams became sites of humiliation, where sex workers' rights to consent, privacy, and dignity were undermined by assumptions that their occupation made them less deserving of respectful treatment. The discrimination they faced was not structural in a distant sense, but produced through everyday interactions: a general practitioner (GP)'s tone, an invasive question, a shaming remark. These women's stories display how institutional stigma is reproduced through the ordinary behaviours of healthcare providers, and how this symbolic devaluation can alienate women from care just as powerfully as outright denial.

Amporn, a documented migrant woman who has worked for ten years as a freelance sex worker, recalled her and others, sex workers, visiting a women's sexual health centre for regular checkups.

> *"Yes, there were 2 or 3 cases where the staff spoke badly and insulted us. Yes, they insulted the way we work like this, our job. Another case was a new girl who was embarrassed by the GP who came to check on her. She didn't want to do a Pap smear because she felt embarrassed with that GP. That GP was insulted and shouted at her…At that time, I remember the new girl lying on the bed waiting for the GP. She didn't want to do a Pap-smear when she noticed that he was a man. So, that GP shouted loudly, scolded her, and said many bad words about sex work. I thought he was annoyed or something like that,*

> *too. It was difficult for me, too…(Amporn, 10 years of sex work as a freelance/activist, documented)"*

Amporn's story was similar to other participants of healthcare providers being openly antagonistic towards and mocking of sex workers. These are not experienced by the women as instances of unprofessional conduct but as instances of professionalised moral judgement, where practitioners become enforcers of dominant social values rather than patient-focused carers.

Rather than being perceived as a patient with rights, the woman was handled as unworthy of respect, and her discomfort was rejected. Several participants confirmed these instances of daily embarrassment and humiliation that appear to disregard the core principles of informed consent and patient dignity, which are rooted in medical ethics.

Benjamas, an undocumented woman who has worked in a massage parlour for three years, explained how a male GP rejected her during a sexual health examination. She recalled asking staff that she did not want to be checked by a male GP, but instead of being offered an alternative clinician, she was asked, *"If you're a sex worker, what's the problem?"*

> *"…I didn't want to open my legs for a man doctor. But they told me, 'If you're a sex worker, what's the problem?...Yes, it's tough and we're feeling the same…'"* (Benjamas, 3 years of sex work in a massage parlour, undocumented).

Her experience illustrates how sex workers' boundaries are frequently downgraded or disregarded in medical settings. Rather than being treated as a patient with rights, she was talked to as if sex work itself removes the right to privacy or bodily autonomy. The rhetorical question put to her both rejects her discomfort as insignificant and defines her work against her, highlighting the idea that sex workers no longer own their bodies, even in a clinical setting. In this argument, sex work not only defines them but also excludes them from the protections commonly provided to patients.

Siriporn, a documented sex worker who has worked online/freelance for five years, stated how uneasy she felt during a session at a women's health clinic. While being

examined, a male GP asked questions about her customers and her sex work in a manner that made her feel judged.

> *"I don't want to go there really…That doctor in a women's clinic, he asked me while he examined me… about my clients, about my work. I didn't like that…Sometimes the way he talks, like he thinks I have no shame or privacy because of my work."* (Siriporn, 5 years of sex work via online/freelancer, documented).

For Siriporn, the medical setting became another place where her work was perceived as validation for offensive questioning, and an absence of basic respect added a layer of emotional and psychological damage. The GP's questions about her customers and work make her feel as though she has "no shame or privacy." The question suggested a medical eye not focused on care, but nosiness and judgment. These types of encounters left her unwilling to return for care.

Panida, who has worked in karaoke shops for seven years, told how a GP once questioned her during a vaginal exam about how many men she had sex with the night before. She defined the question as extremely offensive and inappropriate, but explained that she and her co-sex workers have no choice. They are required to attend regular tests to meet their boss's requirements. For Panida, the experience of being questioned during intimate examination reflected the absence of control she felt, both as a worker and as a patient.

> *"Then, a GP who checked my vagina asked me how many guys I had sex with last night. I wouldn't say I like that kind of question. But we all got to go there because our boss needed our blood and vagina tests three times a month. So, it's tough." (Panida, 7 years of sex work in a karaoke shop, documented)*

MWSW participants may have formal access to reproductive healthcare in Thailand. However, their experiences indicate that the care they receive is frequently morally charged, emotionally damaging, and affected by institutionalised stigma. Through routine humiliations such as unsuitable attitude of clinical staff, poor communication, inappropriate questions, and disregarding boundaries, the MWSWWs are not explicitly

denied care. However, they are symbolically excluded and emotionally disciplined for who they are and what they do.

Goffman's (1963) model of stigma as an act of *spoiled identity* echoes here. The MWSW participants are not only stigmatised, they are overtly degraded through the language, attitude, and conduct of routine medical interactions. Scambler's (2007) note on the distinction between felt and enacted stigma also relates: the women internalise this opposition, anticipating humiliation and, to some extent, withdrawing from care generally.

Here, Suneerat, Malinee, and Yada emphasise further how stigma in the health system occurs when medical care becomes conditional. Suneerat reported how her uneasy encounter began with the first interaction at the healthcare facility.

> *"I think the registration staff wasn't friendly to me. When they see your card or your name, they know you're a migrant. So, they'll not look nice to you, mainly most of the time. They often shouted at me and talked poorly to me. I didn't understand why. I want to seek care, that's all. Or maybe I am a migrant … ?" (Suneerat, 8 years of sex work in go-go bar/activist, documented)*

Suneerat, a documented migrant who works in go-go bar, regularly faces being spoken down to by health facility staff when they see she is a migrant from her name or ID card. Her valid documentation does not protect her from discrimination. Rather, it acts as a sign of difference that allows for profiling and a negative attitude. Kabeer (2000) describes this as adverse incorporation; marginalised people are incorporated into public systems, although on unequal and often degrading terms. Institutional protocols, far from easing access, are instruments of subtle exclusion.

Malinee recounted her repeated humiliating experiences when attending regular checks at a local sexual health clinic.

> *"I have to show my blood result every three months. And my Pap-smear exam every month. But, well, my colleagues who work as full-time girls must show their Pap-smear results three times a month. We are all suffering from such a policy, plus we are humiliated by these health services. We can't escape*

> *anyway because of our jobs, and we're migrants, you see. My friends couldn't afford a private clinic, so they must live with these unkind services. They must go for the test over and over. They have to give their results back to their boss, you know" (Malinee, 8 years of sex work in go-go bar/activist, documented).*

Malinee's story testifies to the fact that while public provision exists at a technical level, in practice, it is intertwined with workplace ownership of their interactions with healthcare facilities. Handing over the results to their boss as a condition of employment converts medical findings into instruments of control. There are strong public health arguments to be made for regular testing, but Malinee sees that the dignity of the women themselves is lost in the name of workplace compliance.

Also, Yada shared her story.

> *"I visited that place (STD/HIV clinic) years ago with other girls, and it was too much for me. I couldn't bear that service. They made me feel dirty and humiliated. I cried after I left that place. I never visit that centre again." (Yada, 16 years as a freelance sex worker, documented)*

Freelance sex-worker Yada, 16 years in this work, remembers visiting an STD/HIV clinic where she was traumatised. Her story captures the emotional burden of social stigma. Feeling *"dirty"* is symbolic violence, the socially constructed lower status that was imposed in a health setting. Her experience confirms that stigma is not just a way of thinking about others, but a driver of exclusion, communicated, but not limited to, tone, interaction, and treatment. When healthcare environments become emotionally unsafe, even the most essential services become effectively inaccessible. She never went back.

The women's accounts above illustrate how structural stigma is reproduced through apparently ordinary medical encounters. This stigma transcends individual behaviour. It extends to the practices and structures in which healthcare is engaged and is exacerbated when attendance at the healthcare facility becomes associated with the coercion by employers and managers with the threat of dismissal for failure to comply.

In Thailand, Utthasit's (2018) recent research offers a rare, rich portrait of the lives of male migrant sex workers from Cambodia, Laos, Myanmar, and Vietnam (CLMV) who work in Bangkok, Thailand. Face-to-face interviews were conducted with 14 male migrant sex workers from the four CLMV countries. Utthasit's (2018) study suggests that CLMV male migrant sex workers also experience structural exclusion from formal healthcare systems because of their uncertain legal status, the criminalisation of sex work, and widespread social stigma. The research reveals that when a participant's occupation or migrant status is disclosed, they often face discrimination from healthcare workers. It is a double stigma of sex worker and immigrant, and it generates an atmosphere of fear and suspicion. As a result, many may delay or forego care, especially for sensitive services like HIV testing, STI treatment, and mental health care, although they are in high-risk groups.

In Russia, Weine et al. (2013) present a robust evaluation of how stigma operates as a structural impact that shapes the healthcare experiences of female migrant sex workers (FMSWs) in Moscow. Their ethnographic investigation found that the intersection of gender, migration status, and ethnic identity increases vulnerability to HIV, not because of individual irresponsibility, but over systemic exclusion and institutional discrimination. FMSWs, specifically those from Central Asia and Eastern Europe, confront racialised stigma that not only exposes them to violence by customers and police forces but also directs them to scepticism and avoidance of healthcare services. The fear of being denied treatment, mistreated, or abused in health settings operates as a disincentive to care-seeking at all. The study emphasises that healthcare settings are not neutral places, but spaces where national, gendered, and moral hierarchies are replicated. They report that the stigma is not just external. Women internalise shame and social judgement, specifically those from Muslim-majority backgrounds where sex work is broadly banned. This internalised stigma turns into a form of self-regulation, driving women to exclude themselves from care even when it is officially available.

Weine et al. (2013)'s work highlights that stigma is not a side effect of marginalisation. It is a leading process by which exclusion is upheld, and healthcare rights are systematically weakened. Rocha-Jiménez et al. (2018) in Guatemala highlighted that the most general challenge to healthcare inclusion was the offensive and degrading

behaviour that healthcare providers addressed to MWSWs. This attitude was harsh in STI clinics, where doctors and nurses struggled visibly when treating MWSWs. Several women said some providers avoided eye contact, rushed through appointments, or shied away from touching them, amplifying their signal that sex work is not to be condoned. These actions bolstered their perception that sex workers were not considered worthy of the same standard of care as other patients.

5.5 Chapter summary

In this chapter, the participants' data reveal the complex and layered ways in which migrant women sex workers (MWSWs) experience healthcare access through two intersecting themes. In Theme 1: *Speaking through silence – structural exclusion and healthcare navigation*, I present how communicative, symbolic, and institutional barriers operate not just to limit MWSWs' ability to access care but essentially disempowers them within the medical interaction. In the subtheme *Exclusion through communicative disempowerment*, data demonstrate how language barriers, epistemic exclusion, and fear of legal or moral repercussions prevent women from understanding, questioning, or actively participating in their own care. Even when technically "included" in care, participants often received services passively, without consent or comprehension - what Kabeer (2000) terms adverse incorporation, and what Bak (2018) describes as relational exclusion. In these encounters, healthcare becomes less a space of healing and more a site of disconnection and risk.

This theme also included accounts of symbolic misrecognition, where women described being overlooked, spoken down to, or visibly marked as 'other' through nonverbal cues or administrative processes, echoing Bak's (2018) argument that exclusion often happens not through denial, but through the subtle communicative signals that render certain patients invisible.

Similarly, in *Systemic inaccessibility*, data demonstrated how institutional expectations, such as reading medical forms, calling clinics, or interpreting test results, assume a literate, Thai-speaking, legally documented user, a profile that MWSWs do not fit. The result is a silent, chronic form of structural neglect.

In *Theme 2: Survival and resistance – navigating through stigmatisation and discrimination*, I shifted focus to how MWSWs encounter and respond to multiple, overlapping forms of stigma. Drawing on Crenshaw's (1991) theory of intersectionality, participants' narratives highlighted how gender, migrant status, occupation, and class interrelate to reproduce vulnerability within healthcare settings. In *Hierarchies of exclusion*, data indicated how institutional structures classify patients along socio-legal lines, with MWSWs constantly finding themselves at the bottom of the social hierarchy. In *Stigma as structure*, participants described being humiliated or singled out or subjected to intrusive questioning, labelling practices, or negative tone, illustrating how healthcare institutions operationalise moral stigma during routine practices. Finally, in *Layered exclusion*, participants' data illustrated how MWSWs experience healthcare not as a protective right, but as a sphere associated with risk, fear, and exposure. However, participants also communicated methods of opposition, such as tactical disclosure, reliance on co-sex worker networks, or quiet refusals to participate in subtle yet intense approaches of asserting agency within a punishing system.

Together, these themes suggest that MWSWs' healthcare access in Thailand is not simply an issue of availability or eligibility, but of exclusion through structural design, communicative power, and social legitimacy. Healthcare encounters, framed by law, language, labour, and gender, both reflect and reproduce broader systems of inequality. Rather than alleviating exclusion, many encounters reinforce it. And yet, within these systems, women also navigate, negotiate, and resist, making visible the need not only for inclusive policy but also for structurally attuned, culturally safe, and linguistically accessible models of care.

In Chapter 7, I synthesise these detailed findings into four interlinked domains of exclusion - *communicative and cultural exclusion, symbolic misrecognition, systemic inaccessibility, and intersectional hierarchies* - to illustrate how these barriers are rooted in the structure and delivery of healthcare. This conversion from thematic detail to conceptual domain explains how my interpretation is informed by participants' descriptions, while also presenting a broader framework for understanding compounded exclusion.

Chapter 6: Negotiating Visibility: The Conditional and Contested Nature of Healthcare Access for MWSWs

6.1 Introduction

Throughout this chapter, I draw on intersectionality (Crenshaw, 1989,1991), spoiled identity (Goffman, 1963), and symbolic exclusion (Bak, 2018), which create adverse incorporation (Kabeer, 2000) as analytical tools to understand how identities such as gender, migration status, and sex work do not operate in isolation but compound to create specific forms of structural vulnerability. These intersecting oppressions are not hypothetical. They are evident in the choices my participants describe to avoid hospitals and clinics, hide their identities, engage with informal networks, or silently endure infections and chronic health conditions to avoid inspection or exposure.

In Chapter 5, I demonstrated how MWSWs are constructed as being peripheral to healthcare through four connected domains of exclusion: *Communicative and Cultural Exclusion, Symbolic Misrecognition, Systemic Inaccessibility and Intersectional Hierarchies* (illustrated further in Chapter 7). These domains demonstrate that exclusion is not produced by a discrete barrier, but rather performatively accomplished through the intersecting force of language, stigma, legal precarity and bureaucratic form. This chapter focuses on how these dynamics render many MWSWs functionally excluded from care, despite any eligibility on paper.

However, this chapter goes a step further to consider how women develop strategies of dealing with this functional exclusion, including alternative forms of caregiving they might use when formal provision is inaccessible. I illustrate my findings in two thematic sections.

In the first theme, 6.2: *Excluded in Plain Sight: Structural, Symbolic, and Social Barriers to Healthcare,* I discuss how participants navigate healthcare systems that are formally available but are perceived as threatening or inaccessible. Many MWSW participants described being excluded not through direct denial of service, but through fear of exposure and possible deportation, language barriers, past mistreatment, and bureaucratic rigidity. I consider that their unwillingness to engage does not result from

ignorance, indifference, or irresponsibility, but is instead a rational response to risk, dehumanisation, and discrimination.

The second theme, 6.3: *Informal Care, Peer Networks and Dignity in the Gaps,* presents how MWSWs find informal, grassroots alternatives to address their healthcare needs. Their communities translate and support, share the emotional stress, and reach out to advocate for others. These kinds of care are not presented as rights, but as negotiated and often precarious acts of solidarity. When care is on occasion experienced as respectful or inclusive, it is described as “surprising” or “lucky”.

In Table 6.1 below, I identify individual participant stories that illustrate each subtheme in this findings chapter, but they are not the only examples from among the MWSWs interviews. In fact, the majority of MWSW participants referenced each identified concern in some form.

Table 6.1: Participant data contributing to the themes

Themes	Subthemes	Participants (Main stories drawn from)	Rationale for selection
6.2 Theme 1: *Excluded in plain sight: structural, symbolic, and social barriers to healthcare.*	Section 6.2.1 Structural fear and access shaped by the interaction of formal policy and informal risk perception	Suranee, Kamonrat, and Ladda	These participants represent the clearest examples of how fear of legal consequences, undocumented status, and bureaucratic exclusion deter MWSWs from seeking care.
	Section 6.2.2 Stigma, silence, and social risk: healthcare avoidance as survival	Kamonrat, Suranee, and Urai	These women's narratives best capture the psychosocial burden of healthcare avoidance due to anticipated stigma, social exposure, and the emotional cost of invisibility.
6.3 Theme 2: *Informal care, peer networks, and dignity in the gaps*	Section 6.3.1 Exceptional encounters with care providers	Wichuda, Orapin, Arisa and Kanokwan,	Described examples of respectful treatment with language assistance and patient healthcare staff. Received care in her own language without being asked about legal status or work. Hospitalised and supported by staff despite language barriers, highlighting the role of individual

Themes	Subthemes	Participants (Main stories drawn from)	Rationale for selection
			empathy. Service provider who explained access to anonymous, user-friendly HIV services at specific hospitals.
	Section 6.3.2 Peer-led navigation and informal support	Ladda, Wipavee, Suneerat, Benjarat, and Monthira	Acted as a translator and support guide for other women during mobile clinic visits at her workplace. Provided translation and emotional support; also described the health education role of EMPOWER. Accessed care through group visits led by peers or NGO staff, highlighting collective strategies. NGO staff who explained how mobile outreach and workplace visits replaced formal care access.

In the next theme and subthemes, I identify the emotional and social costs that lead MWSWs to pause or avoid care altogether. Silence, shame, and fear become survival tactics in response to a system that consistently marginalises.

6.2 Theme 1: Excluded in plain sight: structural, symbolic, and social barriers to healthcare

In this section, I regard health exclusion in MWSWs not as an absolute refusal of care, but as the interaction of structural, symbolic, and social factors that render care suboptimal in practice. MWSWs are excluded in circumstances that are subtle, cumulative, and deeply embedded. Fear of arrest, deportation, or institutional scrutiny discourages many from seeking care, even when they are legally permitted to do so. At the same time, stigma rooted in their sex work occupation, gender, and migration status shapes a persistent fear of exposure, judgment, or moral condemnation within clinical settings. These are compounded by language barriers, lack of bureaucratic flexibility, and insufficient culturally relevant health communication. In combination, these experiences and perceptions demonstrate that exclusion is not only a matter of law or policy, but a reflection of larger systems of value, entitlement, and recognition.

6.2.1 Structural fear and access shaped by the interaction of formal policy and informal risk perception

In this subsection, I illustrate how participants in this study described avoiding public healthcare engagement because they perceived it as a space of legal, emotional, and bureaucratic risk for them. The combination of their migrant status and work in the sex industry rendered them hypervisible and vulnerable.

Participants spoke of seeking care as personally dangerous. Experience of previous arrests or deportation caused them to view hospitals and healthcare facilities as an extension of immigration control.

Suranee shared:

> *“We were all migrant sex workers in that brothel, and no one had a passport. Our papers were fake documents made for us by our boss. So, we worked*

> *together like that for many years, 6 or 7 years, I guess, never going through any health checks or having any health information. We worried that we'd get arrested again and sent back to Myanmar. I already got arrested twice and was deported home, but I managed to return, though. So, we didn't want to contact any further Thai authorities or anyone. I never knew that there were condoms that we were supposed to use or infectious diseases that were linked to our sex work back then; I was young and didn't understand this thing. My Thai was also very bad back then, and no one ever told me about this thing".* (Suranee, 10 years of sex work in a brothel, undocumented*).*

Suranee's story gives a powerful insight into the lived experiences of undocumented migrant women in the Thai sex industry. Her fear is not irrational. This mode of fear is best recognised as structural fear - not only anxiety around potential punishment and disruption of her life, but a rational reaction to controlling systems and state institutions. For MWSWs, even basic health services are threaded with the risk of exposure and legal consequences. Suranee's decision to give up health checks or health information is not because of apathy or ignorance, but is felt as a matter of self-preservation within a system that does not guarantee protection:

"So, we didn't want to contact any further Thai authorities or anyone."

Suranee's undocumented status and false papers supplied by her boss further demonstrate how informal economies enable survival but simultaneously entrench vulnerability. This blurred boundary between employer-protection and employer-control signifies that her workplace, the brothel, is experienced as a place both of defence against the state but also of personal oppression, constraining her health autonomy. Work in the informal economy can tie MWSWs into a cycle of dependence and silence, where asking questions or pursuing external support is perceived as threatening.

Suranee's lack of access to basic sexual health knowledge *("I never knew there were condoms we were supposed to use"*) is not only a sign of her youth or lack of education but becomes part of a systemic denial of rights. Her lack of ability in the Thai language additionally illustrates the healthcare deficit when health information is supplied within the narrow lines of language, citizenship, and power. The knowledge never reached

her, not because it did not exist in the system, but because the system was never designed to reach her.

Intersectionality here is not additive but compounding: being undocumented, woman, a migrant, and a sex worker overlap in respects that not only inhibit healthcare access but convert it into a risky place. For Suranee, attending a clinic could lead to detention. Speaking poor Thai denotes being misheard or overlooked. Ignorance of her rights (or having none to start with) leads to health illiteracy.

From this perspective, informal risk assessment becomes a rational approach. The decision to continue in the shadows, to stay away from clinics, to continue to be uninformed, is formed by how state control and public stigma have been internalised. This paradox - avoiding care to survive - is what makes Suranee's experience characteristic of the structural fear that many MWSWs in this study share.

Even basic procedures triggered anxiety for Kamonrat, an undocumented migrant sex worker of 20 years in Chiang Mai. Ignorance of available sexual health information worked as a system of control and exclusion:

> *"I don't have any cards. I don't have any. A 30-baht healthcare card, like a universal health insurance card, is not yet available. Yes, I just recently came to know that there are condoms to give away. There is a free blood test. There is a free Pap smear in Chiang Mai. Before that, I didn't know about this stuff. I was terrified that healthcare staff would ask me about my papers and job… that's not good for me."* (Kamonrat, 20 years of sex work in a bar, undocumented*)*

Kamonrat expands on how structural fear works not just as a barrier to healthcare but also as a day-to-day reality through which information, right, and visibility are filtered. She recognises that 'the 30-baht' universal healthcare insurance is a mark of state inclusion that is out of her reach.

"I don't have any cards. I don't have any."

Kamonrat's undocumented status cuts her off from the formal health structure, but also, as a consequence, from the reproductive and sexual health informational networks about blood testing and free condoms.

Similar to Suranee, Kamonrat's health illiteracy is not a personal failing but follows from systemic oversight of the unnoticed and the vulnerable. Her fear is structurally rational. State-related healthcare facilities in Thailand often require documentation, and entering these facilities may involve indirect contact with authorities or bureaucratic systems. When her undocumented status and stigmatised work are both subject to possible inspection, the healthcare system is regarded from her perspective less as a safety net and more as a checkpoint.

Finally, her reference to Chiang Mai—*"There is a free Pap smear in Chiang Mai"*—proposes the geographical inequality in healthcare awareness and availability. Even when free services exist, their reach may not extend to marginalised groups such as undocumented MWSWs. Availability is defined not only by services existing, but also about whether individuals feel safe and eligible to access them.

Ladda, who is documented, was misinformed:

> *"I never knew I could go to public hospitals or healthcare centres. I thought they were not for migrant sex workers because we are breaking the law here."* (Ladda, 27 years of sex work in a bar, documented)

Ladda's account adds a critical nuance to this subtheme. Possession of immigration documentation is itself not enough to overcome the deep roots of structural stigma. She still internalises the assumption that public healthcare is barred to someone like her. This illustrates how lawful inclusion on paper can be rendered meaningless by cultural, institutional, and moral exclusion in practice.

Her belief that *"they were not for migrant sex workers because we are breaking the law here"* makes a crucial connection between the criminalisation of sex work in Thailand and perceived exclusion from state institutions.

Ladda does not have actual experience of being denied care. What blocks her from engagement is a perception: the internalised belief that her identity, as a migrant sex worker, denies her access to care. Ladda avoids systems not because she has been clearly excluded, but because she has absorbed through experience, observation, or community dialogue that she is unwelcome.

Access to care is not only a bureaucratic or logistical issue; it is also a matter of whether individuals perceive themselves as morally entitled to exist in that space. The

fact that she *“never knew*” she had permission to access healthcare is not absolutely a personal oversight, but the consequence of a narrative and a system that does not actively include or inform identifiable groups. Informational disregard is itself a structural process of exclusion, one that functions silently, without the need for explicit denial or confrontation.

Such statements reveal that invisibility is a survival tactic, not a sign of apathy. For Ladda, staying away from healthcare is a rational assessment of her lived experience in a society that criminalises, stigmatises, and morally condemns her occupation.

These findings are consistent with Bak’s (2018) ideas about exclusion being relational. Fear, distrust, and uncertainty are not just individual subjective responses. They are also the effects of social division. The legal vulnerabilities of sex work exacerbate migrant sex workers’ vulnerabilities.

Rocha-Jiménez et al. (2018) discuss health systems and migration policies on the Mexico–Guatemala border and the experiences of migrant sex workers there. While there are systems designed to protect and promote the health and safety aspects of vulnerable groups, the research shows that they can “compound” vulnerability for people who face multiple layers of marginalisation and stigma.

Fears of judgment, refusal of care, or involvement of authorities resulted in some avoiding or postponing seeking care. Stigma is not just about social judgment; it is institutionalised in policies, administrative procedures, and clinical encounters that discourage utilising healthcare on the basis of gender, nationality, socioeconomic status, and occupation.

Richter et al. (2014) also found comparably lower levels of health service utilisation among migrant sex workers compared with internal sex workers in South Africa. This was found even in large cities with clinics established specifically for sex workers. Some migrant sex workers were reluctant to use services because they feared interacting with immigration or law enforcement.

Likewise, Malla et al. (2019) highlighted the experiences of Asian migrant sex workers in Toronto, Canada. The study found that more than half of the participants had never accessed a social service, and a third had never accessed a health service. The main barriers identified were language, fear of revealing sex work or immigration status,

lack of knowledge of existing services, and cultural insensitivity or discrimination in healthcare services. Malla et al. (2019) found that their participants consistently stayed clear of the health and social services sector, not because of a lack of need, but because they saw them as institutional spaces of surveillance, moral speculation, and potential legal exposure.

In Australia, Selvey et al. (2018) demonstrated the cultural aspect of intersectional stigma, in which gender, ethnicity, immigration status, and moral norms intersect to separate sex workers from mainstream society and healthcare institutions. This echoes the findings of Ma and Loke (2019) in Hong Kong and Kriitmaa (2023) in Kenya, showing that exclusion occurs even when it is not intended as a matter of policy.

In New Zealand, Roguski (2013) uncovered how migrant sex workers, particularly those from Chinese, Thai, and Vietnamese origins, are racialised and morally judged when accessing healthcare. They reported medical staff assumed they must be either victims of trafficking or drug addicts and said they felt deeply unwelcome in health settings. Some were willfully denied care. Others were dismissed with suspicion, humiliation, or outright hostility.

This section has illustrated how formal policies and informal fears, including concerns about documentation, arrest, or affordability, influence how, when, and if MWSWs attempt to access healthcare. Nevertheless, these structural discouragements are just one layer of a much wider pattern of exclusion. The next section will demonstrate, stigma and social judgment are frequently just as influential in healthcare avoidance. Internalised shame, moral assumptions, and silence drive an approach for survival.

6.2.2 Stigma, silence, and social risk: healthcare avoidance as survival

Here, I explain how participants navigated healthcare while managing stigma, shame, and fear of social exposure. Even where healthcare services are available, women explained that they avoided using them for fear of being judged, having their morals scrutinised, or being publicly outed as sex workers or undocumented migrants.

Kamonrat, who had been in Thailand for more than 20 years, remembered never going to a hospital:

> *“I was terrified that healthcare staff would ask me anything about my paper and job. I just got a passport recently; I have worked here without a passport for over 15 years. So, I didn’t want them to know about these things. In some places, they might ask about what I am doing here in this country. Yes, that’s not good for me ...”* (Kamonrat, 20 years of sex work in a bar, undocumented)

Kamonrat's story highlights why silence is consciously adopted as a form of defence over two decades in illegal and stigmatised work. Her statement, *“I was terrified that healthcare staff would ask me anything about my paper and job”* encapsulates anticipatory fear of questions that might expose work at the expense of her individuality. She made herself invisible to the healthcare system.

Although Kamonrat has just obtained a valid passport, this latest change to her status has not erased feelings of fear and social risk embedded over years of managing in the shadows. The possibility of being judged, reported, or morally scrutinised remains high, despite her new legal status.

Urai’s story highlights a more coercive form of silence and healthcare avoidance in which external control, state-induced fear, and linguistic exclusion collectively shape a world where health is both unknown and unreachable.

> *“As a migrant, I don’t have any papers, no insurance. I live and work with ten other girls in a brothel. It’s been three years here, but I didn’t understand Thai. Now I understand a bit. My boss did not allow us to go out, and he told us that the police would arrest us if we went anywhere. I didn’t know about blood tests, vagina tests or condoms…”.* (Urai, 4 years of sex work in a brothel, undocumented)

Urai’s narrative foregrounds how silence is not only self-imposed but also enforced by both her employer and the wider system in which she operates.

The employer acts as a gatekeeper between the worker and the outside world, using fear of arrest to enforce isolation. In this context, healthcare avoidance is a form of containment by employers to raise levels of fear to keep workers silent and dependent. For Urai, silence is both a condition and an outcome. She is silenced by her boss, by language, and by status. The result is that she remains silent, uninformed, unengaged, and unable to advocate for herself.

Urai's inadequate competence in the Thai language is not just a communication barrier in a clinical setting, as discussed elsewhere; it is an instrument of exclusion from knowing rights, discovering services, and how to seek help.

This form of healthcare avoidance is not only related to the fear of being judged. It is also the fear of being seen at all. Even when information or referrals are available, participants often choose not to act. Suranee, for example, declined a health referral out of fear.

> *"There are many things that we can't say, that we can't ask, and we don't go because we don't speak Thai. They told me to get my blood and vagina exams, but I never went there (sexual health centre). I can't speak their language, and I'm breaking the law here working in this job (sex work), and I don't have a visa."* (Suranee, 10 years of sex work at a brothel, undocumented)

The insight in her statement that *"There are many things that we can't say, that we can't ask",* captures the affective weight of this subtheme: that in the world of migrant women sex workers, silence is not about being unable to converse in Thai, but fear of what might be revealed if they did.

Each part of her statement is situated in a structure of constraint:

First, language exclusion: *"We don't go because we don't speak Thai"; then l*egal precarity: *"I don't have a visa"; and finally, c*riminalised identity: *"I'm breaking the law here working in this job."*

The fact that she was told to attend a sexual health centre but still *"never went"* underscores the power of risk perception, the sense that accessing care might invite interrogation, exposure, or punishment.

Without language, Suranee cannot ask questions or explain symptoms, but neither can she respond to inquiries about her identity. In such a setting, speaking becomes dangerous, but silence becomes isolating.

Through the accounts of Kamonrat, Urai, and Suranee, it becomes clear that a multi-level framework of stigma (Goldenberg et al., 2017; Lam et al., 2021) emerges. At the level of the individual, all three women describe fear and silence: Kamonrat refers to not wanting to be asked questions by health workers; Urai says she does not ask about

testing and condoms; while Suranee communicates that she cannot speak or ask anything. On a meso-level, institutions and intermediaries maintain stigmatisation: healthcare workers are perceived by Kamonrat as gatekeepers, Urai's employer constrains mobility and knowledge, and Suranee is confronted with exclusion through language at the sexual health centre. At a macro-level, structural criminalisation and migration policies shape their collective vulnerability: Kamonrat's 15 years in the country undocumented, Urai's police force warnings about arrest, and Suranee's absence of a visa, each illustrate how legal precarity reproduces healthcare non-attendance.

Mapping this framework onto participants' narratives, stigma is one domain of influence that plays out over a continuum between personal fears, institutional practices, and systemic exclusions. For MWSWs, healthcare avoidance is not simply indifferent neglect, but a calculated reaction in an environment that progressively stigmatises at all levels.

A growing body of international research illustrates how health systems can serve to monitor populations, especially those with undocumented status or who are racialised. Instead of being neutral or protective, health services can subject migrant sex workers to a gaze that increases fear and avoidance (Davis et al, 2016; Goldenberg et al., 2017; Lim et al., 2018).

In Canada, Goldenberg et al. (2017) demonstrate how migrant sex workers were subjected to increased policing under Bill C-36 (especially in the context of raids in indoor workspaces such as massage parlours). Immigration enforcement often accompanied these actions to dissuade people from accessing care. Unlike their counterparts who were born in Canada, migrant sex workers moved through the double fears of criminalisation and deportation, influencing their decision to stay away from formal healthcare services.

Likewise, in Singapore, Lim et al. (2018) elaborate that healthcare became a vehicle of state control with mandatory HIV/STI testing, health surveillance related to immigration, and by making condom possession evidence of crime. Female entertainers who were on short-term visas, without access to subsidised healthcare, were afraid to get tested due to the risk of deportation following an STI diagnosis.

Davis et al. (2016) reported similar situations in China, where Ugandan sex workers feared being harassed at hospitals by regular police troops and by the threat of being profiled on racial grounds, as well as the looming danger of being arrested and deported. This results in what the authors call *medical invisibility*, in which MWSWs escape the eye of public health provision and depend on informal or self-medication.

Combined, these studies demonstrate that in numerous national contexts, MWSWs perceive healthcare structures and systems operating, intentionally or otherwise, less as a care-protective interface and much more like a system of control that serves to perpetuate the conditions under which they continue to be denied medical attention and to be stigmatised socially.

Stigma constitutes a key defining and pervasive factor within this process of healthcare exclusion for sex workers, especially migrant women. It is not only rooted in personal prejudice at the individual interaction but is a structural impediment, embedded in laws, institutional practices, and cultural roles (Goldenberg et al., 2017; Jirattikorn et al., 2022; King et al., 2013; Lam et al., 2021; Socías et al., 2015).

In Thailand, Jirattikorn et al. (2022) found that Shan sex workers who were HIV positive delayed receiving treatment or refused to seek it due to language barriers and bad relations with healthcare personnel. Being ignored, misinterpreted, or interrogated had the effect of putting patients off from coming back to receive care even when they were in very serious health need.

Findings from Russia (King et al., 2013) and Canada (Socías et al., 2015) identify the link between stigma and access. King et al. (2013) found that HIV-related stigma and its perceived impact on street-based sex workers in Russia hindered the uptake of testing, because of concern for social rejection, reputation loss, and breach of confidentiality. Socías et al. (2015) report that even with Canada's universal healthcare system, MWSWs failed to go to check-ups for Hepatitis C, for example, for fear of being identified and therefore having a (coercive) rescue intervention (i.e., protection).

These studies empirically demonstrate that stigma is neither a marginal byproduct nor a supplementary tool of exclusion. Rather, it is an essential component of exclusion that undermines public health objectives and ultimately marginalises the vulnerable at the expense of individual welfare and public health objectives.

While this theme has discussed how stigma can deter MWSWs from accessing formal healthcare systems, the next theme shifts focus to the adaptive approaches and alternative support networks that arise in response. In the absence of safe, respectful care, MWSWs commonly turn to informal sources of care and solidarity within which dignity, trust, and compassion are more readily maintained. This next theme focuses on how peer networks and community-based models of care give not only credible support but also emotional and moral encouragement.

6.3 Theme 2: Informal care, peer networks, and dignity in the gaps

Although this chapter has concentrated on the structural, emotional, and social hurdles that drive MWSWs in this study away from public healthcare, I do want to recognise the ways that alternative approaches to their health needs can fill some of the gaps. In this section, I discuss moments when participants experienced dignity and support, either in the efforts of individual empathetic staff or through the imagination and solidarity of peer networks. These modes of care did not undo the exclusion that many women in this study felt, but they offered moments of survival within systems that were otherwise alienating.

In this final theme section, I discuss how MWSW participants accessed healthcare not directly through Thailand's formal structures of the Universal Health Coverage (UHC) system, but rather through informal and community-based pathways. While the public health system claims universal inclusion, including undocumented migrants (Suphanchaimat et al., 2019), the women in this study rarely experienced it as a space of safety, entitlement, or dignity. Instead, effective care was achieved through negotiation – sometimes through relationships with peers who acted as translators and guides, or with the intervention and support of NGO staff, and occasionally with individual healthcare staff who offered nonjudgmental treatment. These informal strategies were not complementary; they were essential responses to a system that routinely failed to recognise or accommodate the complex realities of migrant sex workers' lives. What emerges here is not simply a story of healthcare access through alternative routes, but a more profound critique of how care is withheld by system

design, making survival contingent on community solidarity rather than fulfilment of state responsibility.

6.3.1 Dignity as a surprise: when care feels exceptional

For most MWSWs in this study, public healthcare was described as unpredictable, emotionally risky, or outright exclusionary. Nevertheless, a few participants shared moments when they felt treated with basic respect. These encounters were not expected. They were described in terms of luck rather than entitlement. This suggests that inclusion is not systematically embedded in public institutions, but depends on the attitudes of individual staff or the presence of community intermediaries. These informal strategies reflect a structural absence: a system that does not itself expect to provide adequate language services, culturally responsive care, or safe spaces for stigmatised and marginalised women. What emerges is a system for MWSWs in which optimum healthcare is not a reasonable expectation, but something negotiated, fragile, and constantly at risk of being withdrawn.

Wichuda's story conveys a moment of genuine recognition and care.

> *"I visited that public hospital, and they have someone who helps me with the Thai language. It was great; that person took me through every process in the hospital. Healthcare providers there were also very patient with me; they spoke slowly and gave me time to say something. I felt like they cared about me in that place. I felt very lucky."* (Wichuda, 11 years of sex work in a brothel, undocumented)

What stands out most in Wichuda's story is not only that she received care, but also that she felt seen, attended to, and respected – all of which are fundamental aspects of effective healthcare. That she recounted it as a memorable experience underscores her low expectations from past interactions and from peer conversations.

Care, in its most profound form, encompasses not only practical and appropriate treatment but also attention, patience, and kindness. These humanising factors are frequently absent from the care that MWSWs report, particularly when stigma and exclusion shape the healthcare culture.

The language support - *“someone who helps me with the Thai language”* - also mirrors practical inclusion. A system or an individual who bridges the language barrier becomes a means of rebuilding dignity. More than translation, it is about enabling dialogue with clinicians, giving voice, and underpinning participation.

Additionally, Wichuda recalled how staff were *“very patient with me… gave me time to say something.”* Her reflection is a description of essential patient-centred care which is linguistically affirming, emotionally safe, and relationally respectful.

Orapin’s story conveys a rare and emotionally connecting experience of stigma-free care, acknowledging linguistically appropriate healthcare.

> *“It was great and surprising that the hospital provided someone who spoke a migrant women’s language and knew everything about what sex workers need, as well as their confidentiality. But again, it only happened in that hospital around here. They might do it somewhere else too, but we must find out where to go. I went there, and they never asked me about my work, ID or insurance, and they were willing to help me. They gave me someone who spoke my language; I felt really understood there.”* (Orapin, 8 years of sex work in a bar, documented)

Similar to Urai, she characterises this interaction as “*surprising”* and “*great*”. It met basic patient needs for respect, privacy, empathy, and understanding, that are often ignored or denied to MWSWs.

What stands out is the recognition that the system ultimately acknowledges her not as a threat, not as an illegal subject, not as a burden, but as someone in need of health care, without questioning or judgment. Her words are emotionally positive - *“they were willing to help me … I felt really understood there”* - which speaks to the transformative power of even an individual, respectful interaction.

Nevertheless, her experience is an exception to the overall narrative drawn from my participant data. She speculates that the approach may be located in that one specific hospital. The burden will be on her to investigate if it would be replicated elsewhere.

Orapin highlights that *“they never asked me about my work, ID, or insurance.”* In this situation, not being questioned develops into a form of dignity not filtered through her documents or her work. She also stressed privacy. The hospital both knew what sex

workers' requirements were and maintained their confidentiality. For MWSWs, trust in healthcare settings is not automatic; it must be earned through action rather than chance or individual interaction.

Arisa's account tells how respect, patience, and practical support came as an unexpected kindness.

> *"It took me by surprise in that hospital… The staff in that hospital was very nice. Although I couldn't read and write, she came and helped me out. She was very kind to me. When I was hospitalised, she put a sign beside my bed about my medicine, like when to take it and when to eat something like that. She was pretty nice because I couldn't read Thai. But that's the only hospital around here has someone to help you with a language. You can't get any help anywhere else. In that hospital, they would have a coordinator to help migrant patients. I think only one hospital had a policy about helping migrant patients, especially those living with HIV."* (Arisa, 5 years of sex work in a bar, undocumented)

What makes this encounter feel special to Arisa is not only the medical care itself, but also the human component, including the nurse who helped her understand her medications, created a visual aid, and made a sign about when to take her pills and eat. Most notably, the nurse recognised her literacy and linguistic needs without embarrassing her.

This patient-centred version is not generally available to migrant sex workers, particularly those living with HIV, whose health challenges are frequently informed by silence, stigma, or fear. That a healthcare staff member took time to support her with compassion is a moment of honourable recognition.

Her reference to a coordinator to support migrant patients, especially those living with HIV, indicates a rare instance where policy adjusts within lived realities.

Kanokwan, a service provider, provided further information about HIV treatment at a particular hospital that provides user-friendly care.

> *So, for the women who we know have HIV or are living with AIDS. Their access to HIV drugs is very good in Chiang Mai, especially in Sansai Hospital. It's a very good program for HIV positive people, and it's free, yes. And they've also*

> *covered all migrants and non-migrants. Other hospitals have such services but you've to search for them. And they all have their own policy. But, Sansai does it friendly and nice and anonymous.* (Kanokwan, 30 years working with sex workers)

Kanokwan's description of Sansai Hospital is a significant confirmation of Wichuda, Orapin, and Arisa's speculation that their dignified, inclusive, and non-judgmental healthcare is the exception for MWSWs, not the rule. She identifies privacy, user-friendliness, and treatment for both migrants and non-migrants as aspects that make Sansai's HIV care stand out. It is not only that the treatment is accessible and free of charge, but it is the manner in which patients are treated that distinguishes the efficacy of its healthcare.

Kanokwan classifies the emotional tone and structural sensitivity of care offered as important features in making an experience of dignity and safety, especially for people living with HIV. Her words highlight how the way care is offered counts just as much as the care delivered.

Kanokwan's involvement in the field provides her with a broader perspective on the healthcare site. She observes that while *"other hospitals have such services, … "You have to find them… ".*

This signifies a fragmented and decentralised system in which interaction and dignity as essential elements of patient care are not the systemic norm throughout Thailand but are dependent on setting, institutional culture, and the interpretation of local strategy, described by participants as "luck" when they experience it.

The study of Velez et al. (2019) with street-based sex workers in an urban setting in Canada observed that harm reduction and trauma-informed practices in health services can allow for greater healthcare utilisation. The participants reported feeling safer and more respected in harm reduction settings, where care was pragmatic, nonjudgmental, and responsive to their lived realities, especially among those who use drugs or suffer unstable housing.

Potter et al. (2022) also identify major facilitators for sex workers to attend healthcare, with a focus on non-judgmental, flexible, and inclusive service models. Qualitative research by Potter et al. (2022) among UK-based female sex workers reported that

respectful, non-stigmatising relationships were necessary to foster trust and care-seeking. Participants mentioned that they avoided services where they felt judged or marginalised and remembered the care they received when staff treated them with empathy and dignity.

In a scoping review, Probst (2023) notes several potentially successful, though variably applied, models for delivering health services that better suit the needs of sex workers. These are rarely incorporated into formal health systems but instead can be based in community or NGO led services. Although these instances of respectful, dignified care within formal healthcare structures were rare, the emotional response of the participants was robust.

Faced with a lack of consistency of support from formal institutions, MWSWs supported each other by creating informal systems of care grounded in solidarity, trust, and collective safety. The second subtheme examines how peer-based networks of care operate as tools for access to the healthcare system, but also as community strategies of survival and dignity in a system which is often hostile to MWSWs.

6.3.2 Peer navigation and collective care

Reluctant to engage with formal health systems that misrecognise, morally regulate, or ignore them (as presented in Chapter 5, Sections 5.2 and 5.3), MWSW participants often seek one another out for care, information, and emotional support. In such spaces - peer-led support groups, informal clinics, or a private moment with a knowledgeable co-worker - women piece together the care that the public system is often failing to provide. They are not alternatives; they are acts of reconfiguration.

In these networks, care becomes relational, responsive, and embodied, grounded in shared experience. MWSW participants feel seen, respected, and trusted in ways that many did not experience in formal healthcare. Such initiatives do not erase the structural inequalities they negotiate, but they make space for moments of recognition and resilience. This section examines the way informal care operates both as a means of survival and as an instrument for dignity in the gaps left by formal health institutions.

Peer and/or community support in the form of translation, information, psychological support, or simple company, is a pragmatic and protective measure. It is a necessary

form of care. I use the term *peer networks* to describe the various care supports and social connections that MWSWs have with one another. For example, some are conducted informally and through community-based organisations, or through organised NGO programmes.

Whether through formal programmes or ad-hoc advice shared in the workplace, peer networks work on the assumption that shared lived experience fosters the confidence and safety that institutions fail to provide. However, such forms of support are unevenly distributed across the country, and their contribution depends on location, social embeddedness, language, and perceived legitimacy within some sex work communities.

Ladda's role in her workplace is not only that of a peer; she becomes a key health interpreter, mediator, and informal navigator within a system that otherwise discourages her co-workers.

> *"In my place, my boss will ask a healthcare provider to visit us for a check-up every month. I'd help all the girls here during the process, like tell her what to do or what to say when the healthcare provider asked. Sometimes a girl gets a vaginal infection or gets a blood exam with something. So, I'll help that girl by explaining that to her, too. Yes, because all girls can't communicate, I got to help them." (Ladda, 27 years of sex work in a bar, documented)*

Ladda's account describes collective care practices in action in which experienced sex workers step in to fulfil the structural and language gaps left by formal healthcare institutions.

She states that her boss coordinates with healthcare providers to come to the workplace, providing a template for mobile or outreach care. Nevertheless, what is remarkable is that this improved access through outreach would encounter the same undermining language barrier without her peer presence. Ladda works as a bridge between institutional healthcare and the women it serves, interpreting not only linguistically but also culturally and emotionally, telling women *"what to do or say,"* and clarifying test results or symptoms.

Ladda converts a potentially intimidating interaction with a healthcare team into a collaborative, practical process, established on mutual understanding and shared experience of sex work.

Additionally, her association is not hierarchical. It is parallel and interactive within a community of women with vulnerabilities in common through language barriers, legal precarity, and gendered labour. Assisting a co-sex worker in understanding a vaginal infection diagnosis or blood test result brings together health knowledge and sex work context arising from lived experience.

Wipavee's story offers a clear example of informal systems of care developed within sex worker communities in response to institutional exclusion and communication failure.

> *"… I was taking care of all the girls, especially those newcomers. Girls couldn't understand Thai, you see. I would be right there with a healthcare worker, yes. I got to stand next to a girl in the examination room. Many new girls couldn't speak or listen to Thai. Well, many words were pretty tricky to understand. Like, um, medical words. So, I'd help translate and coordinate with the staff during that process. Sometimes, the team didn't understand the girl's words, too. And some of the staff's words were a bit complicated, they just spoke words like the language of a doctor and nurse. It's not the language we talk; we didn't understand. I tried my best to help, like if they asked, "What is your name? How old are you?" So, I'd answer those questions for girls… So, girls would not get much information from a staff team because of the language." (Wipavee, 20 years of sex work in a massage shop/activist)*

The healthcare system does not assign her the role of a peer translator, guide, or advocate. This is self-assumed and community-driven, born from years of shared experience and recognition of persistent linguistic and structural barriers.

She describes standing beside new co-workers during medical examinations, providing real-time translation, and navigating both common and institutional language, assisting with the potential double disconnection. Newcomers may struggle to speak or understand Thai, especially in stressful or clinical situations. Medical professionals speak in *"the language of a doctor and nurse"* - formal, technical, and disconnected from the women's lived realities.

Wipavee is not just translating words like *“What is your name?”*; she is translating power, access, and information, allowing her peers to participate in systems that would otherwise render them silent. Wipavee’s role fills an institutional void created by the absence of linguistically appropriate, culturally sensitive communication from formal healthcare providers.

She brings emotional reassurance, especially for newcomers. Secondly, she decodes unfamiliar procedures in a clinical setting. Thirdly, she resolves misunderstandings between healthcare workers and patients. Finally, she protects dignity in a space that can easily become dehumanising when language fails.

This kind of peer navigation is essential because the women *“would not get much information from a staff team because of the language.”* Significantly, her labour goes far beyond language. It includes: first, emotional reassurance, especially for newcomers. Second, decoding unfamiliar procedures in a clinical setting. Third, mediating misunderstanding between healthcare workers and patients. Finally, protecting dignity in a space that can easily become dehumanising when language fails. This is not simply interpretation; it is relational, embedded care, rooted in trust, familiarity, and shared community identity.

Benjarat speaks of the benefits of a strategic, peer-based approach to healthcare access, where group visits, peer translation, and NGO backing combine to mitigate the challenges of legal precarity and language exclusion.

> *“We normally visited a healthcare centre for our check-up in a group, like 10 or 15 of us. One of the girls was very good at Thai, so she’ll help us there. If the healthcare provider asked or said something to us, she’d help. Sometimes, the EMPOWER staff helped us with this visit. So, it made life easier this way because we don’t understand the language.” (Benjarat,15 years of sex work in a bar, undocumented)*

Her experience demonstrates that, for undocumented MWSWs, the healthcare systems that are daunting to an individual can be accessed as a shared journey, made possible through collective support. The attendance of a peer who is *“very good at Thai”*, acts as the de facto interpreter and cultural mediator. As in Wipavee and Ladda’s

accounts, this peer assumes a critical informal role, stepping in where the healthcare system fails to create a linguistically inclusive and culturally appropriate service.

Benjarat explains that EMPOWER staff sometimes accompany them, acknowledging the important role of community-based organisations in bridging the gap between marginalised communities and formal systems of care. The NGO does not only provide information or resources. Wherever possible, a staff member or volunteer physically accompanies the women, helping reduce fear, facilitate communication, and support understanding.

Suneerat's account reveals the emotional depth and protective function of peer navigation, a form of care that extends beyond relaying information or facilitating access.

> *"I went with another girl who works in that bar. She helped me talk to the staff. I felt protected. She knows my work, my life. I didn't need to explain everything to the staff there."(Suneerat, Activist/and 8 years in a go-go bar, documented)*

Suneerat's emphasis on feeling protected is central. It suggests that for sex workers navigating healthcare systems, the presence of a trusted peer radically transforms the sense of the encounter. When she states, *"She knows my work, my life"* she is highlighting the significance of shared lived experiences. Unlike healthcare professionals who may view her through clinical or moralising lenses, her peer already understands the context, risks, language, and silences embedded in sex work. That understanding means Suneerat does not have to perform, hide, or defend her identity in the healthcare setting that may demand disclosure, justification, and moral intrusion.

What is prominent here is the trust and emotional security generated by the peer relationship, something rarely afforded to individual sex workers in formal institutional settings. Peer support is not supplemental to care; it is the care. Without it, Suneerat may have confronted judgment, interrogation, or misunderstanding. Alternatively, she might have withdrawn completely.

Local NGOs, such as EMPOWER Foundation, played a vital role in supporting and facilitating these informal networks. Monthira is a long-time healthcare worker in EMPOWER.

> *"We, as the service provider team, are aware that they're migrant sex workers. They don't understand Thai, especially those who have just arrived in the country. So, we'll ask someone to help us translate for them. Our outreach team will visit the workplace monthly and discuss how to look after all the girls in their shops with the bosses or managers. We'll offer a mobile check-up for all the girls in their shop, so they do not need to come to us. It's better for them because some do not want to visit our healthcare clinic. Some don't understand Thai and are worried about their passports." (Monthira, 10 years of work with sex workers)*

Monthira's role as a healthcare worker is significant in that she recognises and works within the existing social dynamics of sex worker communities, rather than imposing clinic-based, individualised models of care that are often inaccessible or frightening to the target population. Her tactic mirrors a cooperative model, where peer participation, group-based care, and community trust are fundamental to health service delivery.

What is observed in this story is the institutional recognition of peer translation, *"We'll ask someone to help us translate for them."* Rather than assuming that professional medical translators are necessary (or available), the service provider team turns to peer figures, other sex workers, or trusted individuals in the workplace to act as informal health navigators. This mirrors what participants like Wipavee and Ladda described from the grassroots level, but here, it is institutionally supported and normalised.

Monthira's team does not wait for migrant sex workers to enter their clinic. She brings care to them, acknowledging that structural and emotional barriers such as language, fear of legal exposure, stigma, and distrust often make any institutional spaces feel unsafe for them. By visiting workplaces and offering mobile services, the team supports a collective model of care that treats the group, not just the individual, as the unit of engagement.

Importantly, Monthira repeats the fear of visibility that many MWSWs carry, discussed elsewhere. *"Some don't want to visit our healthcare clinic. Some don't understand Thai and are worried about their passports."* This reinforces the need for trusted intermediaries (peer translators, workplace allies) and care environments that feel safe

and private. Her outreach approach reflects a harm reduction attitude, grounded in the understanding that care must be built on the terms of the people receiving it.

Her partnership with bosses or managers is also important. While this may reasonably raise questions about getting too close, in this situation, it seems to be part of a strategic approach to gain access to workplaces where healthcare outreach might otherwise be blocked. It echoes the layered truth of sex work in Thailand, where access to care is negotiated not just over state systems but over workplace hierarchies and peer negotiation.

For some participants, these peer networks were not just sources of health or legal information and support; they were also important sites of emotional validation and cultural safety. Participants described peer-led spaces as those in which their needs were heard without their having to validate or defend their identity.

Wipavee further explained her engagement with EMPOWER:

> *"I have known EMPOWER for about ten years and have gotten help from them. It's more than support there; we're family and sisters. We understand each other, and we speak the same language. We cooked, ate, laughed, drank and cried together. During the COVID-19 pandemic, we couldn't work much and had no money or food, so we came together and helped each other. We shared about our clients and how to deal with them. Sometimes, we talked about our health issues and how to prevent disease from this job. So, I learned about this from other girls. The staff there helped me with my documents and often took me to a health centre. I had a problem with the police and immigration and got arrested twice, and they helped me. I was sick many times, and another time, my ex-boyfriend hit me, so the staff there helped me with that, too. I might have killed myself years ago, but they changed my life, so I feel really lucky. At least I can ask for help there. (Wipavee, activist/sex worker, 20 years in a massage parlour, documented)"*

Wipavee's story is not just how much she received, but how much she participated in a shared, peer-based environment. EMPOWER also served as an informal college of health literacy, mutual learning, and harm reduction.

Wipavee states, *“I might have killed myself years ago, but they changed my life.”* This testimony emphasises the role that community-based organisations can play for individuals struggling to survive pressures and anxieties in every part of their life.

The role of NGOs in bridging the gaps between MWSWs and healthcare institutions suggests that access is not always state-based but can be facilitated by informal associations or mutual support organisations. This may not be health equity. It is a precarious inclusion, reliant on workaround strategies rather than systemic change.

Internationally, MWSWs are found to be reluctant to utilise formal healthcare systems because they fear deportation, stigma from healthcare providers, and the need to avoid immigration policies. They are forced to use informal, insecure, and unregulated medical services (Goldenberg et al., 2017; Kriitmaa, 2023). In response to these system limitations, peer-led and community-based interventions offer essential harm reduction services through healthcare that are accessible, culturally competent, and trust-based (Febres-Cordero et al., 2018, 2020; Zermiani et al., 2012). In contrast to standard medical settings, sex worker-led organisations, NGOs, and harm reduction networks commonly provide safe spaces where MWSWs can access health services, STI/HIV treatments, and psychosocial support without the threat of stigma or persecution (Dias et al., 2017; Folch et al., 2013). Their services, delivered through mobile clinics, outreach education, and anonymity, challenge structural barriers. Peer educators, often but not always, former or current sex workers, serve a critical role in building trust, providing pragmatic health advice, and introducing migrants to non-stigmatising health service providers (Duff et al., 2016; Roguski, 2013).

Research conducted in a variety of international contexts consistently reports that MWSWs qualitatively prefer other models of care, which are also more effective in reaching them. Zermiani et al. (2012) demonstrate that MWSWs in Verona do not visit hospitals due to fear of discrimination, a lack of economic resources, and legal implications. In contrast, mobile outreach efforts such as the Sirio Project provide free, anonymous STI testing and harm reduction services to specific location communities, giving undocumented sex workers the opportunity for care without the state’s watchful eye. As Kriitmaa (2023) explains, in Nairobi, anonymous access, community-based organisations have taken up the space left by the limitation of formal systems, offering

culturally appropriate healthcare in a safe, private environment, of particular importance for Somali MWSWs who face extreme legal and social exclusion.

Even if trust is crucial for these interventions, access remains a significant challenge. Dias et al. (2017) observed that even in Portugal, where HIV testing is legally available to all, undocumented migrant sex workers are the hardest to reach and make up the smallest percentage of those who have ever used testing services because of their fear and marginalisation.

In Thailand, researchers have reported that migrant sex workers face multiple levels of social exclusion. Community-based interventions have developed to become a fundamental contributor to supporting migrant sex workers' health and overall well-being (EMPOWER, 2012). NGOs and sex worker-led organisations have filled some of the gaps in healthcare, providing STI testing, condom distribution, and healthcare referrals through trusted peer outreach workers, who are frequently former or current sex workers (EMPOWER, 2012; Villar, 2019). Community-based efforts, which are led by peers, like those by EMPOWER and SWING Thailand, have succeeded in better levels of effectiveness than state-run programmes, as MWSWs are more willing to access and utilise services through individuals who have lived experiences similar to their own (Jirattikorn et al., 2022; Hongjaisee et al., 2020). This is especially important for undocumented migrant workers, who tend to avoid government facilities due to fear of legal consequences (Webber et al., 2012). NGOs have proved themselves to be crucial actors on the stage of harm reduction and legal advocacy (Janyam et al., 2020; Webber et al., 2015), therefore highlighting trust, cultural competence, and peer guidance as necessary tools to help address the structural barriers that systematically keep MWSWs out of state healthcare.

Peer-delivered outreach interventions, distribution of condoms, education in health and referral from peers to a safe clinic have proven to be successful for overcoming some of these barriers. Successful programmes have shown that healthcare cannot be passive, in the face of evident challenges to the individual health of MWSWs and also to public health. In other words, it has to go out and find marginalised communities. These findings support the proposition that peer-led interventions are not complementary but necessary for confronting the structural exclusion of MWSWs from basic health services.

The work of peer networks and collective approaches shows that MWSWs are not passive receivers of structural neglect; they are also creative navigators and builders of other support systems. However, the demand for such informal care far exceeds the capacity of alternative supports. Any demand for inclusion and the development of safe, culturally sensitive procedures and attitudes within the wider system of health provision should recognise how far NGOs and peer-led initiatives guide the way.

6.4 Chapter summary

In this chapter, I have discussed the ways that migrant women sex workers (MWSWs) in this study negotiate a healthcare system that superficially grants formal access, yet is frequently marked by effective exclusion. My participants demonstrated that access to care is determined not simply by documentation status, but also by fear, stigma, language, and institutional neglect. These barriers intersect with one another to form a terrain where being visible often equates to being vulnerable, and refusal of care can be a rational survival strategy.

Theme 1 in 6.2, focuses on the structures of exclusion, including legal insecurity, surveillance, stigma, and bureaucratic practice, that make care inaccessible even when women are formally entitled to it. These women do not fall through the gaps; they are being systemically misrecognised, doubted, and morally disciplined. For them, the healthcare system becomes less a place of care and more a place of vulnerability. Emerging within this theme is a sense of the limitations of formal health institutions for MWSWs in which care is provided under circumstances that are so unsafe or degrading that avoidance is a rational choice.

Theme 2 in 6.3, emphasises the practices of survival and relational care that emerge in response to these gaps. It does not ignore the exclusions described in the previous theme, but rather elaborates on them, demonstrating how women co-construct informal support networks to help fulfil their information and practical healthcare requirements. The ground of this perspective is not fear but resilience, not simply in a sense of overcoming adversity, but in a humble sense of building dignity where systems deny it. Resilience alone does not create a complete answer, but the theme suggests that even though formal health facilities are defined by exclusion, they do not crush the full extent of women’s ability to care for or associate with others.

Where theme 6.2 focuses on what pushes women away from formal care, theme 6.3 explores where they go instead. The first demonstrates how exclusion is patterned and cumulative and is enacted socially. The second illustrates how resistance is relational, uneven, and necessarily partial. This way, the themes are analytically distinct but causally connected. The insufficiencies of theme 6.2 render the emergent solidarities of theme 6.3 necessary and meaningful.

This chapter has revealed that for MWSWs in this study, access to healthcare is not simply a question of eligibility or availability. It is shaped by a complex process of structural, symbolic, and interpersonal exclusions, beginning with misrecognition at the reception counter to moral controlling in intimate examinations. Participants described a system that delivers conditional care, dishonouring or insecure in its practice. Stigma is rooted not just in regulations and strategies, but also in the tone of a voice, the procedure of a reception area, and the questions asked in an examination room.

These results reveal starkly that enhancing healthcare for MWSWs requires more than authorising access; it requires a fundamental shift in how care is delivered, perceived, and made safe for groups whose identities fall outside established expectations.

In Chapter 7, I draw on these empirical insights to engage in a dialogue with my theoretical contribution and critically examine what these findings imply for understanding access, recognition, and health justice in the context of migration and sex work. I also consider the methodological and political implications of this research and offer some final reflections on how systems might be reimagined to cater to those who are currently marginalised within them.

The findings in this chapter reveal how MWSWs respond to exclusion through bounded strategies of resistance (Kabeer, 2000; Scott, 1990), which incorporate concealment, avoidance, peer solidarity, and NGOs' mediation. These strategies foster resilience and creativity; however, they also remain constrained by the same structures that perpetuate exclusion.

In Chapter 7, I integrate these insights with the domains of exclusion identified in Chapter 5 to create a concept of the ‘exclusion–resistance feedback loop’, which represents how exclusion and resistance operate not as separate stages but as mutually reinforcing mechanisms that uphold healthcare marginalisation.

Chapter 7: Discussion, Conclusion, and Recommendations

7.1 Introduction

In the previous two chapters, I set out the findings of this study. Chapter 5 examined how migrant women sex workers (MWSWs) experience healthcare systems through four primary forms of exclusion: communicative disempowerment, symbolic misrecognition, systemic inaccessibility, and layered hierarchies of stigma. These findings highlighted how barriers to healthcare are not freestanding but are structurally embedded in the design and delivery of services, marking MWSWs as marginal or illegitimate patients.

Chapter 6 turned to the strategies MWSWs adopt in facing these exclusions. It illustrated how the MWSW participants navigated healthcare through bounded forms of resistance, including concealment of their work, avoiding potential harmful interactions, reliance on peer solidarity, and mediation through NGOs such as EMPOWER. While these strategies offered short-term comfort and enabled access between the gaps, they also reinforced dependency and underscored the precarious and conditional nature of their healthcare access.

In this chapter, I draw these strands together and situate them within the broader body of literature on migrant healthcare and sex work. I synthesise the detailed themes from Chapters 5 and 6 into the four conceptual domains of exclusion - Communicative and Cultural exclusion, Symbolic Misrecognition, Systemic Inaccessibility, and Intersectional Hierarchies - and then connect these to the bounded strategies of resistance identified in Chapter 6. This synthesis forms the basis of what I have termed ‘the exclusion–resistance feedback loop’, my central theoretical contribution, which demonstrates how exclusion and resistance are mutually reinforcing processes.

In this chapter, I not only draw together the findings presented in Chapters 5 and 6 but also make explicit how each section addresses my research aims and central research question. My study was guided by the following research question:

How do migrant women sex workers (MWSWs) experience healthcare provision in Thailand, and what are their perceptions about accessing healthcare?

This overarching question was divided into three clarifying aims:

1. Understand the experiences of MWSWs in accessing healthcare services within the Thai context.

2. Identify and understand the barriers that affect access to healthcare from the perspective of MWSWs.

3. To understand the roles of local Thai NGOs for MWSWs to access healthcare.

In this chapter, I show how the picture is built in answering these clarifying aims, and my findings answer the research question. The discussion of the four domains of exclusion, for example, addresses Aim 1. The analysis of bounded resistance strategies speaks directly to Aim 2. The examination of intervention by an NGO, in particular the work of EMPOWER, focuses directly on Aim 3. The construction of the 'exclusion–resistance feedback loop' synthesises and weaves these three strands together to address the main research question, revealing that access to healthcare for MWSWs is not experienced as a universal right but rather as something fragile and conditional.

I also use this chapter to highlight the methodological contribution of applying an intersectional lens within thematic analysis, which enabled me to capture the compounding disadvantages shaping participants' healthcare experiences. Finally, I discuss the theoretical and practical implications of these findings, revisiting my research question and aims to demonstrate how this thesis contributes to both scholarship and policy debate on healthcare access for marginalised groups.

7.1.1 Positioning findings within the literature

In Chapter 3, I identified three main limitations within the current literature in the Thai context: 1) fragmented treatment of migrants and sex workers, 2) single-issue health policies, such as HIV/STD prevention, and 3) minimal application of intersectionality theory.

First, migrants typically are considered separately from sex workers. This misses the unique experience of those who embody both identities. Secondly, the majority of studies are narrow in their focus regarding health concerns, with an emphasis on

particular aspects of ill health (e.g., STD/HIV) (EMPOWER, 2012; Hongjaisee et al., 2024; Jirattikorn et al., 2022). Little attention is given to wider health and everyday navigation issues. Thirdly, intersectionality is frequently invoked as a descriptive concept but rarely applied as a sustained analytical framework in respect of accessing Thai healthcare (Calang & Sunanta, 2025; Chuemchit et al., 2024; Thwe, 2022).

My study directly addresses these gaps. By focusing my research on migrant women sex workers (MWSWs), I examine how migration status, gender, socio-economic inequality, and occupational stigma interweave to impact healthcare engagement. My thematic analysis emphasises the four interwoven areas of exclusion (Table 7.1): communicative and cultural exclusion, symbolic misrecognition, systemic inaccessibility, and intersectional hierarchies, and reveals that barriers that may seem separate and distinct are in fact structurally interconnected.

In contrast to the Thai context literature that focuses mainly on HIV or sexual health (Cheung, 2023a, 2023b; Hongjaisee et al., 2024; Jirattikorn et al., 2022), I recorded both narrow and broad health needs of migrant women sex workers, such as primary care, chronic illness management, and prevention. I applied intersectionality analysis to both exclusion and resistance of care, demonstrating how layered identities (migration status, gender, documentation, stigma, and socio-economic precarity) produce compounded constraints but also drive the kinds of agency women can exercise.

Building on Kabeer's (2000) concept of bounded agency (agency exercised within structural limits such as legal precarity, stigma) enabling short-term navigation the data drawn from my MWSW participants demonstrate how practices of selective disclosure, peer accompaniment, and NGO mediation are purposeful and agentic, while nevertheless also being constrained by legal precarity, administrative gatekeeping, and stigma. Expanding also on Scott's (1990) idea of everyday resistance (subtle, pragmatic acts that reduce harm without overt confrontation, including selective disclosure, clinic avoidance, and peer accompaniment), I recorded "below-the-radar" practices which MWSWs adopt to deal with immediate health situations as an alternative to demanding broader structural change.

To conceptualise these dynamics, I propose the 'exclusion–resistance feedback loop', which I expand upon in section 7.2.3. Trigger-bound resistance, such as hiding, co-

sex worker information sharing, and NGO assistance, is valuable in the moment but also diminishes MWSWs' engagement with formal services. As a result, when they do interact with the system, they tend to perceive healthcare providers as distant, unrelatable, or disconnected from their lived realities. Acceptance and anticipation of ongoing exclusion thus reproduce that exclusion over time. Although this study is situated within the Thai context, the concept may have analytic value across other sites of intersecting marginalisation. I offer it as a transferable heuristic, not an inevitable truth claim, to inform investigations of how cumulative exclusion and bounded resistance co-constitute suboptimal access to healthcare.

This position is situated between the gaps identified in Chapter 3. In Chapter 3, I demonstrated that the current literature on migrant sex workers in Thailand is dominated by HIV/STD focused inquiry and presents very little qualitative insight into the lived experiences of MWSWs navigating Thai healthcare systems. There is also insufficient knowledge of how Thai NGOs perceive, support, or medically represent this population. My findings address these gaps by demonstrating how structural, institutional, and interpersonal exclusions meet in practice and how MWSWs navigate these dynamics in their daily lives.

At the macro-scale, Braithwaite et al. (2024) demonstrate that healthcare seldom operates in the way policymakers imagine it does. Instead, everyday caring depends upon work-as-done: on informal workarounds, dynamic trade-offs, and local 'street-level' adjustments to keep services functioning daily. In my study, NGO mediation, peer accompaniment, and selective disclosure have a similar "off-script" function: access is enabled but not through formal mandates. Similarly, Behrens et al. (2022) caution that systems frequently rely on absorptive or adaptive fixes, which can return short-term function without altering root inequities. This resonates with the 'exclusion–resistance feedback loop' that I propose in 7.2.3: bounded strategies safeguard women in the moment, while diminishing formal care engagement, supporting perceptions of both the women themselves and healthcare staff that MWSWs are outsiders, and thus perpetuating institutional neglect. At the patient and provider level, Eyles et al. (2015) describe how service users and staff in constrained settings cope through endurance, resistance, and resilience.

Lastly, Zhong et al. (2024) measure how inequalities weaken resilience. During the global COVID-19 disruptions in the USA, poorer and racialised populations have undergone slower recovery and seen lower adaptability of necessary services such as maternal care. Their findings underscore my intersectional claim that single barriers do not determine access; instead, structure and status (including documentation, stigma, gendered labour, and precarity) compound to produce fragile, conditional pathways to care. Taken together, these studies corroborate my central contention that when access depends on off-script adaptations (by providers, peers, or NGOs) rather than on-paper entitlements, systems “cope” but do not transform. Exclusion is reproduced over time.

7.1.2 Methodological reflections

In Chapter 4, I introduce the constructivist qualitative approach that underpins this study and propose the use of an intersectionality analytic lens. Indeed, it was this design and theoretical lens that were essential for developing the subtle insights that emerged from my data. The use of semi-structured interviews allowed participants to articulate an account and reveal the layers of complexity within their lives, giving rise to their accounts of exclusion and resistance that more structured forms of examination might overlook.

By applying intersectionality to the analysis, I was able to look beyond discrete barriers that can be addressed by lowering costs, or offering language support, or training administrative staff to understand how layers of disadvantage interweave to impact healthcare experiences. I reached this conclusion by operating a coding matrix that recognised identity categories, structural forces, and lived experiences, ensuring that findings such as Communicative and Cultural Exclusion and Intersectional Hierarchies were fully recorded.

Purposive and snowball sampling were adequate. I reached a highly stigmatised and difficult-to-access population and inevitably selected a sample that was also influenced by these selection effects. Many of the study participants had connections with NGOs, so relatively well-supported women were likely overrepresented, and the most socially isolated were underrepresented. While I mitigated this through multiple recruitment channels, I acknowledge that the findings reflect a segment of the MWSW population.

Reflexivity was central throughout the research process. My dual position inevitably shaped interactions and interpretations - culturally ascribed as a mother and Buddhist woman, and linguistically familiar yet socially and professionally distinct as a Thai registered nurse and now a postgraduate student. I observed, recorded, and questioned these processes with analytic memos and retesting of my intersectional coding framework. This reflexive strategy contributed to the credibility of the results and was congruent with my ethical obligation to represent participants' voices in their full richness and complexity.

Taken together, these methodological choices enabled the study to move beyond surface-level accounts of "barriers" to healthcare, toward a deeper understanding of the dynamic interplay between structural exclusion and bounded resistance (Kabeer, 2000; Scott, 1990). They also underpin the study's contribution to advancing the operational use of intersectionality in healthcare research.

The COVID-19 pandemic informed how I conducted this research, as well as who was able to participate. Whilst the use of telephone and LINE interviews was safe, flexible, and discreet for migrant women sex workers, it also limited rapport building and environmental observations. It excluded potential interviews with those who were more digitally excluded. With further reflection, I would have combined remote interviewing with some in-person fieldwork and made stronger use of online rapport-building techniques. These methodological reflections serve as a reminder that my research, conducted amidst the pandemic and with an ethical commitment to participant safety in compounded sites of precarity, was constrained by these conditions.

Whilst considering my methodological adjustments during the pandemic, I found some commonality in my own strategies as a researcher with the bounded agency of participants. As migrant women sex workers resorted to short-term, pragmatic responses to negotiate structural exclusions, so I adjusted my methods within the constraints of COVID-19 lockdowns and conditions imposed by digital access and ethical considerations. I consider my use of remote interviewing, flexible scheduling, and allowing participants to choose the location as forms of bounded methodological resistance. They enabled me to carry out fieldwork while limiting the depth of my engagement that I would have expected in normal times.

7.2 Discussion of key findings

Table 7.1 maps the thematic findings from Chapters 5 and 6 onto the conceptual framework developed in Chapter 7, showing how participants' narratives of exclusion and resistance were synthesised into broader domains and theoretical contributions.

Table 7.1: From thematic findings to conceptual framework

Chapter 5 & 6 Themes / Sub-Themes	Conceptual Domains	Interpretive Link
Chapter 5: Theme 1: *Speaking through silence: structural exclusion and healthcare navigation*	Communicative and Cultural Exclusion	Language barriers, lack of translation, and silenced voices highlight how healthcare encounters disempower MWSWs, preventing them from expressing their needs safely.
5.3.1 Exclusion through communicative disempowerment		Directly underpins the domain of communicative exclusion.
5.3.2 Symbolic misrecognition: being present but not seen	Symbolic Misrecognition	Accounts of being ignored, misrecognised, or visibly marked (e.g., colour-coded documents) reveal how participants are rendered illegitimate in healthcare spaces.
5.3.3 Systemic inaccessibility: institutional expectations vs. everyday realities	Systemic Inaccessibility	Illustrates misalignment between rigid bureaucratic systems (appointments, documents, insurance) and the precarious, undocumented realities of MWSWs.
Chapter 5: Theme 2: *Survival and resistance: navigating through stigmatisation and discrimination*		Shows how gender, migration, and sex work stigma intersect to produce stratified exclusion, creating

Chapter 5 & 6 Themes / Sub-Themes	Conceptual Domains	Interpretive Link
	Intersectional Hierarchies	hierarchies of “deserving” and “undeserving” patients.
5.4.1 Hierarchies of exclusion in healthcare spaces		Demonstrates how migrant sex workers are positioned at the lowest rung of healthcare hierarchies.
5.4.2 Stigma as structure—how healthcare marks and marginalises		Stigma operates as an institutional structure, not just interpersonal prejudice, reinforcing exclusion.
5.4.3 Layered exclusion: gender, migration, and sex work in clinical encounters		Intersectional disadvantages converge in clinical interactions, reinforcing systemic inequalities.
Chapter 6: Theme 1: *Structural fear and conditional access*		Fear of exposure and deportation explains healthcare avoidance as a rational survival strategy, not ignorance. This shows agency exercised under constraint (bounded agency).
6.2.1 Fear of exposure and deportation		Links directly to strategies like concealment and avoidance of healthcare facilities.

Chapter 5 & 6 Themes / Sub-Themes	Conceptual Domains	Interpretive Link
6.2.2 Silence, stigma, and social risk	Bounded Strategies of Resistance	Demonstrates how stigma silences questions and discourages seeking care.
Chapter 6: Theme 2: *Informal care, peer networks, and dignity in the gaps*	Bounded Strategies of Resistance / Exclusion–Resistance Feedback Loop	Peer support and NGO mediation serve as alternative care pathways, offering short-term protection but often reinforcing dependency and disengagement from formal systems.
6.3.1 Peer solidarity and shared translation		Reflects grassroots strategies of resilience and solidarity that partially compensate for systemic exclusion.
6.3.2 NGO mediation and advocacy		EMPOWER's mediation demonstrates both the importance of NGOs and the structural displacement of responsibility away from the state.
6.3.3 Conditional dignity and "lucky" encounters		Respectful care is described as exceptional rather than systemic, underscoring exclusion as the norm.

As Table 7.1 demonstrates, my conceptual framework is embedded in the lived realities communicated by participants, ensuring that the theoretical contribution of this study remains grounded in empirical evidence. In doing so, it directly addresses the research aims by (1) discovering MWSWs' experience of healthcare over four interwoven domains of exclusion, (2) identifying compounding barriers formed by migration status, gender, stigma, and documentation, and (3) integrating the perspective of EMPOWER to contextualise bounded strategies of resistance. Taken together, this synthesis answers my central research question by indicating that healthcare for MWSWs is not experienced as a universal right, but rather as a precarious, conditional and negotiated process, shaped by compounded inequalities and sustained across fragile networks of support.

The participant's data demonstrates that healthcare access for migrant women sex workers (MWSWs) in Thailand is not simply blocked by discrete barriers but by the compounded interaction of gender, migration status, documentation, and stigma. Using an intersectional lens, I identified that the four interlinked domains of exclusion - *communicative and cultural exclusion, symbolic misrecognition, systemic inaccessibility,* and *intersectional hierarchies* - demonstrate how identifiable barriers are embedded in the design and delivery of healthcare, reinforcing systemic marginalisation.

At the same time, I found that women actively navigated these exclusions through a range of resistance and adaptation strategies. These included individual coping mechanisms such as avoidance or selective disclosure, peer solidarity through information-sharing and accompaniment, and NGO mediation in the form of translation and advocacy. While these strategies offered short-term protection, they were still constrained by the structures that produced exclusion.

My observation, in relation to how access is negotiated through fragile networks (peers, NGOs, and selective disclosure), aligns with findings from systems research, suggesting that a tension remains between work as imagined and work as done. Braithwaite et al. (2024) emphasised that everyday care builds on informal workarounds and local compromises. In my data, NGO mediating and peer accompanying are equivalent "off-script" mechanisms through which care is made possible but not guaranteed.

Based on my findings, I propose the ‘exclusion–resistance feedback loop’. This model reflects the fact that for every act of exclusion in the health system, a parallel form of resistance (i.e., hiding, avoiding care, relying on peers and NGOs) is created. Although these mechanisms enable women to negotiate immediate challenges, they may also serve as discouragement to future use of formal healthcare. This detachment over time causes women to be invisible within the system and, in turn, normalises their ongoing neglect by institutions. In doing so, the exclusion and resistance are to be understood not as an either/or logic but as a co-constitutive practice. The exclusion creates enclosed resistances, and these resistances become part of the condition for reproducing such exclusions.

My study therefore contributes empirically, theoretically, and practically: empirically, by providing an intersectional account of MWSWs’ healthcare experiences in Thailand; theoretically, by conceptualising the ‘exclusion–resistance feedback loop’ as a new way of understanding the co-constitution of exclusion and agency; and practically, by suggesting reforms that address exclusion in its compounded form rather than as observable individual barriers.

7.2.1 Exclusion as an intersectional process

My study shows that the non-inclusion of MWSWs in healthcare is not solely due to single obstacles, such as language or expense. Rather, exclusion is the result of the compounding of migration status, gender, socio-economic status, and stigma related to occupation. I employ intersectionality theory (Crenshaw, 1991) to illustrate how these systems of disadvantage interweave to produce modes of exclusion that are of a different order than the sum of the component elements. For instance, a woman may be refused help with translation not solely on the grounds of being a migrant, but also on account of her culturally “othered”, morally degraded, sex worker identity. These intersecting effects magnify barriers and multiplicatively accumulate their impacts.

The layers of marginalisation can be felt in the four dimensions discussed in Chapter 5, *Communicative and Cultural Exclusion*, which hinders the ability to engage meaningfully with caregivers and perpetuates power differentials in clinical interactions. *Symbolic Misrecognition* challenges the legitimacy of women as patients, figures of everyday marginalisation, mispronouncing names or colour coding records. *Systemic Inaccessibility* represents more entrenched institutional perceptions of an

‘ideal patient’ - Thai, documented, in formal work and settled address - that do not align with MWSWs' lives and are consistent with other research on migrant healthcare in the region (Chuah et al., 2018). Lastly, *Intersectional Hierarchies* demonstrates how gendered exploitation of sex work labour, criminal law, and stigma intersect to hinder healthcare rights.

These findings underscore that intersectionality is not only an abstract theoretical lens but a lived reality for MWSWs. Exclusion is experienced daily at the intersections of multiple disadvantages, shaping encounters with healthcare as sites of both structural marginalisation and personal vulnerability.

7.2.2 Resistance as bounded agency in an intersectional context

My findings show that migrant women sex workers (MWSWs) respond to exclusion through adaptive strategies that demonstrate some agency, but this agency is constrained by the structures that marginalise them. Intersectionality helps explain how these strategies take their particular form. Overlapping disadvantages such as legal precarity, gendered stigma, and economic insecurity shape both the risks women face and the options available to them.

Eyles et al. (2015) describe patient and provider coping as endurance, resistance, resilience, with micro-practices of agency situated within structural constraints. This parallels my own characterisation of MWSWs’ strategies as bounded agency and everyday resistance (Kabeer, 2000; Scott, 1990). The women minimise harm (e.g., by hiding, travelling with friends or a knowledgeable peer navigator, or seeking NGO routing) but do not transform the structural conditions for access at any individual healthcare facility.

I located three paths of resistance. Women's resilience strategies, such as selective disclosure or avoiding healthcare facilities, allow them to escape immediate risks, such as police surveillance or occupational exposure, but commonly at the cost of delayed treatment. Peer solidarity networks offer much-needed emotional and informational support, as well as physical accompaniment to GP, hospital, or clinic. This helps women navigate unfamiliar and unfriendly systems but remains only a partial alternative to welcoming professional care. Thirdly, NGO mediation and advocacy, such as that carried out through bodies like EMPOWER, make it possible for women

to access translation, negotiation, and protection, though ultimately these are called on because of gaps in the state provision.

These strategies correspond to Kabeer's (2000) concept of bounded agency, or the idea that women make choices, but always within the constraints of structural inequalities. They are consistent with Scott's (1990) notion of everyday resistance, by which features like staying away from the clinic or mutual accompaniment are the understated, pragmatic expression of opposition, as distinct from explicit political challenge.

7.2.3 The 'Exclusion–Resistance feedback loop'

Behrens et al. (2022) found that systems tend to exploit short-term adaptive fixes that conserve patient flow and service delivery while leaving underlying inequalities untouched. The dual dynamic at the margins that my feedback-loop model explains is as follows: exclusionary events lead to bounded resistance, which then reduces formal engagement, making MWSWs' health needs invisible to the system and normalising continuing neglect of their healthcare needs - a cycle of coping that reproduces exclusion.

My conceptualisation of the 'exclusion–resistance feedback loop' is shown in Table 7.2 and Diagram 7.1 below. My findings indicate that exclusion and resistance are not sequential stages, but rather co-occurring processes. In a single healthcare encounter, an act of exclusion such as being ignored, denied translation, or dismissed as illegitimate, can prompt an immediate resistance strategy, like seeking NGO mediation, relying on peer support, or just never going back.

Table 7.2: Exclusion domains, data examples, and corresponding resistance strategies

Domain of Exclusion	Example from Data	Corresponding Resistance Strategy
Communicative and Cultural Exclusion	No translation services; medical forms only in Thai; inability to ask clarifying questions.	Relying on NGO translators, bringing a peer to interpret, and memorising key medical phrases.
Symbolic Misrecognition	Staff mispronouncing names, avoiding eye contact, and using colour-coded cards marking sex work status.	Selective disclosure of occupation/migration status; seeking care only in 'friendly' clinics.
Systemic Inaccessibility	Healthcare designed for literate, Thai-speaking, legally documented patients; rigid appointment systems.	Using informal healthcare, seeking NGO referral to bypass bureaucratic barriers.
Intersectional Hierarchies	Gender, class, migrant status, and sex work stigma intersect to amplify discrimination and avoidance.	Building peer solidarity networks, collective accompaniment to clinics, and mobilising NGO advocacy.

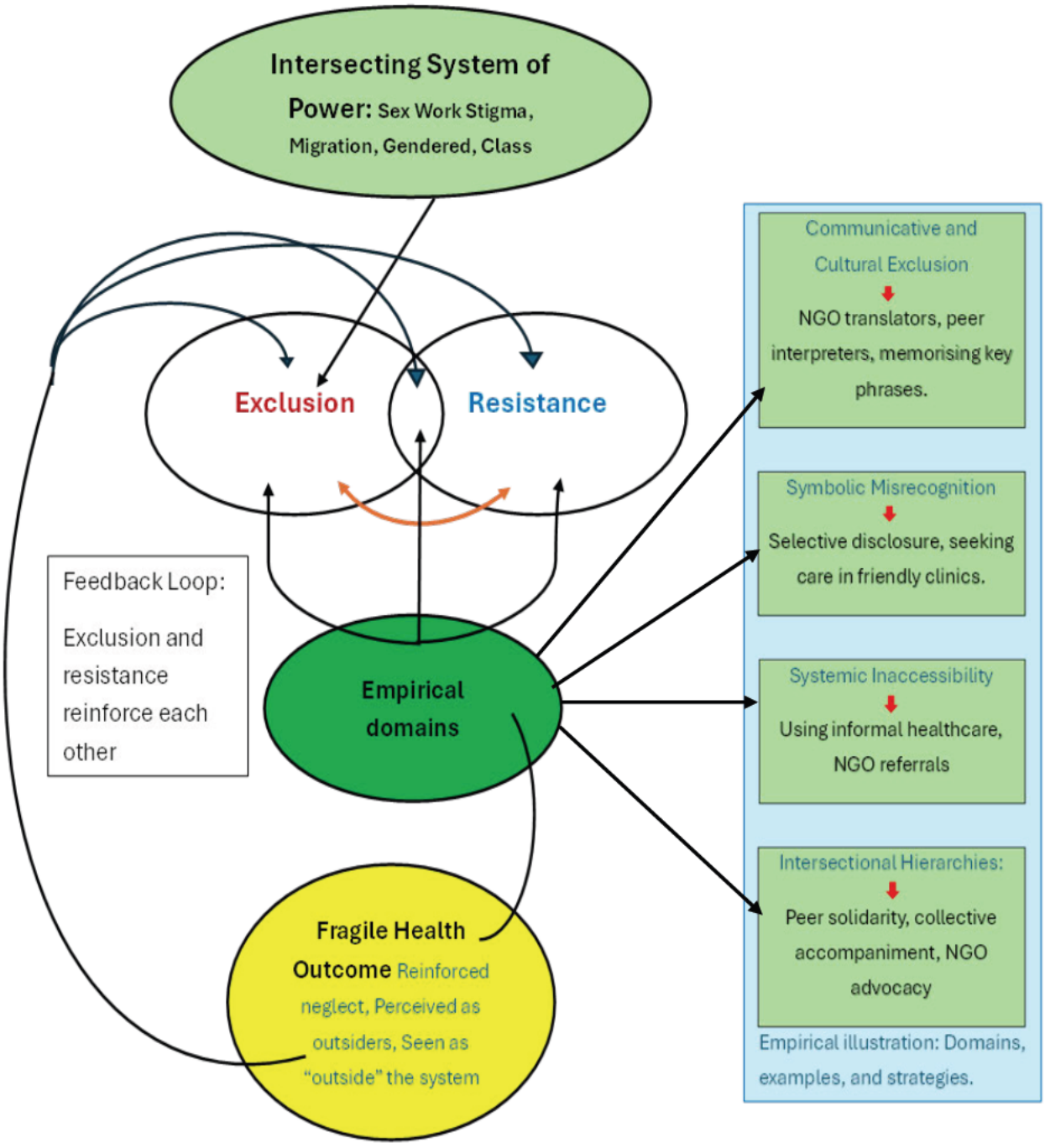


Diagram 7.1: Exclusion-Resistance Feedback Loop

Exclusion and resistance are not sequential stages where exclusion happens first and resistance follows, but co-occurring processes that reinforce one another over time. This analytic diagram elucidates why MWSWs' health may remain fragile despite women's determined attitudes and coping strategies.

Viewed through an intersectional lens, the 'exclusion–resistance feedback loop' illustrates how overlapping systems of power - gendered inequality, migration regimes, class precarity, and sex work stigma - shape both exclusion and resistance. These processes cannot be understood in isolation, because each draws meaning and force from the other.

My aim is that acknowledging this framework will enrich intersectional healthcare research by providing a dynamic way to connect the lived experiences of marginalised groups with the systemic structures of power that govern their access to care.

7.2.4 Intersectionality as compounding oppression

Key to my analysis is the lens of exclusion within which the multiple levels of marginalisation experienced by MWSWs are not additive but cumulative. Intersectionality, as Crenshaw (1991) asserts, illustrates how structures of power intersect and multiply with each other to create new and aggravated forms of discrimination. My findings support this. The experience of women towards healthcare is not the sum of gender, migrant status, or sex work, but their compounding intersection.

Zhong et al. (2024) find that structural inequalities (poverty, racialisation, provider capacity) erode the system's resilience and ability to adapt. This also aligns with my argument that compounded axes, including gender, migration status, documentation, stigma, and precarity, are not merely additive but multiply risk and deepen avoidance of a precarious, conditional access.

Documentation emerged as a particularly powerful axis of compounding exclusion. Lacking legal papers or relying on false or precarious permits excluded women from state health insurance schemes and exposed them to constant fear of detection and punishment. This meant that issues such as language barriers or stigma were never experienced by them in isolation. Asking for an interpreter, for example, risked exposing undocumented status; disclosing sex work could invite both police attention

and moral displeasure. What the literature often treats as separate barriers - language, stigma, legality - merge in practice to multiply risk and deepen avoidance of care.

This multiplicative burden was most apparent in encounters with the healthcare system. Feelings of judgement and disrespect combined with systemic inaccessibility - completing forms in Thai, requests for proof of insurance, and administrative procedures conducted in open reception areas - produce experiences of “double exclusion.” Being undocumented compounded the stigma of being a sex worker, and being a sex worker made the stigma around being undocumented all the more acute. Together, these dynamics created what participants described as a sense of being “nowhere legitimate” within the healthcare system.

Concealing an occupation can minimise the expression of stigma, but it also restricts the optimal, relevant care for the woman. Relying on NGOs provides support but does not disrupt institutionalised exclusions.

By conceptualising intersectionality as compounding rather than additive, my study advances a more nuanced understanding of healthcare exclusion. It exposes that it is insufficient to address individual barriers discretely, though they definitely should be addressed. Instead, they must be addressed as they intersect with one another. I believe this finding contributes to the theoretical discussion on intersectionality and presents a clear case for medical and policy interventions that specifically address intersecting forms of marginalisation.

7.2.5 Policy structures and lived realities

My results reveal the discursive distance between the declared promises of official health and labour policies in Thailand and the everyday lives of MWSWs. Thailand’s Universal Health Coverage (UHC) has frequently been acknowledged as a model of equity (Tangcharoensathien et al., 2018), and the Migrant Health Insurance Scheme (MHIS) was designed to provide access to non-nationals (Suphanchaimat et al., 2019). On paper, such systems seem to ensure that everyone is covered. However, MWSWs’ experiences suggest that these policies can be less tools of inclusion and more tools of exclusion.

Eligibility criteria tied to documentation systematically marginalise undocumented migrants or those with precarious work permits. Even where enrolment in MHIS is

technically possible, high costs and bureaucratic requirements such as employer registration and identity verification place the scheme beyond the reach of women in informal and unstable jobs (Nundy & Bhatt, 2022; Tangcharoensathien et al., 2017). In practice, a policy that claims universality becomes a gatekeeping system that entrenches precarity, strengthens employer control, and increases women's vulnerability.

Legal frameworks compound this exclusion. Sex work has no formal recognition under labour law, and the Prevention and Suppression of Prostitution Act positions sex work as a form of immorality (Godwin, 2012; Hung, 2023a; Khruaham & Lawton, 2012). This removes sex workers from occupational health and creates an environment of reluctance and anxiety around healthcare. As participants conveyed, in revealing their work they faced the risk of police attention or clinic rejection. Avoiding public healthcare became a “logical if expensive” form of survival.

Institutional practices within healthcare settings further reinforce these layers of exclusions. The system design assumes an “ideal patient” who will be Thai, documented, formally employed, settled at one address, and socially respectable. These are not the lived reality of MWSWs. Rigid appointment systems, untranslated forms, segregated queues, and colour-coded documents marking migrant and sex work status produce the exclusions embedded in Thai policy at the point of care.

In comparing official descriptions with lived experience, my research demonstrates that health exclusion is not simply a matter of individual transactions or personal deficits. It is this wider socio-legal context that decides who can legitimately achieve a right to health.

7.3 Theoretical contribution

My study makes three interrelated theoretical contributions to the study of healthcare access under conditions of marginalisation.

First, while intersectionality has previously been employed in Thai health research (Calang & Sunanta, 2025; Cheung, 2023a, 2023b; Chuemchit et al., 2024; Thwe, 2022), I embedded it directly into the analytic process through coding, memoing, and

theme development. This approach allowed me to show how gender, migrant status, documentation, class, and sex work stigma do not operate separately but interact in compounded ways to shape healthcare experiences. By doing so, I provide a replicable model for applying intersectionality within thematic analysis and contribute to strengthening its methodological use in healthcare research.

Second, I conceptualise the 'exclusion–resistance feedback loop'. I show how everyday resistance strategies such as selective disclosure, peer solidarity, or NGO mediation seek to mitigate structural harm in the short term but simultaneously reduce full engagement with formal systems, thereby reinforcing exclusion in the long term. The feedback loop captures this paradox, illustrating that exclusion and resistance are co-constitutive processes. This extends debates on agency and power by demonstrating that resilience can both protect and constrain at the same time.

Third, I bring policy critique into dialogue with lived experience. By contrasting Thailand's universalist health frameworks with the narratives of migrant women sex workers, I show how formal inclusion coexists with substantive exclusion. Rights are formally in place but are de facto inaccessible, an aspect in keeping with Kabeer's (2000) notion of adverse incorporation. This study illustrates how health access is produced not only in clinical encounters, but also within broader socio-legal environments that determine whose rights are acknowledged and under which circumstances.

Collectively, they advance the theoretical discussion on intersectionality, exclusion, and agency. By theorising exclusion and resistance together, I provide a framework for understanding healthcare access that is both intersectional and dynamic, with relevance beyond the Thai context.

7.4 Empirical contribution

This study offers an intersectional analysis of access to healthcare for MWSWs within the Thai context. There is an increasingly rich literature on migrant health (Khongthanachayopit et al., 2017; Naing et al., 2020; Sitkulanan et al., 2024; Tschirhart et al., 2021, 2023; Wongsuwanphon et al., 2024) and sex workers' health (Apidechkul et al., 2018; Decker et al., 2011; Yasami et al., 2023), but limited research

that has explicitly looked at the consequences of these combined identities on healthcare access (Derkinderen, 2017; Janyam, et al., 2020; Jirattikorn et al., 2022). Through the use of a thematic analysis that articulates exclusionary and resistant strategies, this study provides a nuanced representation of how MWSWs engage with health systems which are formally inclusive but substantively exclusionary. The data illuminate the types of barriers experienced, including communicative and cultural exclusion, symbolic misrecognition, systemic inaccessibility, and intersectional hierarchies, and how aspects of the women's lives were impaired in their everyday experiences with healthcare. By describing the particular coping and resistance strategies employed by MWSWs, the study reveals adaptation strategies that are often overlooked in the analysis of literature on the provision and experiences of healthcare.

7.5 Revisiting the research question and objectives

My study set out to answer the research question:

How do migrant women sex workers experience healthcare provision in Thailand, and what are their perceptions about accessing healthcare?

I suggest that access to healthcare is not experienced by migrant women sex workers as an entitlement, but rather as a conditional and contentious process. Exclusions and discouragements borne by MWSWs are compounded at a juncture of gender, migration status and documentation, socio-economic vulnerability, and stigma of sex work. Healthcare is seen as structurally exclusionary, which is to say that policies, institutions, and everyday practices intersect to deprive particular women of legitimacy.

At the same time, participants navigated these exclusions through bounded forms of resistance such as concealing their occupation, seeking NGO mediation, or relying on peer solidarity. These are strategies that reveal both resilience and constraint.

The research aims can now be revisited in light of these findings:

Aim 1: To understand the experiences of MWSWs in accessing healthcare services within the Thai context.

I identified through an intersectionality lens four interlinked domains of exclusion: *Communicative and Cultural Exclusion, Symbolic Misrecognition, Systemic*

Inaccessibility, and *Intersectional Hierarchies*. These domains illustrate how policy, bureaucracy, and stigma converged to shape women's encounters with healthcare and consistently positioned them as marginal or illegitimate patients.

Aim 2: To identify and understand the barriers that affect access to healthcare from the perspective of MWSWs

The findings demonstrated that the barriers were not discrete but correlated. Lack of documentation made them vulnerable. Inability to read or understand Thai, the dominant language in healthcare provision, is a major obstacle to effective diagnosis and treatment. Stigma and judgement around sex work intensified fear about legal consequences. Bureaucratic and administrative procedures at healthcare facilities generated discriminatory practice. These forces often discouraged women from seeking healthcare or drove them to rely on precarious substitutes. Disadvantage was experienced in a compound rather than an additive form.

Aim 3: To understand the roles of local Thai NGOs for MWSWs to access healthcare.

EMPOWER's perspective situated individual accounts within broader struggles for rights and recognition. As mediators and translators, the NGO provided women with the opportunity to access systems that would otherwise be closed to them. Nevertheless, dependence on EMPOWER for many women exposes structural limitations when healthcare inclusion has to depend on intermediaries rather than being a basic within-state provision.

Taken together, these findings demonstrate that MWSWs experience healthcare in Thailand as exclusionary, fragmented, and conditional. The four domains of exclusion and the bounded strategies of resistance collectively answer the research question: healthcare is perceived not as a universal right, but as a precarious and negotiated process, shaped by compounded inequalities and sustained through fragile networks of support.

7.6 Conclusion

In this thesis, I set out to explore how migrant women sex workers (MWSWs) in Thailand experience healthcare access, and how they navigate and resist the

exclusions they encounter. Based on a constructivist paradigm and informed by intersectionality theory, my analysis has shown that access to healthcare is not predicated on single barriers but on the complex interplay of sex work employment, migration status, gender, documentation, socio-economic precarity, and stigma because of the perceived immorality of sex work.

My findings recognised the intersectionality of their contexts when accessing healthcare and evidence four intertwined areas of exclusion: *Communicative and Cultural Exclusion, Symbolic Misrecognition, Systemic Inaccessibility,* and *Intersectional Hierarchies*. These areas display how policies, institutions, and everyday practices interweave to render MWSWs as marginal, illegitimate, or invisible within the Thai healthcare system. At the same time, participants resisted these exclusions through bounded strategies such as selective disclosure, peer solidarity, NGO mediation, and avoidance. While these practices reflect the women's resilience and creativity, they remain constrained by structural inequalities, giving rise to what I have conceptualised as the 'exclusion–resistance feedback loop', a cycle in which exclusion produces resistance that, paradoxically, sustains further exclusion for the MWSWs.

By embedding intersectionality into research analysis, I have made empirically, theoretically, and practically contributions to knowledge on healthcare and marginalisation. Empirically, this study provides a systematic account of MWSWs' healthcare experiences in Thailand, extending debates beyond the narrow focus on HIV/STDs prevention to their broader health needs. Theoretically, it advances the utility of intersectionality in relation to healthcare access. Practically, it identifies reforms to service delivery and policy that contribute to addressing exclusion in its compounded form, including decoupling healthcare from documentation, embedding interpreters and peer mediators, and formally integrating NGOs into service provision.

Ultimately, I demonstrate that Thailand's celebrated universalist healthcare system that won praise for its complete reconstruction 25 years ago (Nundy & Bhatt,2022; Tangcharoensathien et al., 2018), nevertheless reproduces stratified access in which rights for some exist in principle but remain inaccessible in practice. For MWSWs, healthcare is fractured, conditional, and often unattainable. Breaking this cycle requires more than incremental adjustments: it demands new structural reform that

dismantles communicative, symbolic, systemic, and hierarchical exclusions while embedding the strengths of peer and NGO networks into the formal healthcare system.

This conclusion brings the study full circle. Beginning with a policy framework that promises universality, I have shown how the lived realities of a large and vulnerable group in the country diverge sharply from that promise. By analysing exclusion, resistance, and compounding intersectionality together, I have illuminated the healthcare struggles of a marginalised and under-researched population, while also offering broader insights into how healthcare systems reproduce but could potentially transform inequality.

7.7 Recommendations

Based on my findings, I propose recommendations at the levels of policy, practice, and research. These recommendations build directly on the central argument of this thesis: that healthcare access for MWSWs in this study is shaped by compounded exclusions, and that addressing these exclusions requires structural change rather than fragmentary adjustments.

7.7.1 Policy recommendations

First, Thailand's healthcare policy needs to adopt an intersectional approach openly. My findings illustrate that exclusions happen not from single barriers but from the compounded effects of gender, migration status, documentation, socio-economic precarity, and sex work stigma. Policy agendas, then, need to identify these intersecting disadvantages and address them as such.

Second, administrative practices that symbolically mark migrants and sex workers as outsider, as 'other', such as colour-coded documents, segregated queues, or untranslated forms should be eliminated. These practices reinforce symbolic misrecognition and institutionalise stigma at the point of care.

Third, legal reform is essential. Decriminalising sex work may be asking too much but extending workplace protections to undocumented migrants would reduce the fear that

drives avoidance of formal care. Without such reform, health rights for MWSWs will remain elusive rather than substantive.

7.7.2 Practice recommendations

At the service delivery level, I recommend institutionalising cultural and linguistic mediation. Trained interpreters and cultural mediators should be a standard in healthcare facilities serving migrant populations, not an NGO provided service or a coincidental bonus if a member of staff speaks another language.

Second, flexible service models are needed. Mobile clinics, after-hours services, and walk-in schemes would better align with the irregular working arrangements of MWSWs, in so doing, enhancing systemic accessibility for individual health and public health.

Third, peer and NGO cooperation should be welcomed by healthcare teams. I find that women place their trust most in other women and in Thailand's established NGOs. These stakeholders could be doing their part within a formal health facility and in that way improving communication, trust, and reducing care avoidance.

7.7.3 Research recommendations

My study suggests several directions for future research. Follow-up studies are required in order to evaluate the long-term health status of MWSWs participants who had depended on informal or NGO-facilitated care. Comparative work between provinces could generate insights into how access is negotiated in contexts with varying migrant sex work populations. In addition, exploring the perspectives of healthcare providers themselves would provide critical insights into the challenges and needs of staff, and could inform training and institutional change.

My recommendation is consistent with the larger thesis here as a whole. To interrupt the feedback loop of exclusion–resistance, reforms must dismantle communicative, symbolic, systemic, and hierarchical exclusions simultaneously, while incorporating the assets of peer and NGO networks into formal health systems. Then migrant women sex workers in Thailand may enjoy effective healthcare as a right in practice, rather than as a principle on paper for the benefit of individuals but also as a public health improvement.

References

Apidechkul, T., Kaewtep, S., Suttana, W. and Chansareewittaya, K., 2018. Factors supporting young ethnic minority males' engaging in commercial sex and accessing health care in Chiang Mai, Thailand. *Thai Journal of Public Health*, ***48***(2), pp.147–160.

Ariyabuddhiphongs, V. and Li, J., 2016. Buddhist good Karma of giving, optimism, and happiness among Thai female sex workers. *Social Indicators Research*, *127*, pp.903-917.

Arora, R., 2017. Female migration and labor in Thailand: When law and society continue to exclude you. *UCLA Journal of International Law and Foreign Affairs*, **21**(1), pp.73–97.

Association of Southeast Asian Nations (ASEAN), 2017. ASEAN Consensus on the protection and promotion of the rights of migrant workers. [Online]. [Access 3 May 2021]. Available from: https://asean.org/storage/2012/05/ASEAN-Consensus-on-the-Protection-and-Promotion-of-the-Rights-of-Migrant-Workers.pdf.

Avila, S., 2008. Buddhism and its relation to women and prostitution in Thai society. Master's thesis, Florida International University, Miami, FL, USA.

Ayuttacorn, A., Tangmunkongvorakul, A., Musumari, P.M., Srithanaviboonchai, K., Jirattikorn, A. and Aurpibul, L., 2019. Disclosure of HIV status among Shan female migrant workers living with HIV in Northern Thailand: A qualitative study. *PLoS One*, ***14***(5), pp. 1–17.

Ayuttacorn, A., Tangmunkongvorakul, A., Jirattikorn, A., Kelly, M., Banwell, C. and Srithanaviboonchai, K., 2021. Intimate relationships and HIV infection risks among Shan female sex workers from Myanmar in Chiang Mai, Thailand: A qualitative study. *AIDS Education and Prevention*, ***33***(6), pp.551–566.

Bak, C. K., 2018. Definitions and measurement of social exclusion—A conceptual and methodological review. *Advances in Applied Sociology*, **8**(5), pp. 422–443.

Barmania, S., 2013. Thailand's migrant sex workers struggle to access health care. *The Lancet*, ***382***(9891), pp.493-494.

Behrens, D., Rauner, M. S., & Sommersguter-Reichmann, M., 2022. Why resilience in health care systems is more than coping with disasters: Implications for health care policy. *Schmalenbach Journal of Business Research*, ***74***(4), pp.465–495.

Bradbury, H., 2015. From research on to research with: developing skills for research with sex workers. In *The SAGE Handbook of Action Research*. 55 City Road: SAGE Publications Ltd, pp.742–749.

Braithwaite, J., Churruca, K., Ellis, L.A., Leask, E., Long, J.C., Sarkies, M., Zurynski, Y. and Clay-Williams, R., 2024. Resilient health care performance in the real world: fixing problems that never happened', *BMC Health Services Research*, ***24***(1), Article 1250. https://doi.org/10.1186/s12913-024-11639-z

Braun, V. & Clarke, V. 2006. *Using thematic analysis in psychology. Qualitative Research in Psychology*, 3, pp. 77–101.

Braun, V. & Clarke, V., 2022. *Thematic analysis : a practical guide*. Los Angeles: SAGE.

Braun, V., Clarke, V., Hayfield, N. and Terry, G., 2019. Thematic analysis. In *Handbook of research methods in health social sciences*, pp. 843–860. Springer, Singapore.

Brinkmann, S., 2013. *Discussion of Qualitative Interviewing*, in *Qualitative Interviewing*. [Online]. New York: Oxford University Press. p.(chapter 1)

Brinkmann, S., 2013. *Introduction to Qualitative Interviewing, in Qualitative Interviewing*. [Online]. New York: Oxford University Press. p. (chapter 5).

Brinkmann, S. & Kvale, S., 2018. *Doing Interviews*. *Second edition*. Vol. 2. [Online]. London: SAGE Publications, Limited.

Braun, V. and Clarke, V., 2021. To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative research in sport, exercise and health*, *13*(2), pp.201-216.

Bryman, A., 2008. *Social research methods*. *Third edition*. Oxford, [England] ; Oxford University Press.

Calang, K. and Sunanta, S., 2025. Is Bangkok really a gay haven, intersectional negotiations shaping identity and belonging among queer Filipino migrant workers. *Sexuality and Culture*, pp.1–22.

Carbado, D.W., Crenshaw, K.W., Mays, V.M. and Tomlinson, B., 2013. Intersectionality: Mapping the movements of a theory 1. *Du Bois Review: Social science research on Race*, ***10***(2), pp.303–312.

Chaloemtiarana, T., 2007. *Thailand: The Politics of Despotic Paternalism*. Cornell University Press. [online]. [Access 6 Oct 2020]. Available fromhttp://www.jstor.org/stable/10.7591/j.ctv3mt96z

Chandran, R., 2018. Migrants, sex workers take pride of place in Bangkok art festival. *Reuters,* 25 October. [Online]. [Access 3 May 2021]. Available from: https://www.reuters.com/article/usthailand-art-rights/migrantssexworkers-take-pride-of- place-in-bangkokartfestivalidUSKCN1MZ10D.

Chandran, R., 2019. No sewing please, we're sex workers: Thai prostitutes battle stigma. *Reuters*, May 15. [online]. [Access 3 Oct. 2020]. Available from: https://www.reuters.com/article/us-thailandwomensexworkersidUSKCN1SL2Z0

Cheung, H., 2023a. Intersectional stigma and coping strategies of single mothers living with HIV in Thailand. *Culture, Health and Sexuality*, ***25***(3), pp.336–351.

Cheung, H., 2023b. Re-defining stigmatization: intersectional stigma of single mothers in Thailand. *Journal of Family Studies*, ***29***(3), pp.1222–1248.

Chuah, F.L.H., Tan, S.T., Yeo, J. and Legido-Quigley, H., 2018. The health needs and access barriers among refugees and asylum-seekers in Malaysia: a qualitative study. *International Journal for Equity in Health*, ***17***(1), Article 120.

Chuemchit, M., Linn, N., Han, C.P.P., Lynn, Z., Chernkwanma, S., Taneepanichskul, N., Sirichokchatchawan, W. and Somrongthong, R., 2024. Discrimination and violence against women migrant workers in Thailand during the COVID-19 pandemic: A mixed-methods study. *PLoS one*, ***19***(5), p.e0300388.

Clift, B.C., Batlle, I.C., Bekker, S. and Chudzikowski, K., 2023. *Qualitative researcher vulnerability*. *Routledge,*

Crenshaw, K., 1991. Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Review,* **43**(6), pp. 1241–1299.

Crenshaw, K.W., 1989. Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, pp.139–167.

Creswell, J. W., 2013. *Qualitative inquiry and research design: Choosing among five traditions* (3rd ed.). Thousand Oaks, CA: Sage.

Creswell, J.W., 2014. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. London: SAGE Publications Ltd.

Creswell, J.W. and Creswell, J.D., 2018. *Research Design: Qualitative, Quantitative & Mixed Methods Approaches*. Los Angeles: SAGE.

Creswell, J.W. and Poth, C.N., 2018. *Qualitative Inquiry & Research Design: Choosing Among Five Approaches*. 4th ed. Los Angeles: SAGE.

Crotty, M., 1998. *The Foundations of Social Research: Meaning and Perspective in the Research Process*. London: SAGE Publications Inc.

Davis, K., 2014. Intersectionality as critical methodology. In *Writing academic texts differently*. Routledge, pp. 17–29.

Davis, J., 2017. Thailand the global alliances against trafficking in women, 2017. [online]. [Access 12 May 2021]. Available from: http://www.gaatw.org/publications/SWorganising/Thailand-web.pdf

Davis, A., Meyerson, B.E., Aghaulor, B., Brown, K., Watson, A., Muessig, K.E., Yang, L. and Tucker, J.D., 2016. Barriers to health service access among female migrant Ugandan sex workers in Guangzhou, China. *International Journal for Equity in Health*, ***15***(1), pp. 1–8.

Davis, J.D., Miles, G.M. and Quinley III, J.H., 2019. “Same same, but different” A baseline study on the vulnerabilities of transgender sex workers in the sex industry in Bangkok, Thailand. *International Journal of Sociology and Social Policy*, ***39***(7/8), pp.550-573.

Decker, M. R., 2017. Gender-based violence, safety promotion and risk reduction for female sex workers in Thailand: Building the evidence for a marginalised population. [online]. [Access 2 May 2021]. Available from: https://svri.org/blog/gender-based-violence-safety-promotion-and-risk-reduction-female-sex-workers-thailand-building

Decker, M.R., McCauley, H.L., Phuengsamran, D., Janyam, S. and Silverman, J.G., 2011. Sex trafficking, sexual risk, sexually transmitted infection and

reproductive health among female sex workers in Thailand. *Journal of Epidemiology and Community Health*, ***65***(4), pp.334-339.

Deering, K.N., Montaner, J.S., Chettiar, J., Jia, J., Ogilvie, G., Buchner, C., Feng, C., Strathdee, S.A. and Shannon, K., 2015. Successes and gaps in uptake of regular, voluntary HIV testing for hidden street-and off-street sex workers in Vancouver, Canada. *AIDS Care, **27**(4), pp.* 499-506.

Denzin, N.K. & Lincoln, Y.S., 2011. *The Sage Handbook of Qualitative Research*. 4th ed. Thousand Oaks, CA: Sage.

Derkinderen, N., 2017. Knowledge attitude and practice towards HIV/AIDS prevention among Myanmar female sex workers in Mae Sot district, Tak province, Thailand.

Dewey, S. and Zheng, T., 2013. *Ethical Research with Sex Workers: Anthropological Approaches*. New York: Springer.

Dias, S., Gama, A., Pingarilho, M., Simões, D. and Mendão, L., 2017. Health services use and HIV prevalence among migrant and national female sex workers in Portugal: are we providing the services needed. *AIDS and Behaviour*, ***21***(8), pp.2316–2321.

Dickson-Swift, V., James, E.L., Kippen, S. and Liamputtong, P., 2006. Blurring boundaries in qualitative health research on sensitive topics. *Qualitative Health Research*, ***16***(6), pp.853–871.

Duff, P., Ogilvie, G., Shoveller, J., Amram, O., Chettiar, J., Nguyen, P., Dobrer, S., Montaner, J. and Shannon, K., 2016. Barriers to cervical screening among sex workers in Vancouver. *American Journal of Public Health*, ***106***(2), pp.366–373.

EMPOWER Foundation Thailand, 2012. Hit and run: the impact of anti-trafficking policy and practice on sex workers' human rights in Thailand, Empower University Press Nonthaburi. [online]. [Access 8 Oct 2020]. Available from: https://www.nswp.org/resource/hit-run-sex-worker-s-research-anti-trafficking-thailand.

Empower Foundation Thailand, 2016. Moving toward decent work: Empower's community research on decent work and exploitation in Thailand. Chiang Mai, Thailand: Empower University Press. [Access 8 Oct 2020]. Available from: http://www.empowerfoundation.org/.

Elmir, R., Schmied, V., Jackson, D. & Wilkes, L., 2011. Interviewing people about potentially sensitive topics. *Nurse Researcher*, **19**(1), pp.12–16.

Eyles, J., Harris, B., Fried, J., Govender, V., & Munyewende, P., 2015. Endurance, resistance and resilience in the South African health care system: case studies to demonstrate mechanisms of coping within a constrained system. *BMC Health Services Research*, ***15***(1), Article 432.

Falk, M.L., 2010. Feminism, Buddhism and transnational women's movements in Thailand. In *Women's Movements in Asia*, pp. 120-133. Routledge.

Febres-Cordero, B., Brouwer, K.C., Rocha-Jimenez, T., Fernandez-Casanueva, C., Morales-Miranda, S. and Goldenberg, S.M., 2018. Influence of peer support on HIV/STI prevention and safety amongst international migrant sex workers: A qualitative study at the Mexico-Guatemala border. *PLoS One*, ***13***(1), pp. 1–20.

Febres-Cordero, B., Brouwer, K.C., Jimenez, T.R., Fernandez-Casanueva, C., Morales-Miranda, S. and Goldenberg, S.M., 2020. Communication strategies to enhance HIV/STI prevention, sexual and reproductive health, and safety among migrant sex workers at the Mexico-Guatemala border. *Journal of Health Care for the Poor and Underserved*, ***31***(2), pp.767–790.

Field-Springer, K., 2020. Reflexive embodied ethnography with applied sensibilities: methodological reflections on involved qualitative research. *Qualitative Research*, ***20***(2), pp.194-212.

Fisher, O. and A. Olsen, 2019. Chapter 3: Working conditions for migrants in Thailand's sex industry. *Migration Report,* pp. 43–57. [Online], [Access 8 Oct 2020]. Available from: https://www.aidsdatahub.org/sites/default/files/resource/un-thailand-migration-report-2019.pdf#page=67.

Folch, C., Lazar, C., Ferrer, L., Sanclemente, C. and Casabona, J., 2013. Female sex workers and access to social and health services in Catalonia: Influence of region of origin and place of work. *AIDS Care, **25**(8), pp.* 1033–1038.

Ghafouri, R. and Ofoghi, S., 2016. Trustworthiness and rigour in qualitative research. *International Journal of Advanced Biotechnology and Research*, **7**(4), pp.1914-1922.

Gilbert, K.R., 2000. Introduction: why are we interested in emotions. In: *The Emotional Nature of Qualitative Research*. United Kingdom: CRC Press, pp. 23-36.

Global Network of Sex Work Projects, 2021. SWING (service workers in group), Thailand. [Online]. [Access 23 May 2024]. Available from https://www.nswp.org/members/asia-and-the-pacific/swing-service-workers-group

Godwin, J., 2012. Sex work and the law in Asia and the Pacific: laws, HIV and human rights in the context of sex work. [online]. [Access 3 Oct. 2020]. Available from:https://www.aidsdatahub.org/sites/default/files/resource/sex-work-and-law-asia-pacific.pdf

Goffman, E., 1963. *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice-Hall.

Goldenberg, S.M., Krüsi, A., Zhang, E., Chettiar, J. and Shannon, K., 2017. Structural determinants of health among im/migrants in the indoor sex industry: experiences of workers and managers/owners in metropolitan Vancouver. *PLoS One*, ***12***(1), pp. 1–17.

Government Public Relations Department, 2022. Religions in Thailand. [online]. [Access 13 April 2024]. Available from: https://thailand.go.th/page/religion.

Guba, E.G. & Lincoln, Y.S., 1994. *Competing paradigms in qualitative research*. In: N.K. Denzin & Y.S. Lincoln, (eds.). *Handbook of Qualitative Research*. 2nd ed. London: Sage, pp.105–117.

Guba, E.G. & Lincoln, Y.S., 1998. *Competing paradigms in qualitative research*. In: N.K. Denzin & Y.S. Lincoln (eds.), *The Landscape of Qualitative Research: Theories and Issues*. Thousand Oaks, CA: Sage, pp.195–220.

Ham, J., 2020. Using difference in intersectional research with im/migrant and racialised sex workers. *Theoretical Criminology*, **24**(4), pp. 551–567.

Hankins, B., 2019. Thailand migration report. *2019 United Nations Thematic Working Group on Migration in Thailand*. [Online]. [Access 23 May 2024]. Available from https://thailand.un.org/sites/default/files/2020-06/Thailand-Migration-Report-2019.pdf.

Harris, J. & J.L. Maia, 2022. Universal healthcare does not look the same everywhere: divergent experiences with the private sector in Brazil and Thailand. *Global Public Health,* **17**(9), pp. 1809-1826.

Holton, J.A., 2008. Grounded theory as a general research methodology. *Grounded Theory Review*, *7*(02), pp.27-45.

Hongjaisee, S., Khamduang, W., Sripan, P., Choyrum, S., Thepbundit, V., Ngo-Giang-Huong, N. and Tangmunkongvorakul, A., 2020. Prevalence and factors associated with hepatitis B and D virus infections among migrant sex workers in Chiangmai, Thailand: A cross-sectional study in 2019. *International Journal of Infectious Diseases*, *100*, pp.247–254.

Hongjaisee, S., Khamduang, W., Kham-Kjing, N., Ngo-Giang-Huong, N., & Tangmunkongvorakul, A., 2024. Seroprevalence and associated factors of HIV, syphilis, hepatitis B, and hepatitis C infections among sex workers in Chiangmai, Thailand during easing of COVID-19 lockdown measures. *PloS One*, ***19***(12), pp. 1–13.

Hugo, G. J., 2017. Population mobility and prostitution in Southeast Asia. *Moussons (Marseille)*, ***29***(29), pp. 19–39.

Human Rights Watch 2010, From the tiger to the crocodile, [online]. [Access 28 Sep. 2020]. Available from:https://www.hrw.org/sites/default/files/reports/thailand0210webwcover_0.pdf

Hung, J., 2023a. An overview of legalising prostitution in Thailand. *Legalising prostitution in Thailand: a policy-oriented examination of the (de-) construction of commercial sex*, pp.1-14.

Hung, J., 2023b. Socioeconomic construction of prostitution in Thailand. In *Legalising Prostitution in Thailand: A Policy-Oriented Examination of the (De-) Construction of Commercial Sex. Singapore*: Springer Nature Singapore, pp. 15–33.

International Organization of Migrant (IOM)Thailand, 2019. Thailand at a crossroads: challenges and opportunities in leveraging migration for development.

Thailand migration: IOM report 2019, [online]. [Access 9 Oct. 2020]. Available from:https://www.iom.int/news/thailandcrossroads-challengesandopportunities-leveraging-migration-development.

International Organisation for Migration, 2021. Migration in Thailand: a country profile. [Online]. [Access 12 May 2024]. Available from: https://thailand.iom.int/sites/g/files/tmzbdl1371/files/documents/iom-thailand-annual-report-2021.pdf

International Organization for Migration (IOM) Thailand, 2023. Shaping the migration narrative: assessment of the public perception of migrants in Thailand. [online]. [Access 19 April. 2024]. Available from: https://thailand.iom.int/resources/shaping-migration-narrative-assessment-public-perception-migrants-thailand.

International Organization for Migration (IOM) Thailand, 2024. [online]. [Access 19 April. 2024]. Available from:https://thailand.iom.int/sites/g/files/tmzbdl1371/files/documents/2025-05/iom-annual-report-2024_revised-4.pdf

Janyam, S., Phuengsamran, D., Pangnongyang, J., Saripra, W., Jitwattanapataya, L., Songsamphan, C., Benjarattanaporn, P., & Gopinath, D., 2020. Protecting sex workers in Thailand during the COVID-19 pandemic: opportunities to build back better. *WHO South-East Asia Journal of Public Health*, ***9***(2), pp. 100–103.

Jirattikorn, A., Tangmunkongvorakul, A., Ayuttacorn, A., Banwell, C., Kelly, M., Lebel, L., & Srithanaviboonchai, K., 2022. Shan migrant sex workers living with HIV who remain active in sexual entertainment venues in Chiang Mai, Thailand. *Journal of Racial and Ethnic Health Disparities*, ***9***(5), pp. 1616–1625.

Joint United Nations Programme on HIV/AIDS (UNAIDS), 2012. Sex work and the law in Asia and the Pacific, 2012. [Online]. [Access 12 May 2021]. Available from: https://www.snap-undp.org/elibrary/Publications/HIV-2012-SexWorkAndLaw.pdf

Joint United Nations Programme on HIV/AIDS (UNAIDS), 2020. We cannot provide only HIV services while sex workers are hungry: Thai community organisation

steps in. [Online]. [Access 15 May 2024]. Available from: https://www.unaids.org/en

Joint United Nations Programme on HIV/AIDS (UNAIDS), Thailand. 2023a. Universal health coverage.[Online]. [Access 17 May 2024]. Available from: https://www.unaids.org/en/topic/UHC

Joint United Nations Programme on HIV/AIDS (UNAIDS), 2023b. Silence is better: how the criminalisation of sex workers keeps exploitation in the shadows.[Online]. [Access 17 May 2024]. Available from: https://www.unaids.org/en

Kabeer, N., 2000. Social exclusion, poverty and discrimination towards an analytical framework. *IDS bulletin*, **31**(4), pp. 83-97.

Kantayaporn, T.,Srivalai,Y.,Vittaporn., S.,Mallik., S.,Boonyopakorn., R., 2014. From burden to challenges: a decade of learning and development: review of client-friendly health services for cross-border migrant in Thailand, 2004–2014. *World Health Organization, Nonthaburi*.

Keyes, C.F., 1984. Mother or mistress but never a monk: Buddhist notions of female gender in rural Thailand. *American Ethnologist*, **11**(2), pp. 223-241.

Khongthanachayopit, S. and Laohasiriwong, W., 2017. Accessibility to health services among migrant workers in the Northeast of Thailand. *F1000Research*, *6*, p.972.

Khruakham, S., Lawton, B.A., 2012. Assessing the Impact of the 1996 Thai Prostitution Law: a study of police arrest data. *Asian Criminology,* **7**, pp. 23–36.

Kidpromma, A., 2022. Buddhist modernism and the piety of female sex workers in Northern Thailand. *Religions (Basel, Switzerland),**13**(4), p. 350.*

King, E.J., Maman, S., Bowling, J.M., Moracco, K.E. and Dudina, V., **2013.** The influence of stigma and discrimination on female sex workers' access to HIV services in St. Petersburg, Russia. *AIDS and Behavior*, **17** (8), pp.2597–2603**.**

Klunklin, A. and Greenwood, J., 2005. Buddhism, the status of women and the spread of HIV/AIDS in Thailand. *Health Care for Women International*, ***26***(1), pp.46-61.

Kosiyaporn, H., Julchoo, S., Phaiyarom, M., Sinam, P., Kunpeuk, W., Pudpong, N., Allotey, P., Chan, Z.X., Loganathan, T., Pocock, N. and Suphanchaimat, R.,

2020. Strengthening the migrant-friendliness of Thai health services through interpretation and cultural mediation: a system analysis. *Global Health Research and Policy*, ***5***(1), pp. 1-13.

Kriitmaa, K., 2023. *Migration, sex work and risk environments: experiences of Somali migrant female sex workers in Nairobi, Kenya and implications for service access and use* (Doctoral dissertation, London School of Hygiene & Tropical Medicine).

Kunpeuk, W., Julchoo, S., Phaiyarom, M., Sinam, P., Pudpong, N., Loganathan, T., Yi, H., & Suphanchaimat, R. (2022). Access to Healthcare and Social Protection among Migrant Workers in Thailand before and during COVID-19 Era: A Qualitative Study. *International Journal of Environmental Research and Public Health*, ***19***(5), pp. 1-16.

Lam, E., Shih, E., Chin, K. and Zen, K., 2021. The double-edged sword of health and safety: COVID-19 and the policing and exclusion of migrant Asian massage workers in North America. *Social Sciences*, ***10***(5), p.157.

Largent, E.A. and Lynch, H.F., 2017. Paying research participants: regulatory uncertainty, conceptual confusion, and a path forward. *Yale Journal of Health Policy, Law, and Ethics*, **17**(1), pp.61–141.

Lemberger, P.,2023. *Sex entertainment in modernity: affective labour and negotiation of intimacy* (Doctoral dissertation, Chiang Mai: Graduate School, Chiang Mai University).

Lemberger, P. and Waters, T., 2022. Thailand's Sex Entertainment: Alienated Labor and the Construction of Intimacy. *Social Sciences*, ***11***(11), p.524.

Leung, L., 2015. Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care*, **4**(3), pp. 324–327.

Lim, R.B., Cheung, O.N., Tai, B.C., Chen, M.I., Chan, R.K. and Wong, M.L., 2018. Efficacy of multicomponent culturally tailored HIV/STI prevention interventions targeting foreign female entertainment workers: a quasi-experimental trial. *Sexually Transmitted Infections*, ***94***(6), pp.449-456.

Logie, C. H., James, Ll., Tharao, W., & Loutfy, M. R., 2011. HIV, Gender, Race, Sexual Orientation, and Sex Work: A Qualitative Study of Intersectional Stigma Experienced by HIV-Positive Women in Ontario, Canada. *PLoS Medicine*, ***8***(11), e1001124.

Long, H. A., French, D. P., & Brooks, J. M., 2020. Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine and Health Sciences*, ***1***(1), pp. 31–42.

Lotysh, A., Tezcan-Güntekin, H., Kalinowski, O., Kaya, G., Kroehn-Liedtke, F., Mihaylova, H., Schouler-Ocak, M., & Rössler, W., 2025. An explorative qualitative study of barriers to the use of health and mental health services among migrant female sex workers in Germany and needs for action. *Frontiers in Public Health*, *12*, pp. 1–14.

Ma, H. & Loke, A.Y., 2019. A qualitative study into female sex workers' experience of stigma in the health care setting in Hong Kong. *International Journal for Equity in Health*, ***18***(1), pp.1-14.

Madill, A., Jordan, A. & Shirley, C., 2000. Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, **91**(1), pp.1–20.

Malla, A., Lam, E. and van der Meulen, E., 2019. Beyond tales of trafficking: A needs assessment of Asian migrant sex workers in Toronto. Toronto. *Butterfly (Asian and Migrant Sex Workers Support Network*), pp. 1-26.

Malterud, K., Siersma, V.D. and Guassora, A.D., 2016. Sample size in qualitative interview studies: guided by information power. *Qualitative Health Research*, ***26***(13), pp.1753-1760.

Mealer, M. & Jones, J., 2014. Methodological and ethical issues related to qualitative telephone interviews on sensitive topics. *Nurse Researcher*, **21**(4), pp.32–37.

Mekong Migration Network, 2011. Update on nationality verification and MOU Thailand, [online]. [Access 6 Oct 2020]. Available from:https://publications.iom.int/system/files/pdf/tmr_2011.pdf

Mensendiek, M., 1997. Women, migration and prostitution in Thailand. *International Social Work*, ***40***(2), pp.163-176.

Meyer, S. R., Robinson, W. C., Abshir, N., Mar, A. A., & Decker, M. R., 2015. Trafficking, Exploitation and Migration on the Thailand-Burma Border: A Qualitative Study. *International Migration*, ***53***(4), 37–50.

Mills, M.B., 1999. *Thai women in the global labor force: Consuming desires, contested selves*. Rutgers University Press.

Naing, S.H.H., Isaramalai, S.A. and Sukmag, P., 2020. Policy literacy, barriers, and gender impact on accessibility to healthcare services under compulsory migrant health insurance among Myanmar migrant workers in Thailand. *Journal of Environmental and Public Health*, *2020*(1), p.8165492.

Naranong, A., 2019. Migrant female sex workers in Thailand: survey and health policy implications. *Governance Journal*, ***8***(2), pp. 1-25.

Nash, J. C., 2008. Re-thinking intersectionality. *Feminist Review,* **89**(1), pp.1–15.

National Statistical Office, Thailand, 2020. Thailand demographic and health survey. [Online]. [Access 17 May 2024]. Available from: https://www.nso.go.th/public/e-book/Statistical-Yearbook/SYB-2020/6/

National Statistical Office, Ministry of Digital Economy and Society, 2020. *Statistical Yearbook Thailand 2020*. [online]. [Access 5 Oct 2021]. Available from: http://service.nso.go.th/nso/nsopublish/pubs/e-book/SYB-2563/files/assets/basic-html/index.html#1.

National Statistical Office, Ministry of Digital Economy and Society, 2024. *Statistical Yearbook Thailand 2024*. [online]. [Access 5 April 2024]. Available from:https://www.google.co.uk/url?sa=t&source=web&rct=j&opi=89978449&url=https://datareportal.com/reports/digital-2024-thailand&ved=2ahUKEwi83Y2sk_6FAxXgUkEAHWoCA-wQFnoECB4QAQ&usg=AOvVaw2hJg9tg86qJ6D41OXc7jNo

Nowell, L.S., Norris, J.M., White, D.E. and Moules, N.J., 2017. Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*, **16**(1), pp. 1–13.

Nundy, M. and Bhatt, P.,2022. *The health system in the Kingdom of Thailand: reforms, achievements, and challenges* (CSEP Working Paper 45). *New Delhi: Centre for Social and Economic Progress*. [Online]. [Access 17 May 2024]. Available from: https://csep.org/wp-content/uploads/2022/11/Health-System-in-Thailand.pdf

O'Connor, S.Y., Tangmunkongvorakul, A., Srithanaviboonchai, K., Sripan, P., Banwell, C. and Kelly, M., 2022. Association between sociodemographic factors and condom use among migrant sex workers in Chiang Mai, Northern Thailand. *International Journal of Environmental Research and Public Health*, ***19***(16), pp. 1–14.

Open Society Institution, 2006. Eight working papers: case studies examining the intersections of sex work law, policy, rights and health. *Sexual Health and Rights Project*, pp. 1-20. [Online]. [Access 17 May 2024]. Available from: https://www.opensocietyfoundations.org/uploads/cbbc5b3c-e525-4a88-9fea-7b72eed037ae/casestudies_20061012.pdf.

Organisation for Economic Cooperation and Development (OECD) and International Labor Organization (ILO) Thailand, 2017.How immigrants contribute to Thailand's economy. *OECD Development Pathways, OECD Publishing, Paris*. Online, https://www.oecd.org/countries/thailand/Prelim_version_ECLM_Thailand.pdf

Padgett, D.K., 2012. *Qualitative social work research*. In: *The SAGE Handbook of Social Work*. United Kingdom: SAGE Publications, Limited, pp. 454-466.

Page, M.J., McKenzie, J.E., Bossuyt, P.M., Boutron, I., Hoffmann, T.C., Mulrow, C.D., Shamseer, L., Tetzlaff, J.M., Akl, E.A., Brennan, S.E. and Chou, R., 2021. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*, *372*, pp. 1–9.

Peddle, M., 2022. Maintaining reflexivity in qualitative nursing research. *Nursing Open*, ***9***(6), pp.2908–2914.

Petpailin, P., 2024. Boom boom: Thailand ranked in the top 10 for sex workers globally. [Online]. [Access 17 May 2024]. Available from: https://thethaiger.com/news/national/boom-boom-thailand-ranked-in-top-10-for-sex-workers-globally

Pietkiewicz, I., & Smith, J. A., 2014. A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, ***20***(1), pp.7-14.

Potter, L.C., Horwood, J. and Feder, G., 2022. Access to healthcare for street sex workers in the UK: perspectives and best practice guidance from a national cross-sectional survey of frontline workers. *BMC Health Services Research*, ***22***(1), pp. 1-11.

Probst, U., 2023. Health insurance for the good European citizen. Migrant sex workers' quests for health insurance and the moral economy of health care. *Social Science and Medicine*, *319*, pp. 1-8.

Punpuing, S., 2010. Migration and health in Thailand: a literature review. *Asia-Pacific Population Journal*, **25**(2), pp. 61-77.

Ramwong, P., 2019. Changing mother-daughter relationships in Isan rural culture in the context of women's migration.

Richardson, L. and Pettigrew, R.N., 2022. Migrant agricultural workers: a comparative analysis of both policy and COVID-19 response in Thailand, Italy, and Canada. *SN Social Sciences*, ***2***(11), pp.236.

Richter, M., Chersich, M.F., Vearey, J., Sartorius, B., Temmerman, M. and Luchters, S., 2014. Migration status, work conditions and health utilization of female sex workers in three South African cities. *Journal of Immigrant and Minority Health*, 16, pp.7-17.

Rigg, J., Promphaking, B. and Le Mare, A., 2014. Personalizing the middle-income trap: an inter-generational migrant view from rural Thailand. *World Development*, *59*, pp.184-198.

Rocha-Jiménez, T., Brouwer, K.C., Silverman, J.G., Morales-Miranda, S. and Goldenberg, S.M., 2017. Exploring the context and implementation of public health regulations governing sex work: a qualitative study with migrant sex workers in Guatemala. *Journal of Immigrant and Minority Health*, ***19***(5), pp.1235–1244.

Rocha-Jiménez, T., Morales-Miranda, S., Fernández-Casanueva, C., Brouwer, K.C. and Goldenberg, S.M., 2018. Stigma and unmet sexual and reproductive health needs among international migrant sex workers at the Mexico–Guatemala border. *International Journal of Gynecology and Obstetrics*, ***143***(1), pp.37–43.

Roguski, M., 2013. Occupational health and safety of migrant sex workers in New Zealand. *Wellington: Kaitiaki Research. [Online]. [Access 10 January 2025]. Available from: http://www. community research. org. nz/research/occupational-safety-and-health-of-migrant-sex-workers-in-newzealand/*.

Sanders, T., 2006. Sexing up the subject: Methodological nuances in researching the female sex industry. *Sexualities*, **9**(4), pp.449–468.

Sanders, T., Pitcher, J. & O'Neill, M., 2009. *Prostitution: Sex work, policy and politics*. SAGE Publications Inc. *in Chapter 10: Researching in Sex Industry*, pp.165-184.

Scambler, G., 2007. Sex work stigma: Opportunist migrants in London. *Sociology*, ***41***(6), pp.1079–1096.

Scott, J.C., 1990. *Domination and the arts of resistance: Hidden transcripts*. Yale University Press. pp. 14–15, pp.183–184.

Seidman, I., 2013. *Interviewing as Qualitative Research: A Guide for Researchers in Education and the Social Sciences*. 4th ed. New York: Teachers College Press.

Selvey, L.A., Lobo, R.C., McCausland, K.L., Donovan, B., Bates, J. and Hallett, J., 2018. Challenges facing Asian sex workers in Western Australia: implications for health promotion and support services. *Frontiers in Public Health*, *6*, pp. 1-8.

Serrat, O., 2021. *Book Analysis of Interviewing as Qualitative Research* (Seidman, 2013)', in *Leading Solutions*. [Online]. Singapore: Springer Singapore. pp. 281–286.

Shaver, F.M., 2005. Sex work research: Methodological and ethical challenges. *Journal of Interpersonal Violence*, **20**(3), pp.296–319.

Singh, J.P. and Hart, S.A., 2007. Sex workers and cultural policy: Mapping the issues and actors in Thailand. *Review of Policy Research*, ***24***(2), pp.155-173.

Sinha, S., 2017. Ethical and safety issues in doing sex work research: Reflections from a field-based ethnographic study in Kolkata, India. *Qualitative Health Research*, **27**(6), pp.893–908.

Sitkulanan, P., Chaisitsanguan, K., Winaiprasert, P. and Wong-arsa, W., 2024. Problems of Myanmar women of reproductive age in accessing health services as migrant workers in Thailand: A qualitative study. *Nurse Media : Journal of Nursing*, ***14***(1), pp. 53–64.

Smith, J. A., 2021. Interpretative phenomenological analysis : theory, method and research. London, SAGE Publications, Limited UK.

Smith, H., Lim, R. and Harkins, I.B., 2019. 01 Thailand migration profile. *Migration Report*, [Online]. [Access 17 May 2021]. Available from: https://thailand.un.org/sites/default/files/2020-06/Thailand-Migration-Report-2019.pdf

Socías, M.E., 2015. Access to health care among women sex workers in Vancouver, Canada: universal health coverage in a criminalized sex work environment (Doctoral dissertation, University of British Columbia).

Socías, M.E., Shannon, K., Montaner, J.S., Guillemi, S., Dobrer, S., Nguyen, P., Goldenberg, S. and Deering, K., 2015. Gaps in the hepatitis C continuum of care among sex workers in Vancouver, British Columbia: Implications for voluntary hepatitis C virus testing, treatment and care. *Canadian Journal of Gastroenterology and Hepatology*, ***29***(8), pp.411–416.

Stenquist, M., 2023. Regional migrant workers in Thailand: precarity and resistance. [Online]. [Access 17 May 2024]. Available from: https://lup.lub.lu.se/luur/download?func=downloadFile&recordOId=9115863&fileOId=9127271.

Sumriddetchkajorn, K., Shimazaki, K., Ono, T., Kusaba, T., Sato, K. and Kobayashi, N., 2019. Universal health coverage and primary care, Thailand. *Bulletin of the World Health Organization*, ***97***(6), pp.415–422.

Suphanchaimat, R., Putthasri, W., Prakongsai, P. and Tangcharoensathien, V., 2017. Evolution and complexity of government policies to protect the health of undocumented/illegal migrants in Thailand–the unsolved challenges. *Risk Management and Healthcare Policy*, 10, pp.49-62.

Suphanchaimat, R., Pudpong, N., Prakongsai, P., Putthasri, W., Hanefeld, J. and Mills, A., 2019a. The devil is in the detail—understanding divergence between intention and implementation of health policy for undocumented migrants in Thailand. *International Journal of Environmental Research and Public Health*, ***16***(6), pp 1-19.

Suphanchaimat, R., Kosiyaporn, H. and Limwattanayingyong, A., 2019b. Migrant policies in Thailand in light of the universal health coverage: evolution and remaining challenges. *Outbreak, Surveillance, Investigation and Response (OSIR) Journal*, ***12***(2), pp.68–74.

Surit, P., Yasothornsrikul, S. and Mitkitti, R., 2022. HIV/AIDs risk perception and sexual behavior among commercial female sex worker in Thailand. *World Journal of AIDS*, ***12***(3), pp.141-155.

Suriya, N. (2022). *Lived experience of decision making of people living with dementia and family caregivers in Thailand.* The University of Edinburgh.

Tangcharoensathien, V., Limwattananon, S., Patcharanarumol, W., Thammatacharee, J., Jongudomsuk, P., & Sirilak, S., 2015. Achieving

universal health coverage goals in Thailand: the vital role of strategic purchasing. *Health Policy and Planning*, ***30***(9), pp.1152–1161.

Tangcharoensathien, V., Thwin, A. A., & Patcharanarumol, W., 2017. Implementing health insurance for migrants, Thailand. *Bulletin of the World Health Organization*, ***95***(2), pp.146–151.

Tangcharoensathien, V., Witthayapipopsakul, W., Panichkriangkrai, W., Patcharanarumol, W. and Mills, A., 2018. Health systems development in Thailand: a solid platform for successful implementation of universal health coverage. *The Lancet*, ***391***(10126), pp.1205–1223.

Tangcharoensathien, V., Sachdev, S., Viriyathorn, S., Sriprasert, K., Kongkam, L., Srichomphu, K. and Patcharanarumol, W., 2022. Universal access to comprehensive COVID-19 services for everyone in Thailand. *BMJ Global Health*, ***7***(6), pp. 1–6.

Tantiwiramanond, D. and Pandey, S., 1987. The status and role of Thai women in the pre-modern period: A historical and cultural perspective. *Sojourn: Journal of Social Issues in Southeast Asia*, ***2***(1), pp.125-149.

Tawaytibhongs, O., 2022. Universal health coverage for undocumented migrant workers in Thailand: challenges in policy implementation. *Human and Social Science*, **5**(3), pp.206-214.

Temple, B. & Young, A., 2004. Qualitative Research and Translation Dilemmas. *Qualitative Research : QR*, **4**(2), pp. 161–178.

Thailand Life, 2023. Prostitution in Thailand: History, Legal Status & Societal Impact. Retrieved from online. [Online]. [Access 12 May 2024]. Available from: https://www.thethailandlife.com/

Thwe, S.M., 2022. Intersectionality and livelihoods of conflict-induced displaced Myanmar women in Mae Sot, Thailand.

Tipayalai, K., 2020. Impact of international labour migration on regional economic growth in Thailand. *Journal of Economic Structures*, ***9***(1), pp. 1-19.

Tschirhart, N., Jiraporncharoen, W., Thongkhamcharoen, R., Yoonut, K., Ottersen, T. and Angkurawaranon, C., 2021. Including undocumented migrants in universal health coverage: a maternal health case study from the Thailand-Myanmar border. *BMC Health Services Research*, ***21***(1), pp.1315-1319.

Tschirhart, N., Jiraporncharoen, W., Angkurawaranon, C., Hashmi, A., Hla, S., Nosten, S., McGready, R. and Ottersen, T., 2023. Giving birth on the way to the clinic: undocumented migrant women's perceptions and experiences of maternal healthcare accessibility along the Thailand–Myanmar border. *Reproductive Health*, ***20***(1), pp. 1-10.

United Nations Committee on Economic, Social and Cultural Rights (CESCR), 2000. General Comment No. 14: The Right to the Highest Attainable Standard of Health. [Online]. [Access 9 May 2022]. Available from: https://www.refworld.org/docid/4538838d0.html

United Nations General Assembly, 1948. Universal Declaration of Human Rights (UDHR). [Online]. [Access 10 May 2022]. Available from: https://www.un.org/en/about-us/universal-declaration-of-human-rights

United Nations Office on Drugs and Crime (UNODC), 2017. Trafficking in persons from Cambodia, Lao PDR and Myanmar to Thailand. [Online]. [Access 17 May 2024]. Available from: https://www.unodc.org/roseap/uploads/archive/documents/Publications/2017/Trafficking_in_persons_to_Thailand_report.pdf

Utthasit, O.O., 2018. *CLMV male migrant sex workers in Bangkok: livelihoods and social protection*. Chulalongkorn University, Thailand. [Online]. [Access 17 May 2024]. Available from: https://digital.car.chula.ac.th/chulaetd/2427/

van Nes, F., Abma, T., Jonsson, H. and Deeg, D., 2010. Language differences in qualitative research: is meaning lost in translation?. *European Journal of Ageing, **7**(4), pp.* 313-316.

Villar, L. B., 2019. Unacceptable forms of work in the Thai sex and entertainment industry. *Anti-trafficking Review*,(12), pp.108–126., [Online]. [Access 17 May 2024]. Available from: https://antitraffickingreview.org/index.php/atrjournal/article/view/380/316.

Wadekar, N., 2022. Movement in Thailand aims to help sex workers earn fundamental rights and protections. *The Latest*. [Online]. [Access 17 May 2024]. Available from: https://www.pbs.org/newshour/show/movement-in-thailand-aims-to-help-sex-workers-earn-basic-rights-and-protections.

Watts, J.H., 2008. Emotion, empathy and exit: Reflections on doing ethnographic qualitative research on sensitive topics. *Medical Sociology online*, ***3***(2), pp.3-14.

Webber, G., Spitzer, D., Somrongthong, R., Dat, T.C. and Kounnavongsa, S., 2012. Facilitators and barriers to accessing reproductive health care for migrant beer promoters in Cambodia, Laos, Thailand and Vietnam: A mixed methods study. *Globalization and Health*, ***8***(1), pp. 1–18.

Webber, G.C., Spitzer, D.L., Somrongthong, R., Dat, T.C. and Kounnavongsa, S., 2015. Migrant beer promoters' experiences accessing reproductive health care in Cambodia, Laos, Thailand, and Vietnam: lessons for planners and providers. *Asia Pacific Journal of Public Health*, ***27***(2), pp.1228–1240.

Weine, S., Golobof, A., Bahromov, M., Kashuba, A., Kalandarov, T., Jonbekov, J. and Loue, S., 2013. Female migrant sex workers in Moscow: gender and power factors and HIV risk. *Women and Health*, ***53***(1), pp.56–73.

Willig, C., 2013. *Introducing Qualitative Research in Psychology*. 3rd ed. London: McGraw-Hill Education.

Wittman, C., 2011. *From rice fields to red light districts: an economic examination of factors motivating employment in Thailand's sex industry* (Doctoral dissertation, Kansas State University).

Wong, M.L., Chan, R., Tan, H.H., Yong, E., Lee, L., Cutter, J., Tay, J. and Koh, D., 2012. Sex work and risky sexual behaviors among foreign entertainment workers in urban Singapore: findings from mystery client survey. *Journal of Urban Health*, ***89***(6), pp.1031–1044.

Wongsuwanphon, S., Chottanapund, S., Knust, B., Wongjindanon, N. and Suphanchaimat, R., 2024. Access to healthcare services and factors associated with unmet needs among migrants in Phuket Province, Thailand, 2023: a cross-sectional mixed-method study. *BMC Health Services Research*, ***24***(1), pp. 1-13.

World Bank, 2022a. The World Bank in Thailand. [online]. [Access 3 Oct. 2023]. Available from:https://www.worldbank.org/en/ country/thailand/overview.

World Bank, 2022b. Thailand economic monitor. [Online]. [Access 4 May 2024]. Available from: https://www.worldbank.org/en/country/thailand/publication/thailand-economic-monitor-reports

World Health Organization (WHO), 2013. *Ethics and Health Unit. Research Ethics Committees: Basic Concepts for Capacity-building – 'Evaluation of risks and benefits'*. Geneva: WHO Document Production Services.

World Health Organization (WHO), 2016. *International Ethical Guidelines for Health-related Research Involving Humans*. [online]. [Accessed 2 May 2021]. Available from: https://cioms.ch/wp-content/uploads/2017/01/WEB-CIOMS-EthicalGuidelines.pdf, pp.57-60.

World Health Organization, 2023. Promoting the health of refugees and migrants: experiences from around the world. https://iris.who.int/bitstream/handle/10665/366326/9789240067110-eng.pdf?sequence=1

World Health Organization Thailand, 2023. Thailand country cooperation strategy 2022–2026. [online]. [Access 3 April. 2024]. Available from:https://www.who.int/thailand/our-work/country-cooperation-strategy/ccs-2022-2026.

Yarrow, R.,2022. Thailand's economic dilemmas in post-pandemic Asia. Germany: ISEAS Publishing.

Yasami, M., Zhu, H. and Dewan, M., 2023. Poverty, psychological distress, and suicidality among gay men and transgender women sex workers during the COVID-19 pandemic in Phuket, Thailand. *Sexuality Research and Social Policy*, ***20***(3), pp.1203–1219.

Yu, Y., He, A., Zheng, S., Jiang, J., Liang, J., Shrestha, B. and Wang, P., 2022. How does health literacy affect the utilization of basic public health services in Chinese migrants. *Health Promotion International*, ***37***(1),pp. 1-12.

Zermiani, M., Mengoli, C., Rimondo, C., Galvan, U., Cruciani, M. and Serpelloni, G., 2012. Prevalence of sexually transmitted diseases and hepatitis C in a survey of female sex workers in the North-East of Italy. *The Open AIDS Journal*, ***6****(1)*, pp. 60–64.

Zhong, L., Lopez, D., Pei, S. and Gao, J., 2024. Healthcare system resilience and adaptability to pandemic disruptions in the United States', *Nature Medicine*, 30, pp. 2311–2319

APPENDICES

APPENDIX A: Inclusion articles: Healthcare access among migrant women sex workers

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
Davis et al.	2016	China	To explore barriers to healthcare access among migrant Ugandan female sex workers in Guangzhou, China.	19 female Ugandan sex workers	Qualitative study using in-depth interviews with an a priori coding framework and open coding.	Fear of arrest due to lack of documentation discouraged hospital visits. Low income, housing exploitation, and remittances limited financial resources, further inhibiting healthcare access. Social isolation and mistrust of local healthcare institutions were significant barriers.
Dias et al.	2017	Portugal	To examine differences in use of HIV health services, testing, and prevalence among migrant and national female sex workers	853 female sex workers (207 documented migrants, 169 undocumented migrants, 477 nationals)	Cross-sectional bio-behavioral survey with structured questionnaires and HIV rapid testing.	Undocumented migrants reported the lowest use of National Health Service and HIV testing. 15% of undocumented migrants never tested for HIV. Higher HIV prevalence was found in undocumented migrants compared to documented ones. Lack of knowledge on available health services was a barrier.
Febres-Cordero et al.	2018	Mexico-Guatemala border	To analyze the role of peer support in shaping vulnerability and resilience related to HIV/STI	31 international migrant sex workers from Mexico and Guatemala	Qualitative study using semi-structured interviews with sex workers in different migration and work settings	Peer support was crucial for reducing social isolation, improving access to HIV/STI knowledge, and mitigating workplace violence. Challenges included frequent mobility, stigma, and limited

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
			prevention and violence among international migrant sex workers			access to healthcare. Variations in peer support were found depending on work environment, country of work, and migration stage.
Febres-Cordero et al.	2020	Mexico-Guatemala border	To investigate communication strategies used for HIV/STI prevention, sexual and reproductive health, and safety among migrant sex workers.	48 migrant sex workers (28 in Guatemala, 20 in Mexico)	Qualitative study using in-depth semi-structured interviews and ethnographic fieldwork.	Peer-based communication and mobile phone use were key in accessing health and safety information. Formal indoor venues provided better access to health resources compared to informal settings. Barriers to accessing healthcare included fear of deportation, criminalization, and economic constraints. Structural reforms are needed to improve health access and reduce vulnerability.
Folch et al.	2013	Catalonia, Spain	To describe the use of social and health services by female sex workers in Catalonia and explore barriers to access based on region of origin and work setting.	400 female sex workers (149 street-based, 143 club-based, 108 flat-based)	Mixed-methods study including a cross-sectional survey and focus groups	Over 60% of female sex workers accessed healthcare in the past 6 months, with variations in service use by work setting and region of origin. Club-based workers relied on private healthcare, while street-based workers had more contact with NGOs. Eastern European women in clubs were the most isolated and least likely to access social services. Barriers

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
						included stigma, language difficulties, and fear of discrimination in the public healthcare system.
Goldenberg et al.	2017	Canada (Metropolitan Vancouver)	To analyze the social and structural determinants of health and safety among migrant women in the indoor sex industry	198 migrant sex workers (78.3% Chinese-born, median duration in Canada: 6 years)	Mixed-methods study using qualitative interviews (44 participants) and quantitative data from a community-based cohort (AESHA).	Migrant sex workers faced significant barriers including language difficulties, police harassment, and fear of deportation. The majority entered the sex industry voluntarily due to economic necessity and limited job opportunities. Fear of legal repercussions discouraged access to health and legal services. Structural reforms emphasizing human rights and decriminalization were recommended to improve health and safety.
King et al.	2013	Russia (St. Petersburg	To examine the influence of stigma and discrimination on female sex workers' access to HIV services.	139 female sex workers (street-based sex workers in St. Petersburg)	Cross-sectional study using an interviewer-administered questionnaire.	HIV-related stigma negatively affected HIV testing uptake, while sex work-related stigma was positively associated with testing. 30% of sex workers reported being refused medical care. 58% avoided medical visits due to fear of mistreatment. HIV-positive sex workers were more likely to experience discrimination. The study highlights the need for

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
						policy reforms to reduce stigma and improve access to healthcare services for sex workers.
Kriitmaa, K.	2023	Kenya (Nairobi)	To explore why Somali female sex workers in Nairobi remain at high risk of HIV despite the availability of targeted HIV prevention services.	15 Somali migrant female sex workers (50 interviews conducted)	Qualitative research using in-depth interviews with repeat interactions and case studies.	Somali FSWs face structural barriers including lack of documented migration status, harassment by law enforcement, economic struggles, and systematic violence. Religious beliefs contributed to low health-seeking behavior, with participants believing 'Allah will fix it'. Healthcare access was deprioritized due to economic constraints, with a focus on food and shelter for children. Intersectionality and risk environments influence their vulnerability and service utilization.
Lam et al.	2021	USA and Canada	To examine how the COVID-19 pandemic and anti-trafficking policing measures have affected migrant Asian massage workers' access	Survey of 106 migrant Asian massage workers; ethnographic data from two advocacy organizations (Butterfly, Toronto; Red	Mixed-methods study using surveys, ethnographic fieldwork, and interviews with migrant Asian massage workers.	Migrant Asian massage workers faced heightened economic precarity and exclusion from healthcare and government relief due to COVID-19 and policing. Fear of deportation, criminalization, and language barriers further restricted access to health services. Workers reported

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
			to healthcare and social services.	Canary Song, NYC).		xenophobic discrimination, lack of pandemic support, and the use of anti-trafficking policies to justify over-policing
Lim et al.	2018	Singapore	To assess barriers to healthcare access and the effectiveness of a culturally appropriate STI prevention intervention for foreign female entertainment workers in Singapore.	706 foreign female entertainment workers (376 Vietnamese, 330 Thai)	Qualitative research using in-depth interviews, observations, informal conversational interviews, mystery client, and census enumeration techniques	Workers faced challenges in healthcare access due to fear of identity exposure, stigma, cost, and language barriers. A peer-led intervention significantly increased consistent condom use and reduced STI incidence. Community-based engagement strategies improved participation, with a follow-up rate of over 66%.
Lotysh et al.	2025	Germany (Berlin)	To explore barriers to healthcare and mental health service use among migrant female sex workers in Berlin and identify needs for action.	10 migrant female sex workers	Qualitative study using semi-structured interviews and structuring qualitative content analysis.	Barriers were categorized at three levels: patient, provider, and system. Patient-level barriers included lack of health insurance, language barriers, self-stigma, and financial constraints. Provider-level barriers involved stigma, cultural insensitivity, language barriers, misdiagnosis, and unprofessional behavior. System-level barriers included a complex healthcare system, long waiting times, uncovered services, and lack of

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
						information. Key recommendations included increasing awareness, improving mental health support, reducing waiting times, ensuring anonymity, and providing more specialized services.
Ma and Loke	2019	Hong Kong	To explore how female sex workers (FSWs) experience stigma and develop coping strategies when accessing health care services in Hong Kong.	22 female sex workers recruited via NGOs	Qualitative study using in-depth interviews analyzed with directed content analysis.	FSWs experienced multiple levels of stigma (experienced, anticipated, and internalized), leading to fear, shame, and reluctance to seek care. Some adopted passive coping strategies (concealing identity, avoiding stigmatizing situations), while others engaged in active coping (justifying sex work, seeking peer support). FSWs called for non-judgmental, holistic health care addressing mental health and other needs beyond STDs.
Malla et al.	2019	Canada (Toronto)	To assess the needs of Asian migrant sex workers in Toronto and explore barriers to accessing	52 migrant Asian women (10 in-depth interviews, 52 surveys)	Mixed-methods study using surveys, in-depth interviews, and ethnographic observations.	Sex workers faced multiple barriers including language difficulties, fear of disclosing immigration or sex work status, and mistrust of law enforcement. Most participants preferred sex work over other low-paying and exploitative

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
			health and social services.			jobs. One-third of participants never accessed a health service; mental health issues were prevalent but under-addressed. Recommendations included increasing accessible services in multiple languages, challenging misconceptions, and ending punitive policing practices.
Duff et al.	2016	Canada (Vancouver)	To examine social, structural, and geographic factors influencing cervical screening among sex workers in Vancouver.	611 sex workers (2010-2013 data from AESHA cohort)	Longitudinal study using multivariable logistic regression with generalized estimating equations (GEE).	At baseline, only 38.6% of sex workers had received cervical screening, with HIV-positive individuals more likely to have been screened. Barriers included poor treatment by healthcare staff, limited clinic hours, and language barriers. Outreach services increased screening access, but geographic proximity to clinics did not significantly affect screening rates. The study recommends mobile and outreach-based cervical screening for sex workers.
Richter et al.	2014	South Africa (Johannesburg, Rustenburg, Cape Town)	To assess structural determinants of vulnerability of migrant female sex workers	1,653 female sex workers (85.3% migrants: 39% internal, 46.3% cross-border)	Cross-sectional survey using structured interviews conducted by sex workers.	Cross-border migrants had lower healthcare service utilization compared to non-migrants. Despite higher education and higher earnings per client, they experienced

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
			(FSWs), focusing on economic conditions, work environments, and healthcare access.			significant barriers to health service contact. Migrant sex workers were more likely to work in safer indoor environments but faced police harassment, including bribes and immigration-related issues. Migrant-sensitive, sex work-specific healthcare and education interventions are needed to improve access.
Rocha-Jiménez et al.	2017	Guatemala (Tecún Umán & Quetzaltenango)	To explore the implementation of sex work regulations and their impact on HIV prevention and healthcare among migrant sex workers.	53 migrant female sex workers (El Salvador: 10, Honduras: 11, Nicaragua: 4, Mexico: 2, Guatemala: 26)	Qualitative study using 33 in-depth interviews and 20 focus group discussions.	Public health regulations improved access to HIV/STI testing but had unintended negative consequences such as police abuse and harassment. Migrant sex workers faced challenges in accessing services due to migration status, privacy concerns, and fear of police enforcement. The study highlighted the need for non-coercive, evidence-based policies that protect sex workers' rights while improving healthcare access.
Rocha-Jiménez et al.	2018	Mexico–Guatemala Border	To explore international migrant sex workers' experiences and	31 migrant female sex workers	Inductive qualitative analysis based on ethnographic fieldwork (2012–	The greatest unmet needs included access to contraception and treatment for sexually transmitted infections. Barriers included

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
			narratives pertaining to the unmet need for and access to sexual and reproductive health (SRH) services at the Mexico–Guatemala border.		2015), including participant observation and in-depth interviews.	poor knowledge of healthcare systems, stigma, and affordability issues. Women preferred private doctors or delayed care until returning home. Health services were mostly accessed through sex work regulations or urgent care. The study recommends rights-based SRH services for migrant sex workers
Roguski	2013	New Zealand	To examine occupational health and safety issues and access to sexual and reproductive health services among migrant sex workers in New Zealand.	124 migrant sex workers (qualitative interviews with 12 participants; clinic records review of 51 migrant sex workers and 51 non-migrants)	Mixed-methods study including qualitative interviews, clinic record review, and a survey of migrant sex workers.	Migrant sex workers supported amending the Prostitution Reform Act (2003) to allow them legal work rights. Barriers included fear of deportation, language difficulties, and avoidance of healthcare due to immigration status concerns. No evidence of human trafficking was found, and condom use was high. Migrant workers were more likely to access sexual health services via peer networks. Recommendations included legal reforms, increased access to healthcare, and community support programs.

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
Selvey et al.	2018	Australia (Western Australia)	To assess the challenges faced by Asian sex workers in WA, including legal issues, stigma, discrimination, and healthcare access.	354 sex workers surveyed, 94 identified as Asian (27%)	Mixed-methods study using surveys, semi-structured interviews with sex workers and key advisors, and site visits to sexual service premises	Asian sex workers were more likely to work exclusively in massage parlors, experience social isolation, and face language barriers. Fear of law enforcement and immigration authorities prevented them from seeking support or reporting violence. Many had poor English skills, limiting their employment opportunities outside of sex work. Recommendations included peer-based outreach programs, better language services, and decriminalization of sex work to improve safety and healthcare access.
Socías et al.	2015	Canada (Vancouver)	To assess the engagement of sex workers in the hepatitis C virus (HCV) continuum of care and identify barriers to testing, treatment, and care	705 sex workers (302 HCV seropositive, 552 HCV seronegative)	Cross-sectional study using baseline data from an ongoing cohort study (AESHA) with multivariable logistic regression analysis.	42.8% of sex workers tested positive for HCV, with 22.5% unaware of their status. Only 41.7% accessed HCV-related care, 13.9% were offered treatment, and only 1% received treatment. Recent HCV testing was lower among immigrant sex workers, highlighting structural barriers. Key factors associated with recent HCV testing included drug use, sexual/gender

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
						minority status, and residence in high-risk areas.
Weine et al	2013	Russia (Moscow)	To explore gender and power factors influencing HIV risk behaviors among female migrant sex workers in Moscow.	24 female migrant sex workers	Qualitative ethnographic study using minimally structured interviews and thematic analysis.	Female migrant sex workers engaged in high HIV-risk behaviors, with inadequate condom use influenced by gender and power dynamics. Economic hardship pushed or pulled them into sex work, particularly serving male migrant laborers. Barriers included fear of violence, social isolation, and limited healthcare access. Many experienced stigma and emotional distress, which further hindered their ability to negotiate safer practices. Interventions addressing socioeconomic, behavioral, and cultural factors were recommended to improve HIV prevention.
Wong et al.	2012	Singapore	To assess the prevalence of sexual services, condom use, and self-initiated STI screening among foreign female entertainment	317 female entertainment workers from 93 establishments	Cross-sectional survey using a mystery client approach in a two-stage proportional cluster sample.	71% of entertainment establishments offered sexual services, with 53% of workers selling sex. Consistent condom use was low (51.9% for vaginal sex, 46.9% for anal sex, and 37.9% for oral sex). Less than half (48.9%) had ever been screened for STIs,

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
			workers in Singapore.			with many preferring to do so in their home country due to cost and familiarity. Asking clients to use condoms was significantly associated with increased condom use. Recommendations included better access to STI screening, education, and condom negotiation training.
Zermiani et al.	2012	Italy (North-East, Verona)	To assess the prevalence of sexually transmitted diseases (STDs) and Hepatitis C virus (HCV) among immigrant female sex workers.	345 female sex workers (FSWs) from Africa, Eastern Europe, and South America (1999-2007)	Cross-sectional survey with serological screening for STDs (HIV, syphilis, HBV, and HCV).	HIV prevalence was 4.6%, HBsAg 3.5%, syphilis 2.0%, and HCV 0.9%. No significant difference in HIV and HBV rates between African and other FSWs, but syphilis was more prevalent among Eastern European FSWs. Older FSWs and those with earlier immigration dates had higher infection rates. Health service interventions included mobile outreach units and free, anonymous testing.
in Studies Thailand						
Ayuttacorn et al.	2019	Thailand (Northern Region, Chiang Mai)	To explore the challenges of HIV status disclosure among Shan female migrant workers and its	18 HIV-infected Shan female migrant workers; 29 healthcare	Qualitative study using in-depth interviews and content analysis.	Non-disclosure of HIV status was common due to fear of stigma, rejection, and loss of financial support. Non-disclosure prevented effective condom negotiation,

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
			impact on sexual behaviors and ART adherence	workers interviewed		increasing risk for HIV transmission. Many participants believed that good ART adherence reduced transmission risk, leading to inconsistent condom use. Healthcare providers encouraged disclosure, but cultural and financial barriers made it difficult for migrant women to disclose their status. Study recommends culturally sensitive disclosure strategies and improved support systems for HIV-positive migrant workers
Ayuttacorn et al.	2021	Thailand (Northern Region, Chiang Mai)	To investigate HIV risks among Shan female sex workers and how their intimate relationships influence inconsistent condom use.	17 Shan female sex workers (aged 18–45)	Qualitative study using in-depth interviews.	FSWs sustained intimacy with regular clients for emotional and financial support, leading to inconsistent condom use. Gender norms and male dominance influenced condom negotiation. Some participants lacked proper knowledge about HIV prevention, particularly regarding condom breakage and risk perception. Effective interventions should address the role of intimacy in HIV prevention and include couples-based communication strategies.

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
Derkinderen	2017	Thailand (Mae Sot, Tak Province)	To assess knowledge, attitudes, and practices (KAP) regarding HIV/AIDS prevention among Myanmar female sex workers (MFSW) in Mae Sot district.	120 Myanmar female sex workers	Quantitative study using structured questionnaires and statistical analysis (Mann-Whitney U, Kruskal-Wallis, and Spearman's correlation).	52.5% of respondents were aged 18-24 years, 56.7% were undocumented migrants, and 78.3% had been in sex work for 3 years. General knowledge, attitudes, and practices towards HIV/AIDS prevention were at a moderate level. Earning levels showed a negative correlation with HIV/AIDS preventive behavior ($r = -0.233$, $p = 0.010$). Barriers to preventive behaviors included business type, work location, and peer/employer influence. Recommendations included gender-sensitive and culturally appropriate HIV/AIDS interventions.
Empower Foundation	2012	Thailand	To analyze the impact of anti-trafficking laws and policies on the human rights of migrant sex workers in Thailand	206 sex workers involved in research, including 170 research partners and 36 research leaders.	Community-based research using storytelling, interviews, legal document reviews, and policy analysis.	Anti-trafficking policies have led to widespread human rights violations against sex workers, including wrongful detention, forced rehabilitation, deportation, and police harassment. Raids and entrapment operations disproportionately target migrant sex workers, leading to fear and economic insecurity. Mandatory health

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
						screenings, lack of legal protections, and discrimination in shelters further exacerbate vulnerabilities. Recommendations include legal reforms, recognition of sex work as labor, and the elimination of punitive anti-trafficking practices.
Hongjaisee et al.	2020	Thailand (Chiangmai)	To determine the prevalence of Hepatitis B surface antigen (HBsAg) and anti-hepatitis D virus (HDV) antibodies, and associated factors among migrant sex workers in Chiangmai.	396 migrant sex workers (198 females, 198 males)	Cross-sectional study conducted in 2019 using questionnaire-based interviews and serological testing.	HBsAg prevalence was 11.4% overall (8.1% in females, 14.7% in males). No participants tested positive for anti-HDV antibodies. HBsAg positivity was significantly associated with being male, having attended school, being separated/divorced/widowed, and having unprotected sex. 42.2% of participants were still susceptible to HBV infection, highlighting the need for HBV vaccination and screening programs.
Hongjaisee et al.	2024	Thailand (Chiangmai)	To assess the seroprevalence of HIV, syphilis, HBV, and HCV and associated factors among sex workers after the easing of	264 sex workers (52.3% male), recruited between March and December 2022.	Cross-sectional study using interview-based questionnaires and serological testing. Logistic regression	HIV seroprevalence was 9.1% overall, higher in males (13%) than females (4.8%). Syphilis prevalence was 15.5%, again higher in males (23.9%) than females (6.4%). HBsAg prevalence was higher in females (9.5%) than males

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
			COVID-19 lockdown measures.		models used for data analysis.	(4.4%). HCV prevalence was 4.6%, with males (6.5%) at higher risk than females (2.4%). Key risk factors included age at first sex, receptive anal sex, drug injection, and sex work duration. Study highlights the continued spread of HIV/STIs despite lockdown measures, emphasizing the need for accessible HIV/STI testing and treatment.
Janyam et al.	2020	Thailand	To examine the impact of COVID-19 lockdown measures on sex workers in Thailand and explore potential policy changes to improve their social and economic conditions.	255 sex workers surveyed (170 female, 38 male, 26 transgender; 207 Thai, 27 non-Thai)	Community-led rapid assessment using online self-administered questionnaires.	91% of respondents reported unemployment due to COVID-19 restrictions. 75% could not cover daily expenses, while 66% could not afford food, housing, or necessities. Many sex workers, especially undocumented migrants, were excluded from government relief measures. Access to HIV/STI services dropped significantly, with a 90% reduction in sex workers seeking STI screening. Community-based organizations played a key role in supporting sex workers, providing food, PPE, and HIV-related services. The study

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
						calls for the decriminalization of sex work and inclusion of sex workers in government social protection programs.
Jirattikorn et al.	2022	Thailand (Chiang Mai)	To explore the lived experiences of Shan migrant female sex workers (MFSW) living with HIV who remain active in sex work, focusing on risk perception, condom use, and barriers to leaving sex work.	8 Shan female sex workers living with HIV	Qualitative study using in-depth narrative interviews.	Most participants contracted HIV through non-paying partners rather than clients. MFSW in brothels used condoms more consistently than those in massage parlors and karaoke bars. Many continued sex work due to financial necessity, lack of alternative employment, and a desire to stay in Thailand. Barriers to HIV care included misconceptions about ARV treatment, migration-related healthcare access issues, and social stigma. Recommendations included improved healthcare access, tailored HIV education for migrant workers, and policies to support alternative employment opportunities.
O'Connor et al.	2022	Thailand (Chiang Mai)	To investigate how sociodemographic factors influence condom use patterns	396 migrant sex workers (198 male, 198 female) recruited from 23 sex work-	Cross-sectional study using surveys to collect sociodemographic, health behavior, sexual	Overall condom use was highest with clients (87.9%), moderate with casual partners (53.7%), and lowest with regular partners (17.0%). Education level was

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
			among migrant sex workers in Chiang Mai, Thailand.	identified venues.	risk behavior, quality of life, and depression data. Logistic regression was used for data analysis.	significantly associated with condom use, with those who had started high school more likely to use condoms consistently (OR = 0.41, 95% CI: 0.20–0.82). Male sex workers were significantly less likely than females to use condoms consistently with clients (AOR = 0.24, 95% CI: 0.09–0.63). Workplace type also influenced condom use, with those in karaoke venues less likely to use condoms consistently with casual partners. Findings suggest targeted interventions are needed to promote consistent condom use, especially among regular and casual partners.
Surit et al.	2022	Thailand (Bangkok)	To assess HIV/AIDS risk perception and associated sexual behaviors among commercial female sex workers (CFSWs) in Bangkok.	141 commercial female sex workers (CFSWs)	Cross-sectional study using self-administered questionnaires; logistic regression analysis used to assess factors associated with HIV risk perception.	51.77% of CFSWs perceived themselves at high risk for HIV/AIDS. 57.45% reported inconsistent condom use with clients, while 52.48% never used condoms with intimate partners. Factors significantly associated with high HIV risk perception included higher education level (OR=2.23), knowledge of HIV and STDs

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
						(OR=3.65), condom use (OR=2.56), longer duration in sex work (OR=3.33), and having undergone HIV/STD testing (OR=3.22). Illicit drug use, smoking, and alcohol consumption were also significantly associated with higher risk perception.
Villar	2019	Thailand	To examine working conditions in the Thai sex and entertainment industry through the Unacceptable Forms of Work (UFW) framework.	107 respondents (73 sex workers, 24 employers, 7 public health officials, and 3 representatives from civil society organizations).	Mixed-methods study using site surveys, interviews, and literature review.	Criminalization of sex work increases vulnerability to police harassment and labor rights violations. Sex workers, especially migrants, face barriers in accessing legal and social protections. Many experience poor working conditions, wage deductions, and lack of job security. Public health services for sex workers are inadequate, with stigma discouraging healthcare access. Policy recommendations include decriminalizing sex work, updating labor laws, and improving oversight of working conditions.
Webber et al.	2012	Cambodia, Laos, Thailand, Vietnam	To assess access to sexual and reproductive health services	Mixed-methods study with focus groups and	Qualitative focus groups and key informant interviews;	Key barriers included work demands, financial constraints, location, long waiting times, and healthcare

Author(s)	Year of Publication	Country of Settings	Aims	Population and Sample Size	Research Methods and Design	Key Findings
			for migrant beer promoters in four Southeast Asian cities.	surveys; 390 beer promoters surveyed	quantitative survey conducted in four major health institutions	provider stigma. Institutional factors like high costs, inconvenient clinic hours, and poor service attitudes deterred access. Beer promoters had high rates of sexual activity and many engaged in sex work to supplement income. Recommendations included extending clinic hours, reducing costs, improving provider attitudes, and establishing mobile health services.
Webber et al.	2015	Cambodia, Laos, Thailand, Vietnam	To examine the experiences of migrant beer promoters in accessing reproductive health care services in major Southeast Asian cities.	390 beer promoters surveyed across 7 healthcare institutions in Phnom Penh, Vientiane, Bangkok, and Hanoi.	Mixed-methods study including surveys and interviews with healthcare providers and beer promoters.	Beer promoters were generally satisfied with cost, location, and friendliness of healthcare providers but had concerns about confidentiality and waiting times. Discrepancies existed between staff-reported services and beer promoters' experiences. Barriers included stigma, financial limitations, and lack of healthcare insurance for migrant women. Recommendations included addressing confidentiality concerns, reducing waiting times, and ensuring inclusive health policies.

APPENDIX B: Ethical Approval

SCHOOL *of* HEALTH IN SOCIAL SCIENCE
The University of Edinburgh
Medical School
Doorway 6, Teviot Place
Edinburgh EH8 9AG
Email ethics.hiss@ed.ac.uk

09 February 2022

Dear Paichit,

Reference: NUST015
Project Title: Exploration of healthcare access among migrant female sex workers in Thailand

Thank you for submitting the above research project for review by the School of Health in Social Science Research Ethics Committee (REC). I can confirm that the submission has been independently reviewed and has received a favourable opinion on 20 January 2022.

The standard conditions of this are:

I. Conduct the project strictly in accordance with the proposal that you have submitted and that has been granted ethics favourable opinion, including any amendments made to the proposal required by the REC.
II. Advise the REC (by email to ethics.hiss@ed.ac.uk) of any complaints or other issues in relation to the project, which may warrant review of the favourable opinion granted to the project.
III. Make submission for approval of amendments to the project before implementing such changes.
IV. Advise in writing if the project has been discontinued.

The School's Research Ethics Policy and further information and resources are available on the School's website.
Best of luck with your project.
Yours sincerely,

Sergio Mori
Administrative Secretary
School of Health in Social Science

APPENDIX C: PARTICIPANT CONSENT FORM

School of Health in Social Science
University of Edinburgh

Study Title: A thematic analysis of health care experiences while being a sex worker, barriers and opportunities in accessing health care: an NGO staff/volunteers perceptions and migrant female sex worker's views and experiences about health care provision in Thailand.

Researcher's name and contact details: Paichit Amsri, email: ; Mobile +44 7932334537; LINE ID: Toi195413

Please initial box

1. I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. ☐

3. I understand that my data used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) will be shared anonymously with other researchers. ☐

4. I understand that my audio recording and transcripts will be long-term preserved (seven years) in a digital repository hosted by the University of Edinburgh and may be used in future ethically approved research. ☐

5. I understand that data collected during the study may be looked at by individuals from the Sponsor (University of Edinburgh), where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data. ☐

6. I agree with my interview being audio/video recorded. ☐

7. I agree to take part in the above study. ☐

Name of person giving consent	Date	Signature
_____	_____	

Name of person taking consent	Date	Signature
_____	_____	

Finally, if you have any concerns about your feelings, please get in touch with SWING Thailand or EMPOWER outreach clinics you have already contacted. You also can contact the following online site:
Hotline services:

- SWING Thailand: +66 2 632 9501
- EMPOWER : +66 2 5268311
- Fountain of Life Women's Center: +66 38 415 881
- Mental Health Hotline by the Department of Mental Health: “1323”
- Online Therapy for Depression in Thailand
  WhatsApp: +91 9013-262626
  Call Us: +91 9013-262626
- Thailand’s First Mental Health App; hivelive.com

“Hive Live

APPENDIX D: Informed Consent Form Thai

ใบยินยอมเข้าร่วมการวิจัย

หัวข้อวิจัย เรื่องการศึกษาการเข้าถึงและการได้รับบริการด้านสุขภาพของพนักงานบริการหญิงที่เป็นแรงงานข้ามชาติ

วันให้คำยินยอม วันที่.....เดือน.....พ.ศ.....

ก่อนที่จะลงนามในใบคำยินยอมเข้าร่วมการวิจัยนี้ ข้าพเจ้าได้รับการอธิบายจากผู้วิจัยถึงวัตถุประสงค์ของการวิจัย วิธีการวิจัย ประโยชน์ที่จะเกิดขึ้นจากการวิจัยอย่างละเอียดและมีความเข้าใจดีแล้ว ข้าพเจ้ายินดีเข้าร่วมโครงการวิจัยนี้ด้วยความสมัครใจ ข้าพเจ้าอนุญาตให้ผู้วิจัยบันทึกเสียงบทสัมภาษณ์ และข้าพเจ้ามีสิทธิที่จะบอกเลิกการเข้าร่วมในโครงการวิจัยนี้เมื่อใดก็ได้ และการบอกเลิกการเข้าร่วมการวิจัยนี้ จะไม่มีผลกระทบใดๆ ต่อข้าพเจ้า

ผู้วิจัยรับรองว่าจะตอบคำถามต่างๆที่ข้าพเจ้าสงสัยด้วยความเต็มใจ ไม่ปิดบัง ซ่อนเร้นจนข้าพเจ้าพอใจ ข้อมูลเฉพาะที่เกี่ยวกับตัวข้าพเจ้าจะถูกเก็บเป็นความลับและจะเปิดเผยในภาพรวมที่เป็นการสรุปผลการวิจัย

ข้าพเจ้าได้อ่านข้อความข้างต้นแล้ว และมีความเข้าใจดีทุกประการ และได้ลงนามในใบยินยอมนี้ด้วยความเต็มใจ

ลงนาม.....ผู้ยินยอม

(.....)

ลงนาม.....ผู้วิจัย

(นางสาวไพรจิตร อ่ำศรี)

APPENDIX E : PARTICIPANT INFORMATION SHEET

Information Sheet for migrant female sex worker

Research title: A thematic analysis of health care experiences while being a sex worker, barriers and opportunities in accessing health care: an NGO staff/volunteers perceptions and migrant female sex worker's views and experiences about health care provision in Thailand.

I would like to invite you to take part in an interview for a research study:

- This information sheet describes the research project, the interview I would like you to participate in, and why it is being done.
- Please read through the information carefully before you decide whether to take part in the interview. It is important you understand the purpose of the interview and what it will involve.
- If there are any points that are unclear or if you would like to find out more about the project, please contact Paichit Amsri
- If you would like to participate in the study after reading the information sheet, please contact Paichit Amsri or the organisation member who gave you this information sheet.

What is the research project?

This is an inviting letter for you to participate in a research study where the purpose is to understand better what health care access among migrant female sex workers in Thailand. This qualitative research will invite migrant female sex workers and staff/volunteers who support these women through organisations or projects (SWING and EMPOWER). You will be asked to join the interviews. Hopefully, your contributions from these interviews will offer important recommendations for future measures favourable to migrant sex workers group and those who work with them.

To increase knowledge about this health care access among migrant female sex worker groups, I want to talk to migrant women who are working in the sex business. The interview will be conducted via LINE application (audio/video) or mobile with migrant female sex workers. These interviews will be with me as a researcher, and I will ask various questions related to the health care access that you might have been received during you are working in Thailand. Important topics will be: what kind of health problems you have, where and how you seek health care and the perceptions and experiences about its care. In addition, I want to focus on your reflections on these topics, what are the strengths of healthcare access for you and what needs to be improved in support of your health care access.

Why am I being asked to participate in this interview study?

You are being invited to participate in an interview for this study as you were identified as a migrant female sex worker. For this reason, I would like to hear more about your views and experiences of working as a sex worker and what are health care access during your work in Thailand. Moreover, I would like to hear your perceptions about the barriers and opportunities for you when accessing health care.

Why is this information being collected, and what will it be used for?

I want to interview migrant female sex workers. This will allow me to understand subjects regarding health care access among migrant female sex workers and make sure the research project is able to understand and recognise your experiences and perceptions about health care access. In addition, I will use the information collect in this study to inform those who already work directly with migrant sex worker communities such as SWING Thailand, EMPOWER and community-based services. Finally, I consider that increasing a better understanding of this research subject is central to assessing the current services and future policy proposals in providing better care for migrant female sex workers groups.

Who is running the project?

This research is used as part of the Doctor of Philosophy degree "Nursing studies**"** at the School of Health in Social Science, College of Arts, Humanities and Social Sciences.
The researcher who will conduct these interviews is a PhD student, has trained in interview techniques, and is passionate about improving people's health and wellbeing.

What will the interview involve?

Once you have read and understood this information sheet, I will ask that you complete and give the consent form (verbally with a recorder) to show that you agree to participate in the study. The interview will involve either a mobile or LINE application (audio/video) interview in a time and place that is convenient for you, then asking you some questions related to your experiences and perceptions in seeking health services. In addition, you may be asked to participate in a follow-up interview and a member checking. I will also ask you about your health subjects. For example, what kind of health problems you have, where and how you seek health care and the attitudes and experiences about its care. In addition, I want to focus on your reflections on these topics and your opinions about services and what services you need during work as a sex worker.
Further, I want to hear from you about what made health care access more challenging for you. The interview will be recorded on a small electronic voice recording device and will last about 60 minutes. After this interview, if you should have more information about your experiences and give further details about health care access, you can contact me anytime to arrange another interview. I will send the interview transcripts to you for a recheck to record, and you may give some comments about the transcripts.

Do I have to take part in this interview?

No, you don't need to take part in the interview if you don't want to. Participation is completely voluntary.
After you have read this information sheet, you will be given the opportunity to ask me any questions, and you can then choose if you want to take part in the interview or not.
If you choose to take part and during the interview, you decide you don't want to take part anymore, that is okay. You can choose to withdraw at any time without giving a reason. Please just tell me.
You can choose the interview date and time to not conflict with your working hours or other tasks. If you want to change something you have said or do not want the interview to be used anyway, you have the opportunity to withdraw your consent until the publication date.

What are the benefits of taking part in the interview?

By taking part in an interview as part of this research project, you will be helping me to understand and recognise what is health care access among migrant female sex workers in Thailand. This will inform valuable information about health care services toward migrant sex worker groups to make any necessary supports to the migrant women sex worker communities.
Participation in this study is based on volunteering, and you will be paid about 16 USD (500 THB) for your time and knowledge.

Could anything go wrong?

Nothing is likely to go wrong, but I may ask you some personal questions about your work in sex work, your health concerns and your opinions and experiences with health care services. However, I will ask these questions in a sensitive way, and you can say you would rather not answer any questions that you are not comfortable with answering. I will ensure that there are appropriately service providers' staff/volunteers available to offer any support during the interview if it is needed. If you feel uncomfortable or wish to stop participating in the interview at any time, that is okay. Further, you can reschedule the interview at the time and date you are free.

All information will be treated in the strictest confidence, and when I write up the findings, your name will not be used.

What will happen to the findings from the interview?

The information gathered during the interview will be used together with the findings from service provider's interviews to see trends and patterns about health care access among migrant female sex workers and whether it is helping individuals who are working as sex workers and what should be improved. Everyone's responses will be anonymised (any information that could be used to identify someone will be removed) before I do this. I will not share any of your sensitive information with any other organisation.

What will happen to the information I give during this study?

All the information that will collect from you during the interview will be kept confidential. I will record the interview on a password-protected voice recording device and securely type the interviews by me. The only person who will have access to the recording and the typed

transcript is me. Once I have the typed interview transcript, the voice recording will be permanently deleted. All your data will be kept in secure locked filing cabinets and on password-protected computers within the University of Edinburgh secure research offices. I will keep the typed transcripts for a maximum of seven years before they are permanently destroyed. No information I keep will contain any of your sensitive information, such as your name or address.

Who has checked the project follows ethical research guidelines?

The School of Health in Social Science Ethics Group at the University of Edinburgh has checked that the project follows ethical research guidelines.

What if I have questions or would like more information about the project?

If you have questions or would like more information about the project, please contact Paichit Amsri . ; LINE ID: Toi195413

What if I am unhappy or have a concern about the project?

If you are unhappy or have a concern about the project, please contact my supervisors of Research, Dr Fiona Cuthill: (Supervisor) and

Dr Elaine Haycock-Stuart: (Co-Supervisor)

What if I have a complaint about something that has happened in the project?

If you have any complaints about this research, please contact my supervisors

Dr Fiona Cuthill: (Supervisor) and

Dr Elaine Haycock-Stuart: (Co-Supervisor)

Finally, if you have any concerns about your feelings, please get in touch with staff/volunteers from SWING Thailand or EMPOWER outreach clinics you have already contacted. You also can contact the following free online site:

- SWING Thailand: +66 2 632 9501
- EMPOWER : +66 2 5268311
- Fountain of Life Women's Center: +66 38 415 881
- Mental Health Hotline by the Department of Mental Health: “1323”
- Online Therapy for Depression in Thailand

  WhatsApp: +91 9013-262626
- Thailand’s First Mental Health App; hivelive.com

  “Hive Live”

Thank you for taking the time to read this information.

PARTICIPANT INFORMATION SHEET

Information Sheet for a service provider

Research title: A thematic analysis of health care experiences while being a sex worker, barriers and opportunities in accessing health care: an NGO staff/volunteers perceptions and migrant female sex worker's views and experiences about health care provision in Thailand.

I would like to invite you to take part in an interview for a research study:

- This information sheet describes the research project, the interview I would like you to participate in, and why it is being done.
- Please read through the information carefully before you decide whether to take part in the interview. It is important you understand the purpose of the interview and what it will involve.
- If there are any points that are unclear or if you would like to find out more about the project, please contact Paichit Amsri

- If you would like to participate in the study after reading the information sheet, please contact Paichit Amsri or the organisation member who gave you this information sheet.

What is the research project?

This is an inviting letter for you to participate in a research study where the purpose is to understand better what health care access among migrant female sex workers in Thailand. This qualitative research will invite staff/volunteers (service providers) who support these women through organisations or projects (SWING and EMPOWER). You will be asked to join the interviews. Hopefully, your contributions from these interviews will offer important recommendations for future measures favourable to migrant sex workers group and those who work with them.
To increase knowledge about this health care access among migrant female sex worker groups, I want to talk to people who work to assist women who are working in the sex business. The interview will be conducted via LINE (audio/video) or mobile with people who may have supported migrant female sex workers. These interviews will be with me as a researcher, and I will ask various questions related to the healthcare services of this group. Important topics will be: what kind of health problems they have, where and how they seek health care and the attitudes about its care. In addition, I want to focus on your reflections on these topics, what needs to be improved in support of women and how your work improved these woman's health.

Why am I being asked to participate in this interview study?

You are being invited to participate in an interview for this study as you were identified as supporting migrant female sex workers. For this reason, I would like to hear more about your

views of delivery support for these women and what are health care services regardless of this group. Moreover, I would like to hear your perceptions about the barriers and opportunities for migrant sex workers when accessing health care.

Why is this information being collected, and what will it be used for?

I want to interview people who have supported migrant female sex workers from the local Thai organisation (SWING Thailand and EMPOWER Foundation). This will allow me to understand subjects regarding health care access among migrant female sex workers and make sure the research project is able to meet its aims. In addition, I will use the information collect in this study to inform those who already work directly with migrant women; increasing a better understanding of this research subject is central to assessing the current services and future policy proposals with the aim to improve care for migrant sex worker groups.

Who is running the project?

This research is used as part of the Doctor of Philosophy degree "Nursing studies**"** at the School of Health in Social Science, College of Arts, Humanities and Social Sciences.
The researcher who will conduct these interviews is a PhD student, has trained in interview techniques, and is passionate about improving people's health and wellbeing.

What will the interview involve?

Once you have read and understood this information sheet, I will ask that you complete and give the consent form (verbally with a recorder) to show that you agree to take part in the study. The interview will involve either a mobile or LINE (audio/video) interview at a time and place that is convenient for you. I will then asking you some questions related to your experiences in providing support for migrant female sex workers. I will also ask you questions about your current role in SWING or EMPOWER and how your role in supporting migrant female sex workers. The interview will be recorded on a small electronic voice recording device and will last about 60 minutes.

Do I have to take part in this interview?

No, you don't need to take part in the interview if you don't want to. Participation is completely voluntary.

After you have read this information sheet, you will be given the opportunity to ask me any questions, and you can then choose if you want to take part in the interview or not.

If you choose to take part and during the interview, you decide you don't want to take part anymore, that is okay. You can choose to withdraw at any time without giving a reason. Please just tell me.

What are the benefits of taking part in the interview?

By taking part in an interview as part of this research project, you will be helping me to understand and recognise what is health care access among migrant female sex workers in

Thailand. This will inform valuable information about healthcare services toward migrant sex worker groups to make any necessary supports to the migrant women groups.

Participation in this study is based on volunteering, and you will be paid about 16 USD (500THB) for your time and knowledge.

Could anything go wrong?

Nothing is likely to go wrong, but I may ask you some personal questions about your role in SWING or EMPOWER and your experiences with supporting migrant sex workers. However, I will ask these questions in a sensitive way, and you can say you would rather not answer any questions that you are not comfortable with answering. I will ensure that there are appropriately service providers' staff available to offer any support during the interview if it is needed. If you feel uncomfortable or wish to stop participating in the interview at any time, that is okay.

All information will be treated in the strictest confidence, and when I write up the findings, your name will not be used.

What will happen to the findings from the interview?

The information gathered during the interview will be used together with the findings from migrant sex workers interviews to see trends and patterns about health care access among migrant female sex workers and whether it is helping individuals who are working as sex workers. Everyone's responses will be anonymised (any information that could be used to identify someone will be removed) before I do this. I will not share any of your sensitive information with any other organisation.

What will happen to the information I give during this study?

All the information that will collect from you during the interview will be kept confidential. I will record the interview on a password-protected voice recording device and securely type the interviews by me. The only person who will have access to the recording and the typed transcript is me. Once I have the typed interview transcript, the voice recording will be permanently deleted. All your data will be kept in secure locked filing cabinets and on password-protected computers within the University of Edinburgh secure research offices. I will keep the typed transcripts for a maximum of five years before they are permanently destroyed. No information I keep will contain any of your sensitive information, such as your name or address.

Who has checked the project follows ethical research guidelines?

The School of Health in Social Science Ethics Group at the University of Edinburgh has checked that the project follows ethical research guidelines.

What if I have questions or would like more information about the project?

If you have questions or would like more information about the project, please contact Paichit Amsri ; LINE ID: Toi195413

What if I am unhappy or have a concern about the project?

If you are unhappy or have a concern about the project, please contact my supervisors of Research:

Dr Fiona Cuthill: (Supervisor) and

Dr Elaine Haycock-Stuart: (Co-Supervisor)

What if I have a complaint about something that has happened in the project?

If you have any complaints about this research, please contact my supervisors:

Dr Fiona Cuthill: (Supervisor) and

Dr Elaine Haycock-Stuart: (Co-Supervisor)

Finally, if you have any concerns about your feelings, please get in touch with SWING Thailand or EMPOWER outreach clinics you have already contacted. You also can contact the following online site:

- SWING Thailand: +66 2 632 9501
- EMPOWER : +66 2 5268311
- Fountain of Life Women's Center: +66 38 415 881
- Mental Health Hotline by the Department of Mental Health: “1323”
- Online Therapy for Depression in Thailand: WhatsApp: +91 9013-262626

Thank you for taking the time to read this information

APPENDIX F: Participant Information Sheet Thai

เอกสารชี้แจงผู้เข้าร่วมการวิจัยสำหรับเจ้าหน้าที่ (EMPOWER FOUNDATION/SWING Thailand)

การวิจัยเรื่อง การศึกษาการเข้าถึงและการได้รับบริการด้านสุขภาพของพนักงานบริการหญิงที่เป็นแรงงานข้ามชาติ

ชื่อผู้ทำวิจัย นางสาวไพรจิตร อ่ำศรี
สถานที่ติดต่อผู้วิจัย โทรศัพท์มือถือ 0627213898, LINE ID : toi195413, email ,

1. การวิจัยครั้งนี้ทำขึ้นเพื่อศึกษาการเข้าถึงและการได้รับบริการในระบบบริการสุขภาพในประเทศไทย ในกลุ่มพนักงานบริการหญิงที่เป็นแรงงานข้ามชาติ คุณได้รับเชิญให้เข้าร่วมการวิจัยครั้งนี้เนื่องจากคุณเป็นเจ้าหน้าที่จากมูลนิธิเอ็มพาวเวอร์หรือมูลนิธิเพื่อนพนักงานบริการ ที่มีประสบการณ์ตรงในการดูแลให้ความช่วยเหลือพนักงานบริการทั้งไทยและแรงงานข้ามชาติ
2. หากคุณตัดสินใจเข้าร่วมการวิจัยแล้ว ผู้วิจัยจะขอสัมภาษณ์คุณ/ให้คุณตอบแบบสอบถาม ในประเด็นเกี่ยวกับ ข้อมูลส่วนตัวเกี่ยวกับคุณ ความคิดเห็นของคุณในการดูแลให้บริการพนักงานบริการ โดยเฉพาะการเข้าถึง และการได้รับบริการด้านสุขภาพในกลุ่มพนักงานบริการหญิงที่เป็นแรงงานข้ามชาติ
3. เมื่อคุณเข้าร่วมการวิจัยแล้ว สิ่งที่คุณจะต้องปฏิบัติคือ ตอบแบบสอบถามตามความเป็นจริงด้วยตัวของคุณเอง แบบสอบถาม 1 ชุด ได้แก่ 1) แบบสอบถามข้อมูลส่วนบุคคลจำนวน 7 ข้อ 2) เข้าร่วมการสัมภาษณ์ออนไลน์กับผู้วิจัยแบบส่วนตัวทาง (โทรศัพท์/ไลน์แอปพลิเคชั่น/ Zoom business/MS Teams) ใช้เวลาทั้งสิ้นประมาณ 60 นาที (วัน/เวลาสัมภาษณ์คุณสามารถกำหนดเองได้โดยไม่มีผลรบกวนการทำงานของคุณ) คุณจะได้รับค่าตอบแทนสำหรับเวลาและความรู้ที่คุณได้แบ่งปันกับผู้วิจัยเป็นจำนวนเงิน 1,000 บาทถ้วน
4. ข้อมูลที่ได้จากการสัมภาษณ์/การตอบแบบสอบถาม ผู้วิจัยจะขออนุญาต บันทึกเสียง และถอดเทปบันทึกเสียง และจะดำเนินการทำลายข้อมูลตลอดจนข้อมูลอื่น ๆ ทั้งหมดที่เกี่ยวข้องกับคุณภายหลังเสร็จสิ้นการวิจัย
5. ประโยชน์ที่จะได้รับจากการวิจัยครั้งนี้ เพื่อเป็นข้อมูลพื้นฐานสำหรับการดูแลและทำความเข้าใจถึงการได้รับและการเข้าถึงระบบบริการสุขภาพสำหรับพนักงานบริการในประเทศไทย โดยเฉพาะอย่างยิ่งในกลุ่มพนักงานบริการหญิงที่เป็นแรงงานข้ามชาติ อย่างไรก็ตามคุณอาจเกิดความกังวลต่อการตอบคำถาม คุณสามารถเลี่ยงหรือปฏิเสธที่จะไม่ตอบคำถามที่ทำให้คุณรู้สึกไม่สบายใจ ผู้วิจัยจะให้คุณเป็นตรวจสอบคำตอบในแบบสอบถามและบทถอดเทปบันทึกเสียงบทสัมภาษณ์ทุกข้อด้วยตนเองก่อนนำไปสรุปผลการวิจัยหากคุณต้องการ
6. การเข้าร่วมวิจัยของคุณครั้งนี้เป็นไปตามความสมัครใจ คุณมีสิทธิในการเข้าร่วมโครงการวิจัยหรือถอนตัวออกจากโครงการวิจัยได้ตลอดเวลาโดยไม่มีผลกระทบใดๆทั้งสิ้น และไม่ต้องแจ้งให้ผู้วิจัยทราบล่วงหน้า ผู้วิจัยจะเก็บรักษาข้อมูลของคุณโดยใช้รหัสตัวเลขแทนการระบุชื่อ และสิ่งต่างๆที่อาจอ้างอิงหรือทราบได้ว่าข้อมูลนี้เป็นของคุณ ข้อมูลของคุณที่เป็นกระดาษแบบสอบถามจะถูกเก็บอย่างมิดชิด และปลอดภัยในตู้เก็บเอกสารและล็อคกุญแจตลอดเวลา สำหรับข้อมูลที่เก็บในคอมพิวเตอร์ของผู้วิจัยจะถูกใส่รหัสผ่าน ข้อมูลที่กล่าวมาทั้งหมดจะมีเพียงผู้วิจัยและอาจารย์ที่ปรึกษาเท่านั้นที่สามารถเข้าถึงข้อมูลได้ ผู้วิจัยจะรายงายผลการวิจัย

และเผยแพร่ผลการวิจัยในภาพรวม โดยไม่ระบุข้อมูลส่วนบุคคลของคุณ ดังนั้นผู้อ่านงานวิจัยจะทราบเฉพาะผลการวิจัยเท่านั้น สุดท้ายหลังจากผลการวิจัยได้รับการตีพิมพ์เผยแพร่ในวารสารเรียบร้อยแล้วข้อมูลทั้งหมดจะถูกทำลายภายใน 7ปี

7. หากคุณมีปัญหาหรือข้อสงสัยประการใด สามารถสอบถามได้โดยตรงจากผู้วิจัยในวันทำการรวบรวมข้อมูลหรือสามารถติดต่อสอบถามเกี่ยวกับการวิจัยครั้งนี้ได้ตลอดเวลาที่ นางสาวไพรจิตร อ่ำศรี หมายเลขโทรศัพท์ 0627213898 หรือที่ Dr Fiona Cuthill ( ) และ DR Elaine Haycock-Stuart (

อาจารย์ที่ปรึกษาหลัก

นางสาวไพรจิตร อ่ำศรี
ผู้วิจัย

หากท่านได้รับการปฏิบัติที่ไม่ตรงตามที่ได้ระบุไว้ในเอกสารชี้แจงนี้ ท่านจะสามารถแจ้งให้ Dr Matthias Schwannauer, head of School of Health in Social Science at the University of Edinburgh, Scotland: headofschool.health@ed.ac.uk, Tel: +44 (0)131 651 3954

APPENDIX G: Reflective journal

Fieldwork Focus	Reflective Commentary
Initial access and early interviews	With support from EMPOWER, I was able to connect with my first participants. These early conversations, mainly with service providers, helped me learn some key phrases used among sex workers and understand the broader context of healthcare discrimination. I reflected deeply after each interview, often surprised by how revealing and powerful their stories were.
Interviews with MWSWs	Speaking with MWSWs was emotionally moving. They were open and honest about their lives, challenges, and trauma. One participant spoke for nearly five hours about her journey into sex work. I was both fascinated and overwhelmed. It became clear that for some, the interview was also a moment of emotional release — a space where their voices could finally be heard.
Participant referrals and building trust	Undocumented participants later joined the study through snowball sampling. One woman told me no one had ever asked about her well-being in 18 years of sex work. She cried, thanked me, and later accessed EMPOWER services through the contact I provided. She even referred others. It reminded me of the power of simply listening with care.
Reflections on the insider–outsider role	As an outsider to participants' lived realities, I was constantly aware of my position. Some participants viewed me as a confidante, or even a therapist. I believe my empathetic approach allowed them to open up, and I see empathy not as a limitation, but as essential to qualitative, participant-led research.

Fieldwork Focus	Reflective Commentary
Data analysis and methodological decisions	Though I began with NVivo, I found manual analysis in Word better suited to my reflective style. It allowed me to stay close to the narratives and notice details that might otherwise have been missed. Themes were revised multiple times to ensure they truly reflected the lived realities participants had shared with me.
Doing fieldwork during COVID-19	I carried out my fieldwork during a time of ongoing COVID-19 restrictions and social anxiety. Though I conducted all interviews online or by phone, I stayed in a hotel in Chiang Mai, close to the communities I was studying. Being physically present helped me understand the local context, including where participants worked and how they connected with EMPOWER.
Participant-led interviews and use of LINE	Participants chose their interview method — most used LINE video, while two opted for phone. I allowed them full control over visibility. Some began with video on, then turned it off to feel safer discussing personal matters. This flexibility helped build trust and allowed participants to set their own boundaries.
Navigating ethical concerns	Given the criminalised nature of sex work and the undocumented status of some participants, recruitment and interviewing carried serious ethical implications. I relied on trust-based recruitment through EMPOWER and peer referrals, and always prioritised safety, informed consent, and confidentiality.
Facilitating open dialogue	Rather than using a rigid interview guide, I asked open-ended questions to let participants steer the conversation. Prompts like 'What brings you to Thailand?' and 'Can you tell me about your experiences?' helped us explore their stories in their own words, before moving into discussions about healthcare. This kept the interviews grounded in their lived realities.

APPENDIX H: INTERVIEW GUIDE

INTRODUCTORY PROCEDURE

Thank you again for taking part in this research on the experience of migrant women sex workers concerning health care access provision in Thailand.

- You were chosen to talk with me today because you have been known as someone who can communicate about the barriers and facilitators of healthcare access in Thailand.
- The interview questions are designed to support you in expressing your individual experiences and feelings associated with your received support and care.
- You are welcome to decline to reply to any subject that causes you distress. You are also able to leave from the study at any stage.
- Your privacy and confidentiality are of the utmost importance, and I will do everything possible to ensure privacy.
- There are no likely dangers related to contributing to this study.
- Your answers to the interview questions are precious. Thus, it is necessary to audiotape this discussion so that I can record everything you talk about.
- You might also see me writing notes throughout the interview, which I will quote in the data analysis stage of the study.
- I will also transcribe your audio report, and I will use an alternative approach to preserve privacy.
- I want to start recording this interview now. Is that all right with you?

(Audio record to start)

- To meet the university's human subject requests, respondents must read and give the Informed Consent Form delivered to you.
- Thank you for giving me your consent to participate in this study.
- To check, this text, which you agreed, declares that:

(a) Altogether, data collected will be kept confidential
(b) Your involvement is voluntary, and you can discontinue whenever you wish, and
(c) I do not mean to cause any damage.

- Do you have any questions or concerns about the interview or this form?
- I have prepared for this interview to last around 60-90 minutes.

- Do you have any concerns at this time?

INTERVIEW QUESTIONS FOR SEX WORKERS

Thank you very much for joining this interview. Do I have your agreement to audiotape this conversation? Thank you. We will get started.

Interview Questions:

1) Please tell me about your experience of moving to Thailand
(Please tell me about yourself; why did you want to travel and work here?)
2) Please tell me about your experience of working in Thailand
3) Please describe any views or concerns you had when you felt unwell during your work in Thailand. (Have you ever felt unwell while working and living in Thailand? How do you manage your physical and emotional health?)
4) Please tell me about your experience when you engaged in or received healthcare services in Thailand.
5) Please describe any feelings or thoughts you had when you accessed healthcare facilities in Thailand.
6) If you received services from any Thai healthcare facility, what was your experience(s)?
7) Please describe what you thought essential help/values as healthcare support for migrant women sex workers.
a. Probe 1: Could you tell me why you consider these services necessary?
b. Probe 2: What is your view of the quality of support received?
8) Is there anything else you would like to discuss regarding your experience when you accessed or received healthcare support?

Thank you very much for joining this interview. If I find that I need to gather further information, I will call you with follow-up questions. Is that okay with you?

- Also, I will show you a transcription of this interview when available and my primary notes and interpretations.
- Finally, I will ask that you give any comments or reviews within a specific timeframe.
- Could you please double-check your contact information and the email address you would like me to send this data to?
- Do you have questions for me?
- If not, thank you once more for joining this interview.

(Audio recording ends)

An interview guide, service providers

Theme: health needs of sex workers

1. What are your thoughts on the health concerns of migrant female sex workers?
    Follow-up: Is there a difference between the different groups (indoor/outdoor sex workers) of sex workers in terms of health needs and state of health?

Elaboration: Which group is most concerned with health-related issues?

2. Have you discussed health needs with this type of sex worker?

Follow-up: Is there anything they discuss or highlight more?

Elaboration: Can you give some examples?

Theme: health access

1. What is your idea of health access for these women?
    Follow-up: What do you think is important for them when they decide whether they seek healthcare in Thailand?

Follow-up: What do you think is essential for them to receive healthcare in Thailand?
    Elaboration: Can you think of some processes that can make it easier for this group to access healthcare?

2. Are many of these women asking you where they can get healthcare?

Follow-up: If so, where do you refer them?

Follow-up: Can you give an example?

3. How do these women solve chronic health problems or access treatments, which requires more inclusive healthcare?

Follow-up: Can you say something more about it?

4. What are the barriers for migrant female sex workers in accessing healthcare in Thailand?

5. What are the opportunities for migrant female sex workers in accessing healthcare in Thailand?

6. What should be done differently in providing healthcare access among migrant female sex workers in Thailand?

Theme: experiences with the healthcare system

1. Have you experienced/heard about how these women are treated by health workers in Thailand?

Follow-up: Do you have an example or story about this?

Theme: the role of the support system concerning health

1. Do you think the work you do affects the health of this group of sex workers?

Follow-up, if yes: How?

Follow-up: Have you received any feedback from these women?

Elaboration: What did you think about it?

2. Do you think that stigma and discrimination in health services affect the health of these women?

Follow-up, if yes: How?

3. What do you think about outreach work and the health of these women?

4. Have you ever given this group of sex workers information about health, and possibly provided healthcare?

Follow-up if yes: What kind of information or help did you provide?

Follow-up: Who contacted whom, where and how